August 12, 2019

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

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

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

Dear Secretary Azar and Mr. Severino:

The National Health Law Program (NHeLP) appreciates the opportunity to comment on the proposed rule (NPRM) on Section 1557 of the Patient Protection and Affordable Care Act (ACA) ("Health Care Rights Law" or "Section 1557"). For over fifty years, NHeLP has worked to improve health access and quality through education, advocacy and litigation on behalf of low-income and underserved individuals. Given both our history and our decade of work ensuring Section 1557 is implemented according to Congressional intent, we are especially concerned with the proposed changes sought by HHS.

Section 1557 is the key nondiscrimination provision of the Affordable Care Act (ACA).[1] It 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. Section 1557's protections extend to discrimination on the basis of race, color, national origin (including language access), sex, age, and disability by building on existing civil rights laws.[2] It is the first federal law to ban sex discrimination in health care. Section 1557 recognizes that individuals may be part of multiple protected classes and may face discrimination because they belong to one or more of these classes.

The Department of Health and Human Services (HHS) underwent an extensive process to develop regulations for Section 1557, including a Request for Information, proposed rule, and final rule.[3] HHS considered more than 24,875 public comments submitted for the 2016 rule.[4] This new proposed rule ignores the reasoned process HHS has already undertaken.

As an organization committed to upholding the civil rights of all persons, we strongly oppose the NPRM provisions which seek to eliminate and limit protections for individuals who are limited English proficient, LGBTQ+ persons, women and persons with disabilities and chronic conditions. Section 1557 addresses not only protections for each protected class covered, but the intersection of those protections. As such, an attack on the civil rights of one group in the NPRM is an attack on the civil rights of all. We strongly recommend that HHS not finalize any part of the proposed changes to the

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[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.].

[3] U.S. Dep't of Health & Human Servs., *Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities*, 78 Fed. Reg. 46558 (Aug. 1, 2013); U.S. Dep't of Health & Human Servs., *Nondiscrimination in Health Programs and Activities* (Notice of Proposed Rulemaking), 80 Fed. Reg. 54172 (Sept. 8, 2015); U.S. Dep't of Health & Human Servs.,*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] 81 Fed. Reg. 31376.

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.

II. Reasons for the Proposed Rulemaking

A. Section 1557 of the PPACA Does not Prevent or Limit Reconsideration of the Proposed Rule &
B. Litigation Challenging the Section 1557 Regulation

Rather than respond individually to each statement under II.A. and II. B. as outlined in the NPRM, we are providing comments for these statements based on our own organization. That said, we believe we have addressed each of these specific statements.

a. HHS posits specious reasons for revising the current Section 1557 regulations

HHS repeatedly cites to the preliminary injunction issued by a federal district court in the *Franciscan Alliance v. Azar* case as its reason for revising or eliminating much of the current Section 1557 regulations.[5] However, the preliminary injunction issued by Judge Reed O'Connor does not overturn the 2016 Final Rule in whole or in part; nor does it order HHS to revise the rule.[6] In its discussion of reasons to revise the current regulations, HHS fails to explain why it gives greater weight to Judge's O'Connor's preliminary injunction invalidating Section 1557's regulatory protections against gender identity discrimination, while ignoring the decisions reached by other courts upholding Section 1557's gender identity protections.[7] It is imprudent for HHS to invest considerable time and resources in a proposed rulemaking process based upon a legally-suspect preliminary injunction.

HHS further states that, in light of Judge O'Connor's preliminary injunction, the repeal or revision of current Section 1557 regulations would "minimize litigation risk."[8] This is an

[5] *E.g.*, 84 Fed. Reg. 27848, 27856, 27870.
[6] See generally *Franciscan Alliance v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016).
[7] *Prescott v. Rady Children's Hosp.*, 265 F. Supp. 3d 1090 (S.D. Cal. 2017), *Flack v. Wisconsin Dept. of Health Srvs*., 18-cv-309, 2018 WL 3574875 (W.D. Wis. Jul. 25, 2018), *Flack v. Wis. Dep't of Health Servs*., No. 18-cv-309-wmc, 2019 U.S. Dist. LEXIS 68824 *3 (W.D. Wis. Apr. 23, 2019), *Boyden v. Conlin*, No. 17-cv264-WMC, 2018 (W.D. Wis. September 18, 2018), *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018).
[8] 84 Fed. Reg. 27849.

absurd contention, since changes in the regulations will increase, rather than decrease, confusion and uncertainty. At the very least, HHS should wait until the pending legal challenges to the 2016 Final Rule are resolved, since even a final ruling from Judge O'Connor would not end litigation.[9]

Even if the ultimate resolution of *Franciscan Alliance* were at hand, current regulations for Section 1557 provide for the severability of any provision upon a holding of "utter invalidity or unenforceability."[10] The proposed rule not only ignores this provision, but eliminates it without explanation.

HHS fails to provide explanation, evidence, or reasoning when in its proposal to eliminate significant portions of the current Section 1557 regulations. HHS repeatedly cites to "independent" analyses apart from the proposed rule's Regulatory Impact Analysis ("RIA") and which are not specified or the underlying data and methodology of which are not publicly available.[11] In addition, as described in more detail below (*infra*, Section VI), HHS bases its RIA on a number of assumptions without providing any explanation or evidence of their bases.[12] We are therefore unable to fully comment on many aspects of HHS' revision and rollback of key regulatory protections.

Instead of providing, as HHS predicts, "finality, predictability, administrability (*sic*), consistency, relief of burdens, and clarity," the proposed rule, if finalized, would create confusion, uncertainty, noncompliance, and, without a doubt, legal challenges.[13] Of greater concern, however, are the countless individuals who will denied access to medically necessary care, or avoid seeking care altogether, because of ongoing, unchecked discriminatory practices by insurers and providers.

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[9] Since his confirmation to the federal bench in 2007, Judge O'Connor has issued final verdicts in only 1% of more than 3,000 cases heard. Of those decisions, one in five has been reversed, remanded, or vacated. See *Litigation Analytics Report for Hon. Reed O'Connor*, Westlaw Edge (last visited July 15, 2019), https://1.next.westlaw.com/Analytics/Profiler?docGUID=I2005BD7E1DD211B2BA18A50062060E54&contentType=judge&view=profile&dataOrchGUID=68f821f1f9404fdf986029b7644666ca&transitionType=LegalLitigation&contextData=(sc.Default)#/judge/I2005BD7E1DD211B2BA18A50062060E54/profile.

[10] 45 C.F.R. § 92.2(c).

[11] See *e.g.*, 84 Fed. Reg. 27858.

[12] See e.g., 84 Fed. Reg. 27876.

[13] 84 Fed. Reg. 27849.

Given these fundamental flaws in HHS reasoning for rolling back critically important regulations protecting against discrimination, we strongly urge HHS to withdraw this ill-conceived and haphazard "deregulatory action."[14]

b. The 2016 Final Rule properly blended substantive requirements and enforcement mechanisms of the referenced statutes

The proposed rule selectively cites to court cases involving Section 1557, offering an incomplete and distorted version of developing case law for enforcing Section 1557. The NPRM cites *SEPTA v. Gilead Sciences, Inc.,* a district court case out of Pennsylvania, for the notion that the statute imported the "various different standards and burdens of proof" into Section 1557, "depending on the protected class at issue."[15] The NPRM suggests that courts are settled on the issue and have clear standards for Section 1557 cases, when courts certainly are not.[16]

The NPRM largely ignores the decision of *Rumble v. Fairview Health Services* and subsequent case law in its discussion of enforcement mechanisms under Section 1557.[17] Its only mention of *Rumble* mischaracterizes its holding and provides the wrong year in its citation.[18] HHS suggests that the *Rumble* opinion aligns with *SEPTA,* despite the fundamental conflict between the two decisions.[19]

Rumble concludes that Section 1557's text provides a "new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff's protected class status."[20] *Rumble* has been repeatedly cited by federal courts for the interpretation that Section 1557 has a private right of action.[21] The *Rumble* court

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[14] *Id*.

[15] 102 F. Supp. 3d 688, 698–99 (E.D. Pa. 2015).

[16] See, e.*g*., *Doe One v. CVS Pharmacy, Inc*., 348 F. Supp. 3d 967, 981 (N.D. Cal. 2018) (stating that "[n]o consensus has yet emerged as to the standard for assessing ACA anti-discrimination claims" and describing the different standards of *Rumble* and *SEPTA*). Only one appellate decision has addressed this question to date, so there is also no consensus from the appellate courts. *See Doe v. BlueCross BlueShield of Tennessee, Inc*., 926 F.3d 235, 241 (6th Cir. 2019).

[17] *Rumble v. Fairview Health Servs*., 2015 WL 1197415 at *11 (D. Minn. 2015).

[18] *See* 84 Fed. Reg. 27873, citing to a nonexistent 2017 ruling. Presumably, HHS is referring to the 2015 decision cited above.

[19] *Id*.

[20] *Rumble v. Fairview Health Servs.,* 2015 WL 1197415 at *11 (D. Minn. 2015).

[21] *See, e.g., Callum v. CVS Health Corp.*, 137 F.Supp.3d 817, 845 (D.S.C. 2015); *Esparza v. Univ. Med. Ctr. Mgmt. Corp.*, No. CV 17-4803, 2017 WL 4791185, at *4 (E.D. La. Oct. 24,

further explains that allowing disparate impact actions for some plaintiffs but not others, depending on their protected class, would be an "absurd inconsistency" that would also leave courts with no clear standard when a plaintiff alleging discrimination belonged to more than one protected class.[22]

HHS also overstates the impact of pre-ACA cases and misrepresents their holdings when arguing that disparate impact claims are not available under Section 1557.[23] For example, the NPRM cites to *Crocker* for support, yet *Crocker* refused to make a decision on whether there was a private right of action for disparate impact discrimination under Section 504 and discussed the issue only in dicta.[24] HHS then makes a second leap that the *Crocker* dicta applies to Section 1557 claims.[25] In its analysis, HHS also fails to recognize that Congress passed Section 1557 as a key component of the ACA, a set of sweeping reforms that changed what health care and health insurance practices were acceptable and banning discriminatory activities that courts had previously allowed. Cases cited in the NPRM have overly relied on interpretations of the underlying statutes without recognizing the inherent shifts that ACA made in the health care realm. If Section 1557 were limited by the constraints of the referenced statutes, its passage would have been largely unnecessary, as the four civil rights statutes already apply to organizations "in the business of providing . . . health care."[26]

HHS' reliance on select case law to support regulatory changes is misleading and presents a distorted picture of Section 1557's enforcement mechanisms. The changes suggested in the proposed rule will not clarify the law, and may make it harder for people who experience discrimination to enforce their rights through administrative and judicial complaints.

2017); *Griffin v. Gen. Elec. Co.*, No. 1:15-CV-4439-AT, 2017 WL 8785572, at *3 (N.D. Ga. Dec. 6, 2017), aff'd, 752 F. App'x 947 (11th Cir. 2019); *Audia v. Briar Place, Ltd.*, No. 17 CV 6618, 2018 WL 1920082, at *3 (N.D. Ill. Apr. 24, 2018); *Ass'n of New Jersey v. Horizon Healthcare Servs., Inc.*, No. CV 16-08400(FLW), 2017 WL 2560350, at *4 (D.N.J. June 13, 2017); *York v. Wellmark, Inc.*, 2017 WL 11261026, at *16 (S.D.Iowa Sep. 06, 2017); *Briscoe v. Health Care Serv. Corp.*, 281 F.Supp.3d 725, 737 (N.D. Ill. 2017).

[22] *Rumble* at *11-12.

[23] 84 Fed. Reg. 27851.

[24] *Crocker v. Runyon*, 207 F.3d 314 (6th Cir. 2000).

[25] 84 Fed. Reg. 27851.

[26] See, *e.g.*, 29 U.S.C. § 794 (2018) (Rehabilitation Act).

c. The current regulations are already consistent with the regulations of HHS and other agencies

HHS vastly overstates the need for the Section 1557 regulations to be consistent with other HHS regulations and the regulations of other agencies, and the extent to which the current Section 1557 regulations are inconsistent with other regulations.

The current regulations underwent extensive review for consistency with the regulations of HHS and other agencies before they were promulgated. As HHS notes, Executive Order 12250 § 1-201 requires the Attorney General to "coordinate the implementation and enforcement of [Title VI, Title IX, Section 504 and a]ny other provision of other provision of Federal statutory law which provides, in whole or in part, that no person in the United States shall, on the ground of race, color, national origin, handicap, religion, or sex, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance."[27] In the case of the current Section 1557 regulations, DOJ did indeed review the rule before it was published. Another Executive Order, Executive Order 12866, explicitly requires that: "Each agency shall avoid regulations that are inconsistent, incompatible, or duplicative with its other regulations or those of other Federal agencies."[28] As required by that executive order the current Section 1557 rule was vetted by OMB/OIRA and deemed consistent with other regulations by HHS and other agencies.[29]. Despite HHS's suggestion to the contrary, the current Section 1557 rule was extensively reviewed by the executive branch for consistency with other regulations before it was finalized. HHS provides no explanation for why these review processes were not sufficient or failed to identify purported inconsistencies.

In the preamble to this proposed rule, HHS also cites 42 U.S.C. § 6103(a)(4) requiring consistency with other regulations.[30] That part of the Age Discrimination Act requires:

> the head of each Federal department or agency which extends Federal financial assistance to any program or activity by way of grant, entitlement, loan, or contract other than a contract of insurance or guaranty, shall transmit to the Secretary and publish in the Federal Register proposed regulations to carry out

[27] Cited at 84 Fed. Reg. 27851 n. 28.
[28] Executive Order 12866 § 1(b)(10).
[29] *See* Executive Order 12866 §§ 2(b), 3(f)(2), 4(c)(5); *see also* Executive Order 13563 § 1(a).
[30] Cited at 84 Fed. Reg. 27851 n. 28.

> the provisions of section 6102 [prohibiting age discrimination] and to provide appropriate investigative, conciliation, and enforcement procedures. Such regulations shall be consistent with the final general regulations issued by the Secretary [of HHS], and shall not become effective until approved by the Secretary.[31]

Since the 1557 final rule was promulgated by HHS, by the terms of this statutory provision, it did not need to undergo separate HHS review. Thus, this provision is simply not relevant to the question of consistency, since it only applies to other agencies besides HHS, and applies in the specific context of applying the provisions of the Age Discrimination Act. In any event, HHS drafted the final rule with knowledge of its prior regulations on age discrimination and crafted the rule to be consistent with its other regulations.

Moreover, the specific examples of purported inconsistencies given by HHS in the preamble are not actually inconsistent with the current Section 1557 regulations. For example, the fact that NIH has a policy that its grants should explain certain differences between males and females based on biological factors is not inconsistent with the current Section 1557 regulations' determination that discrimination on the basis of sex encompasses discrimination on the basis of gender identity.[32] Making a clinical distinction between two sexes based on factors such as sex chromosomes, gonads, sex hormones, and non-ambiguous internal and external genitals in no way negates the experience of discrimination by transgender people, whose gender identity does not match the sex they were assigned at birth. Nor does the fact that OCR has separately defined "gender" and "sex" separately in certain regulations imply that "gender" is a concept wholly unrelated to sex, such that discrimination on the basis of sex can never include discrimination based on gender identity or transgender status.[33] And the position taken by DOJ in Title VII litigation and an internal memo as to whether discrimination on the basis of sex includes discrimination on the basis of gender identity is completely irrelevant to the question of whether Section 1557 protects against discrimination on the basis of gender identity.[34] Rather, as described in more detail *infra* Section III.B, the current regulations that protect against discrimination on the basis of gender identity

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[31] 42 U.S.C. § 6103(a)(4).

[32] *See* 84 Fed. Reg. 27853-54.

[33] 84 Fed. Reg. 27854.

[34] 84 Fed. Reg. 27856-57. *See Kisor v. Wilkie*, 139 S. Ct. 2400 (2019) ("[A]n agency's reading of a rule must reflect its 'fair and considered judgment,' . . . . [so a] court should decline to defer, for example, to a merely 'convenient litigating position,' . . . or to a new interpretation that creates 'unfair surprise' to regulated parties.") (citations omitted).

appropriately implement Section 1557. In any event, the proposed changes to the regulations create just as many, if not more inconsistencies with current regulations as described throughout our comments below. This supposed basis for completely overhauling the current regulations is unsupported and unsound.

d. The Costs of the Final Rule Were Unnecessary and Unjustified

Please see our discussion under III.B regarding repealing the notice and tagline requirements as well as our comments regarding the Regulatory Impact Analysis.

III. Nondiscrimination in health programs or activities

Proposed Subpart A – General Provisions

§ 92.2 Nondiscrimination Requirements & § 92.3 Scope of Application

a. The ACA's nondiscrimination protections have broad applicability and scope

Prior to the ACA, health insurance companies routinely discriminated by denying coverage to individuals with pre-existing conditions. Insurance companies charged women higher premiums than men, and often imposed annual and lifetime caps on benefits, which disproportionately affected people living with serious, chronic, or life-threatening medical conditions.

Congress passed the ACA to put an end to these discriminatory practices. The ACA requires guaranteed issue of coverage in the individual and small group health insurance markets so that no one can be denied health insurance due to a preexisting condition.[35] Health insurers may no longer exclude coverage of a preexisting condition.[36]

The ACA further prohibits discrimination against individual participants and beneficiaries based on health status or medical condition, and it prevents insurers from imposing annual or lifetime limits on benefits.[37] The ACA also sought to end discrimination in the types of health benefits offered by requiring most individual and small group health

[35] 42 U.S.C. § 300gg-1.
[36] *Id*.
[37] 42 U.S.C. §§ 300gg–4; 300gg-11.

plans to provide comprehensive health benefits in ten broad categories of coverage, known as Essential Health Benefits, or EHBs.[38]

In the 2016 Final Rule, HHS acknowledged the invidious nature of discrimination prior to the ACA:

> Prior to the enactment of the ACA, insurance companies were allowed to impose higher premiums on women or deny women coverage altogether. If issuers did cover women, they frequently did not cover a number of women's health services, including routine preventive services, such as pap smears or mammograms. Insurance premiums previously could differ by sex, and were often higher for females relative to males. The ACA prohibits differential treatment based on sex, includes maternity coverage essential health benefits, and requires non-grandfathered plans to cover women's preventive services without copays, among other benefits.[39]

In the 2016 Final Rule, HHS further highlighted the purposes of the ACA and how Section 1557's protections are inexorably 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."[40] 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." [41]

Congress has repeatedly rejected attempts to repeal the ACA.[42] The ACA's protections, including Section 1557, remain vitally important for persons with preexisting conditions and those who experience discrimination by health insurance companies and providers. HHS' proposal to rewrite or eliminate regulations implementing Section 1557 is nothing less than an end run around the ACA's statutory protections against discrimination.

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[38] 42 U.S.C. § 18022.

[39] 81 Fed. Reg. 31460.

[40] 81 Fed, Reg. 31379.

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

[42] *See* C. Stephen Redhead & Janet Kinzer, *Legislative Actions in the 112th, 113th, and 114th Congresses to Repeal, Defund, or Delay the Affordable Care Act*, Congressional Research Service (Feb. 7, 2017), https://fas.org/sgp/crs/misc/R43289.pdf.

b. The proposed rule contravenes Congress' intent to broadly apply the ACA's nondiscrimination protections

Section 1557, 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, including Medicare and the Indian Health Service (IHS); 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.[43] If an entity is principally engaged in providing or administering health services or health insurance coverage, the current regulations state that all of its activities are covered by Section 1557 if any part receives federal financial assistance.[44]

The current regulations are consistent with Congress's intent in enacting Section 1557. Congress's intended Section 1557 to build and expand upon existing civil rights laws, while providing broad protection against discrimination in health care. Moreover, Congress has repeatedly expressed that it intends civil rights laws to be broadly interpreted in order to effectuate their remedial purposes.[45]

The proposed rule seeks to significantly narrow the scope and applicability of Section 1557 contrary to the plain meaning of the statute and well-established implementation of civil rights laws.

c. HHS proposed definition of federal financial assistance is overly narrow and inconsistent with other regulations

HHS proposes to eliminate the current definition of federal financial assistance (FFA) under Section 1557, and to construe narrowly what entities qualify as a recipient of FFA. This proposed interpretation is inconsistent with Section 1557, and with other HHS regulations defining FFA recipients. For example, in the health care refusals rule *Protecting Statutory Conscience Rights in Health Care* finalized in May 2019, HHS defined FFA broadly as:

1) grants and loans of Federal funds;

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[43] 42 U.S.C. § 18116(a); 45 C.F.R. §§ 92.2(a), 92.4.

[44] 45 C.F.R. § 92.4.

[45] *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").

2) "the grant or loan of Federal property and interests in property;
3) the detail of Federal personnel;
4) "the sale or lease of, and the permission to use (on other than a casual or transient basis), Federal property or any interest in such property without consideration or at a nominal consideration […]; and
5) "any agreement or other contract between the Federal government and a recipient that has as one of its purposes the provision of a subsidy to the recipient.[46]

HHS explained that this definition "mirrors the definition used in the Department's regulations implementing Title VI, and is intended to carry the same meaning as it has traditionally been understood to carry in the application of those regulations."[47] HHS further argues that modelling the health care refusals' FFA definition on Title VI regulations will make compliance easier since entities subject to this regulation "will be sufficiently familiar with that meaning to understand its application in this final rule."[48]

The 2016 Final Rule defines FFA in the same way – adding only clarifications regarding subsidies and contracts as required by statute and reiterating FFA includes "grants, loans, and other types of assistance in accordance with the definition of Federal financial assistance in the regulations implementing Section 504 and the Age Discrimination Act… and Title IX."[49] This interpretation flows from the text and context of Section 1557, and is correct.

HHS now proposes to eliminate all definitions under Section 1557, including FFA and recipients, and to instead interpret both FFA and recipients narrowly. As justification, HHS contends that the 2016 Final Rule exceeded the bounds of the statute by describing FFA which HHS has a primary responsibility for administering, as well as FFA in which HHS "plays a role in administering.'"[50] (See further discussion on FFA in which HHS "plays a role" in subsection (d) below). Not only is this interpretation inconsistent with Section 1557, but it is inconsistent with HHS's own regulations. The 2019 health care refusals rule does not limit applicability to assistance HHS has a

[46] 45 C.F.R. § 88.2.
[47] 84 Fed. Reg. 23193.
[48] *Id*. citing to 45 C.F.R. § 80.13(f).
[49] 81 Fed. Reg. 31467. In the 2016 Final Rule, HHS relies on Title IX regulations to establish that premium tax credits, while paid to the individual (and for the benefit of the individual) amount to financial assistance for the institution (e.g., insurers and the QHPs they provide) – just as student loans or grants are for the student, but ultimately paid to the institution. 81 Fed. Reg. 31383.
[50] 84 Fed. Reg. 27861, citing 45 C.F.R. § 92.4.

primary responsibility for administering, but instead broadly encompasses "grants and loans of Federal funds" as part of its definition of FFA.[51]

In the Section 1557 proposed rule, HHS does not explain why it defines FFA very broadly for the purposes of allowing providers to deny medically necessary care based upon religious or moral grounds in one regulatory context, yet defines FFA very narrowly for purposes of nondiscrimination in this proposed rule. The proposed, narrow interpretation of FFA is unjustified, and inconsistent with its other regulations defining FFA and is certain to cause confusion about Section 1557's applicability.

Further, if this change 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. Exempting STDLI plans from Section 1557's protections is not consistent with Congress's intent to provide broad protection against discrimination in health care.

We oppose eliminating the current regulation defining FFA, because HHS' selective interpretation that FFA applies narrowly under Section 1557 is incorrect.

d. Section 1557 extends to federal financial assistance in which HHS "plays a role"

The 2016 Final Rule recognizes that premium tax credits constitute FFA which subjects Qualified Health Plans (QHPs) and their issuers to Section 1557 protections.[52] However, the proposed rule says that only FFA administered by HHS constitutes FFA for purpose of the applicability of the rule, since premium tax credits are ultimately provided by the Internal Revenue Service (IRS).[53] The proposed rule also eliminates language in the current rule saying it applies to FFA that HHS "plays a role" in administering.[54]

HHS' proposal would create confusion and seemingly attempts to exempt key parts of ACA Marketplace coverage from Section 1557 regulations. HHS states that QHPs "may" still be subject to HHS regulations and enforcement for Section 1557 on "other

[51] 45 C.F.R. § 88.2.
[52] *See* 45 C.F.R. § 92.4.
[53] 84 Fed. Reg. 27861.
[54] 84 Fed. Reg. 27859.

grounds."[55] Later, HHS says QHPs are subject to HHS regulations as Title I entities (see discussion in subsection (e) below).[56]

Under the proposed rule, the Marketplaces would presumably be covered as entities created under Title I of the ACA. However, premium tax credits and other functions, such as income, identity, and other verifications performed through the data hub might not be. The result would be confusion and fragmentation in applicability of Section 1557.

e. The proposed rule creates confusion regarding its applicability to Title I entities

In the proposed rule, HHS says that "exchange plans" *may* be subject to Section 1557; and QHPs *are* subject to Section 1557 because they are sold through exchanges created by Title I.[57] The ACA defines QHPs, stating that they must meet certification standards established by the exchange "through which such plan is offered."[58] However, stand-alone dental plans and catastrophic plans are also sold through exchanges created by Title I. HHS does not explain why or when an "exchange plan" that is not a QHP would be exempt from Section 1557.

QHPs and other plans sold through exchanges are subject to Section 1557 in two ways – they receive FFA and are entities created under Title I. Instead of adding clarity, HHS' proposed rule creates considerable confusion by suggesting that some exchange plans are subject to Section 1557 while others are not.

f. HHS seeks to exempt itself and other federal programs and agencies from Section 1557's nondiscrimination requirements

The plain language of Section 1557, as well as the 2016 Final Rule, establishes that any health "program or activity" administered by an Executive agency is subject to the law's provisions.[59] However, the proposed rule seeks to exempt from Section 1557 most federal health programs and agencies administering those programs. HHS imagines that Congress sought to limit application Section 1557 only to federal health programs or activities created under Title I of the ACA. This theory stands contrary to the statutory text, design, and intent of Section 1557 and the ACA.

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[55] 84 Fed. Reg. 27861.
[56] *Id*.
[57] 84 Fed Reg. 27861 (emphasis added).
[58] 42 U.S.C. § 18021(a)(1)(A).
[59] 42 U.S.C. § 18116 (a); 42 C.F.R. §§ 92.1, 92.2, 92.4.

HHS' new interpretation of Section 1557 in effect changes the word "or" to "and," specifying that the law applies to health programs or activities administered by an Executive agency "and" created under Title I.[60] This reading of statute would create a surplusage. If Congress had intended to limit Section 1557 only to those entities created under Title I, it would not have included the clause pertaining to executive agencies. *See*, *e.g.*, *Colautti v. Franklin*, 439 U.S. 379, 392 (1979) ("Appellants' argument . . . would make either the first or the second condition redundant or largely superfluous, in violation of the elementary canon of construction that a statute should be interpreted so as not to render one part inoperative.").[61]

Moreover, if implemented, it would lead to a situation whereby recipients of FFA would be subject to Section 1557, but the programs themselves, and the agencies administering them, would be exempt. For example, under HHS new interpretation, state Medicaid programs would be subject to Section 1557 as recipients of FFA, but the Centers for Medicare & Medicaid Services, which administers these programs, would be exempt. Such an interpretation is not only inconsistent with the plain meaning of Section 1557, but it is also inconsistent with section 504, and therefore likely to cause significant confusion. HHS and all its components, including CMS, the Health Resources Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA), are subject to section 504's prohibition on discrimination.[62]

We strongly urge HHS to retain the current regulations addressing the applicability of Section 1557 and not finalize the proposed 45 C.F.R. § 92.3.

g. Health insurance is health care

The current definition of "health program or activity" promulgated by HHS in the 2016 Final Rule cites to the Civil Rights Restoration Act's ("CRRA") definition of "program or activity" as including "all of the operations of an entity [that is] principally engaged" in a covered service.[63] HHS explained that its interpretation of "principally engaged" follows the approach of the CRRA, which it says Congress included in Section 1557 via the four

[60] 84 Fed. Reg. 27862.
[61] See also, *Yates v. United States*, 135 S. Ct. 1074, 1085 (2015) (plurality opinion) (declining to read statute so as to "significantly overlap" with a distinct statute, resisting a reading that would "render superfluous an entire provision passed in proximity as part of the same Act").
[62] 29 U.S.C. § 794; 45 C.F.R. Part 85.
[63] 81 Fed. Reg. 31385.

civil rights statutes referenced therein.[64] HHS acknowledges that under the CRRA, "the entire program or activity is required to comply with the prohibitions on discrimination if any part of the program or activity receives Federal financial assistance."[65] HHS reasonably concluded because "Congress adopted a similar approach with respect to the scope of health programs and activities covered by Section 1557. If any part of a health care entity receives Federal financial assistance, then all of its programs and activities are subject to the discrimination prohibition."[66]

However, in the proposed rule, HHS seeks reverse the current rule, positing that providing health care "differs substantially" from providing health insurance coverage.[67] As such, HHS seeks to exempt a broad swath of health insurance companies from the application of Section 1557. This nonsensical result would, if fully implemented, would significantly reduce the application of the law through regulation. Moreover, it is inconsistent with the plain language of Section 1557 and Congress's intent.

HHS provides no support for its tortured interpretation that health insurance is not a health program or activity within the meaning of Section 1557. An insurer does not simply process claims. Insurers design benefits, establish formularies, payment structures, and networks. Insurers conduct prior authorization, and establish 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.[68] In the 2016 Final Rule, HHS directly addressed the responsibility of insurers to comply with Section 1557 when insurers act as third party administrators for self-insured plans.[69]

HHS' new interpretation, that health insurance is not health care, is not only contrary to the design and intent of the ACA but is contrary to the plan language of Section 1557 which applies to "*any* health program or activity."[70] Thus, at a minimum, Section 1557's

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[64] *Id*. at 31386.
[65] *Id*.
[66] *Id*. See also 45 C.F.R. § 92.4.
[67] 84 Fed. Reg. 27850.
[68] See, *e.g.*, Institute of Medicine*, Controlling Costs and Changing Patient Care? The Role of Utilization Management* 13 (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).
[69] 81 Fed Reg. 31432.
[70] 42 U.S.C. § 18116(a) (emphasis added).

applicability all of the operations of an entity principally engaged in health care, including health insurers, is the only plausible reading of the CRRA and Section 1557.

As HHS emphasized in the 2016 Final Rule, applying Section 1557 to all the operations of a health insurer, or any other health program or activity, if any part receives FFA, is the very purpose of the ACA and its nondiscrimination protections:

> 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.[71]

The proposed rule makes no mention of the potential consequences to millions of people if health insurance companies were exempt from Section 1557.

However, in the 2016 Final Rule, HHS explained:

> 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.[72]

Without question, Congress intended the ACA and its key nondiscrimination provision, Section 1557, to broadly provide protections against insurance company abuses. The very notion that HHS would seek to exempt insurers from nondiscrimination requirements defies rational explanation. We oppose proposed § 92.3.

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[71] 81 Fed. Reg. 31386.
[72] 81 Fed. Reg. 31444.

§ 92.4 Assurances required

We strongly support having assurances required for compliance with Section 1557 for those receiving federal funds.

§ 92.5 Enforcement Mechanisms

We oppose the proposed changes to § 92.301 as newly designated § 92.5. HHS's proposed rule incorrectly limits the remedies available under Section 1557. Congress intentionally designed Section 1557 to build and expand on prior civil rights laws such that individuals seeking to enforce their rights would have access to the full range of available civil rights remedies and not be limited to only the remedies provided to a particular protected group under prior civil rights laws. Section 1557 expressly provides individuals access to any and all of the "rights, remedies, procedures, or legal standards available" under the cited civil rights statutes, regardless of the type of discrimination. Rather than recognizing that the statute creates a single standard for addressing health care discrimination, HHS's interpretation of the statute in these regulations as amended and re-designated would instead create multiple piecemeal legal standards and burdens of proof derived from different statutory contexts. HHS's interpretation is contrary to the statutory language and Congress's intent.

The proposed language is not a valid interpretation of Section 1557. While the statute expressly sets out the grounds for discrimination by reference to the cited civil rights statutes, it does not set forth separate remedies, legal standards, and burdens of proof applicable to each prohibited basis of discrimination based on the statutes from which each was incorporated.[73] 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."[74] The use of the disjunctive "or" indicates that any of the enforcement mechanisms applicable under any of the incorporated statutes are available to every claim of discrimination under Section 1557, regardless of the particular type of discrimination triggering the claim. Applying standard rules of construction, all the enforcement mechanisms provided for and available under each of the referenced statutes in Section 1557 are available to every claim of discrimination under Section 1557.

[7373] *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) ("[T]here is no indication in § 1557 that each listed statute's enforcement mechanisms apply only to its own protected classes.").

[74] 42 U.S.C. § 18116(a) (emphasis added).

It is also necessary to read Section 1557 as establishing a single standard for addressing health care discrimination to avoid "patently absurd consequences."[75] HHS's reading of Section 1557 in this proposed section "would lead to an illogical result, as different enforcement mechanisms and standards would apply to a Section 1557 plaintiff depending on whether the plaintiff's claim is based on her race, sex, age, or disability."[76] Moreover, courts would be left without guidance on how to address intersectional claims—should a person who alleges discrimination on the basis of both race and age be subject to the standards and enforcement mechanisms under a title IX analysis or the Age Discrimination Act? 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."[77] Thus, the law aimed to make it easier for people to file complaints of intersectional discrimination in one place. The proposed rule will only make it harder for people to file complaints. Congress explicitly adopted one provision to prohibit all discrimination in health care. It strains the imagination to read that one provision would require agencies and courts to apply a hodgepodge of standards and enforcement mechanisms.

Further, the proposed changes to the regulation do not comport with congressional intent. Congress did not intend that the enforcement mechanisms and standards available under Section 1557 be tethered to the nature of the claim. Rather, in enacting Section 1557, Congress sought to "create a new right and remedy in a new context without altering existing laws."[78] Congress has repeatedly expressed that it intends civil rights laws to be broadly interpreted in order to effectuate their remedial purposes.[79] By narrowly limiting the legal standards and burdens of proof that apply to those who have experienced health care discrimination, HHS's interpretation in the proposed rule would ignore Congress's intent to provide broad remedies to address discrimination. HHS should not finalize the proposed language in § 92.5.

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[75] *United States v. Brown*, 333 U.S. 18, 27 (1948).
[76] See *Rumble*, 2015 WL 1197415, at *11.
[77] 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.
[78] *Rumble v. Fairview Health Servs*., No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at *11 n.6 (D. Minn. Mar. 16, 2015).
[79] *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").

As HHS notes, some courts have interpreted Section 1557 to apply different enforcement mechanisms and standards depending on whether someone's claim is based on race, sex, age, or disability. These cases rely on the fact that Congress incorporated the enforcement mechanisms from the four cited civil rights statutes to interpret Section 1557 to limit the standards and enforcement mechanisms available based on the statute that defines the grounds for discrimination.[80] But the courts in these cases miscomprehend the statutory language and context. As discussed above, Section 1557 expressly provides for broad and uniform enforcement, consistent with Congress's intent that civil rights laws provide broad remedies. While Congress could perhaps have more clearly articulated its intent to establish a single statutory standard for determining discrimination and enforcing Section 1557, its failure to perfectly articulate such a standard does not necessitate the narrow reading of the statute articulated in the proposed rule and the cases it cites.[81] These cases overly rely on interpretations of the underlying statutes without recognizing the inherent shifts that ACA made in the health care realm.[82] If Section 1557 were limited by the constraints of the referenced statutes, its passage would have been largely unnecessary, as the four civil rights statutes already apply to organizations "in the business of providing . . . health care."[83] HHS's interpretation of the statute is incorrect and proposed § 92.5 should not be finalized.

Section 1557 is the law. 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. Many people who

[80] *See, e.g., Southeastern Pennsylvania v. Gilead*, 102 F. Supp. 3d 688, 699 n.3 (E.D. Pa. 2015); *Briscoe v. Health Care Serv. Corp*., 281 F. Supp. 3d 725, 738 (N.D. Ill. 2017); *see also, e.g., Doe v. BlueCross BlueShield of Tennessee, Inc*., 926 F.3d 235, 241 (6th Cir. 2019).

[81] *See King v. Burwell*, 135 S. Ct. 2480, 2492 (2015) (noting that the ACA "contains more than a few examples of inartful drafting" and thus emphasizing the importance of considering the broader context of the statute).

[82] The Supreme Court has recognized that the broader purpose of the ACA is to "expand insurance coverage. . . . [and] ensure that anyone can buy insurance." *King*, 135 S. Ct. at 2493. An expansive prohibition on discrimination in health care is key to ensuring that *anyone* can buy insurance. Thus other courts have properly concluded that a single standard and burden of proof apply under Section 1557: "looking at Section 1557 and the Affordable Care Act as a whole, it appears that Congress intended to create a new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff's protected class status." *Rumble*, 2015 WL 1197415, at *10.

[83] *See, e.g*., 29 U.S.C. § 794 (2018) (Rehabilitation Act).

experience discrimination cannot access the court system due to cost.[84] When people can afford to bring judicial actions, they generally receive little in the form of compensatory relief.[85] This could make it even more expensive for people to enforce their rights, deterring them from filing complaints of discrimination.

Thus, we particularly oppose HHS's proposal to replace current § 92.301(b) with proposed § 92.5(b). 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 existence of such a right is clear from the statutory language in Section 1557, which explicitly references and incorporates the "enforcement mechanisms" of the four civil rights laws listed—all of which contain a private right of action. Once again, this understanding is also consistent with Congress's intent that civil rights laws be broadly interpreted to effectuate the remedial purposes of those laws. Removing the regulatory language that makes clear that private right of action and monetary damages are available to redress violations of 1557 will serve only to confuse. HHS should not finalize proposed § 92.5(b).

§ 92.6 Relationship to Other Laws

HHS proposes to re-designate and combine current § 92.2 and § 92.3 into a new § 92.6, titled "Relationship to Other Laws." These changes are unnecessary, and the proposed revisions conflict with the statutory language and congressional intent.

a. The deletion of current § 92.3(a) and amendments to current § 92.3(b) are unnecessary and confusing

HHS proposes to entirely delete what is now § 92.3(a), which provides a rule of interpretation for Section 1557. HHS also proposes to amend current § 92.3(b) and re-designate the amended language as § 92.6(a). These proposed changes are unnecessary and should not be finalized. The deletion of current § 92.3(a) is likely to cause confusion, since it will leave both entities and courts with less information about

[84] *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.

[85] 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.

HHS's intent with respect to Section 1557. The current provision makes clear that the four pre-existing civil rights laws referenced by Section 1557 set the floor in terms of the scope of protections afforded by Section 1557. This is consistent with Congress's intent that Section 1557 build and expand upon these existing civil rights laws, while providing broad protection against discrimination in health care. We share HHS's objective of providing clear guidance on Section 1557's scope and application to covered entities and other stakeholders to reduce unnecessary litigation. The deletion of this provision will have the opposite result; creating more confusion among stakeholders that is likely to lead to more litigation over the scope and interpretation of Section 1557. HHS should not finalize the proposed revisions.

b. Section 1557 does not incorporate exemptions beyond those expressly enumerated in the ACA

HHS proposes to substantially amend current § 92.2 and re-designate the amended language as § 92.6(b). We oppose this change. Nothing in the legislative history or language of the regulation itself permits exceptions to Section 1557's prohibition on discrimination. Moreover, existing statutes that allow individuals and entities to refuse to provide certain services are more than sufficient to accommodate any religious objections. HHS's attempt to import some of these statutes into Section 1557 by regulation goes too far. The proposed new language is inconsistent with the statutory text of Section 1557, conflicts with the purpose of the ACA, and will cause confusion among entities.

The proposed rule would impose exemptions, rights, and protections from the following laws into Section 1557:

- Section 1553 of the Patient Protection and Affordable Care Act (42 U.S.C. 18113);
- Section 1303 of the Patient Protection and Affordable Care Act (42 U.S.C. 18023);
- Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.);
- Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.);
- The Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.);
- Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794);
- Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.);
- The Architectural Barriers Act of 1968 (42 U.S.C. 4151 et seq.);
- The Americans with Disabilities Act of 1990, as amended by the Americans with Disabilities Act Amendments Act of 2008 (42 U.S.C. 12181 et seq.);

- Section 508 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794d);
- The Coats-Snowe Amendment (42 U.S.C. 238n);
- The Church Amendments (42 U.S.C. 300a-7);
- The Religious Freedom Restoration Act (42 U.S.C. 2000bb et seq.);
- The Weldon Amendment (Consolidated Appropriations Act, 2019, Pub. L. 115-245, Div. B sec. 209 and sec. 506(d) (Sept. 28, 2018)); and
- Any related, successor, or similar Federal laws or regulations.

Neither statutory nor legislative history supports adding exemptions to Section 1557, and the only exceptions to Section 1557's broad nondiscrimination mandate are specifically and explicitly contained in Title I of the ACA, including §§ 1553 and 1303.[86] Because the exemptions contained in those two provisions are already explicit, there is no need to incorporate them into this regulation.

In addition, while Title VI, Title VII, Title IX, the Age Discrimination Act, and Section 504 of the Rehabilitation Act are referenced in Section 1557, the plain language of the statute does not incorporate any exemptions contained in those statutes. Thus, this regulation goes too far in attempting to import exemptions from these statutes into Section 1557. For example, while it is true that Title IX contains limited exceptions to its protection in certain circumstances, these exceptions are not incorporated into Section 1557. First, because those limited exceptions are not explicitly stated in Section 1557, they cannot be read to apply to it, therefore, Section 1557 does not import any exceptions from Title IX. Section 1557 references Title IX solely for the ground on which it prohibits discrimination, which is sex.[87] Since Title IX has codified pregnancy discrimination as a form of sex discrimination, and in light of Section 1557's expansive and unprecedented antidiscrimination provisions, it is clear that refusals that center on reproductive health care—including contraception, sterilization, abortion, and other reproductive health care services—are not protected under Section 1557, as they comprise a kind of sex discrimination. The sex discrimination provision, therefore, limits the scope of permissible health care refusals.

HHS considered in its 2016 final rule a blanket religious exemption, and determined such an exemption is not needed. In its assessment, HHS concluded that application of

[86] *See* 42 U.S.C. § 18116(a).

[87] The Supreme Court held in a similar context that the incorporation by reference of protections from one civil rights statute into another does not mean that the limitations of the first apply to the second. *See Consolidated Rail Corp. v. Darrone,* 465 U.S. 624 (1984) (holding that Section 504's reference to Title VI's remedies, procedures, and rights did not import limitations from Title VI not expressly provided in Section 504).

Section 1557 would not be required of federally funded programs and entities if doing so would violate existing religious freedom and conscience protections. The Department noted that:

> certain protections already exist in Federal law with respect to religious beliefs, particularly with regard to the provision of certain health related services. For example, [the 2016] rule would not displace the protections afforded by provider conscience laws, RFRA, provisions in the ACA related to abortion services, or regulations issued under the ACA related to preventive health services.[88]

Moreover, the proposal fails to specify exactly what exemptions it would incorporate into Section 1557. For example, the Americans with Disabilities Act (ADA) does not contain a defined list of exemptions, so it is completely unclear what the proposed language would include. The ADA has that list of miscellaneous provisions that, among other things, exempts certain people or conditions from definition of disability – but without additional explanation from HHS it is not clear who or what HHS is proposing to exempt. The ADA also explicitly exempts from its application "an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks," and for "a person or organization [that] establish[es], sponsor[s], observ[es] or administer[s] the terms of a bona fide benefit plan."[89] In addition, Title I of the ADA contains a list of communicable diseases that are exempt from employment protection, and some religious exemptions, and Title III contains other exemptions for private clubs or religious institutions. These exemptions do not appear in Section 1557 and run counter to its purpose. In any event, since HHS has not delineated what exemptions it proposes to import into Section 1557 by referencing the ADA and other statutes, we are not able to provide meaningful comment on this proposal.

Moreover, the Architectural Barriers Act, the ADA, Section 508 of the Rehabilitation Act, the Coats-Snowe Amendment, the Church Amendments, the Religious Freedom Restoration Act, the Weldon Amendment, and any other federal laws are not mentioned at all in Section 1557. Nor is there is anything in the legislative history or language of the ACA that permits additional exceptions to Section 1557's prohibition on discrimination. Any exemption to the antidiscrimination mandate of the ACA would undermine the goal of health reform to combat practices that have negatively and profoundly impacted the health of the protected classes enumerated in Section 1557.

[88] 81 Fed. Reg. 31379.
[89] 42 U.S.C. § 12201(c).

The proposed regulation may affect overall access to care for women and others. Because the proposed regulation incorporates Title IX's religious exemption, a religious provider could say that they do not have to comply with sex discrimination protections. 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 health care providers and entities could allow their beliefs to determine patient care and open the door to discrimination. If implemented, this could allow religiously-affiliated hospitals and other health care entities to discriminate against people seeking reproductive health services and LGBTQ people. Providers, hospitals, or clinics could also be permitted to refuse to provide health services to a woman who is not married.

We oppose the inclusion of Title IX exemptions since they do not apply to health care situations and settings. As HHS concluded in the 2016 Final Rule:

> [S]tudents or parents selecting religious educational institutions typically do so as a matter of choice; a student can attend public school (if K–12) or choose a different college. In the healthcare context, by contrast, individuals may have limited or no choice of providers, particularly in rural areas or where hospitals have merged with or are run by religious institutions. Moreover, the choice of providers may be even further circumscribed in emergency circumstances.
>
> Second, a blanket religious exemption could result in a denial or delay in the provision of health care to individuals and in discouraging individuals from seeking necessary care, with serious and, in some cases, life threatening results. Thus, it is appropriate to adopt a more nuanced approach in the health care context, rather than the blanket religious exemption applied for educational institutions under Title IX.[90]

c. *HHS may not limit the application of Section 1557 when it violates, departs from, or contradicts other, pre-existing laws*

HHS lacks the authority to mandate that any requirements of Section 1557 that "violate, depart from, or contradict definitions, exemptions, affirmative rights, or protections" from the laws listed above that pre-date the ACA will not be imposed. This language sharply deviates from the language in Section 1557 which states that Title I of the ACA should

[90] 81 Fed. Reg. 31380.

not be "construed to invalidate or limit the rights, remedies, procedures, or legal standards" from only Title VI, Title VII, Title IX, the Age Discrimination Act, and Section 504 of the Rehabilitation Act.[91] This language makes clear that the ACA establishes a floor in terms of civil rights protections that may be exceeded by certain other civil rights laws. HHS's proposed rule would instead establish Section 1557 as a ceiling by permitting its protections to be abrogated or even completely overridden by other federal laws. This interpretation is impermissible.

In the first place, HHS fails to specify what provisions of Section 1557 violate, depart from, or contradict the listed provisions. We are unable to provide meaningful comment without more information.

Further, it is the role of courts, not administrative agencies, to harmonize potentially conflicting laws, especially where Congress has not delegated the agency the authority to interpret those laws.[92] In addition, the Architectural Barriers Act, the Americans with Disabilities Act, Section 508 of the Rehabilitation Act, the Coats-Snowe Amendment, the Church Amendments, the Religious Freedom Restoration Act, the Weldon Amendment, and any other federal laws are not mentioned at all in Section 1557. Thus, the plain language of the statute cannot be read to allow those laws to automatically limit or supersede its application.

Rather, if anything, Section 1557 should take precedence to the extent that it violates, departs from, or contradicts a provision of one the listed statutes. The ACA represents a sweeping reform to the U.S. health care system that "comprehensively overhauled" the existing legal landscape on health care rights and discrimination.[93] The non-ACA provisions listed in this proposed regulation involve statutes that are not specific to health care. Thus, to the extent that any part of Section 1557 violates, departs from, or contradicts definitions, exemptions, affirmative rights, or protections that exist elsewhere in the law, it must be read to supersede those laws as they apply in the health care space. Such a reading is necessary, since "reconciling many laws enacted over time, and getting them to 'make sense' in combination, necessarily assumes that the implications of a statute may be altered by the implications of a later statute."[94] HHS's proposed regulation improperly attempts the opposite, purporting to constrain the application of the ACA's reforms by limiting its scope to that of pre-existing laws.

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[91] 42 U.S.C. 18116(b).
[92] *See Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 844 (1984).
[93] *United States v. Fausto*, 484 U.S. 439, 443 (1988).
[94] *Id.* at 453.

HHS's proposed rule would lead to absurd results that Congress could not have intended. For example, the ADA currently includes a safe harbor provision for "an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks," and for "a person or organization [that] establish[es], sponsor[s], observ[es] or administer[s] the terms of a bona fide benefit plan."[95] The ACA was specifically intended by Congress to prohibit discrimination in these areas. HHS cannot incorporate the ADA's safe harbor for insurers and other health care entities into Section 1557 by regulation, contrary to Congress's intent. Similarly, the ADA provides a broad exemption from its application to "religious organizations or entities controlled by religious organizations."[96] At least one court has applied this exemption to a religious hospital.[97] The ACA contains no comparable provisions that exempt entities controlled by religious organizations to be exempt from its prohibitions on discrimination, beyond any such exemptions that are set forth elsewhere in Title I of the ACA. Incorporating these contradictory rules into Section 1557 is contrary to the plain language of the ACA, and will create confusion, rather than clarify, about the scope of protection available under the Section 1557. HHS should not finalize proposed § 92.6(b).

Proposed Subpart B – Specific Application to Health Programs or Activities

§ 92.201 Meaningful Access for individuals with limited English proficiency

Language barriers can impede access to and the quality of care that the estimated 25 million people with LEP in the United States receive. The Joint Commission notes that "[i]ndividuals whose care is inhibited due to a communication barrier. . .may be at risk for poor outcomes."[98] The IOM noted, in its report *Unequal Treatment*,

> Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding

[95] 42 U.S.C. § 12201(c).
[96] 42 U.S.C. § 12187.
[97] *Cole v. Saint Francis Med. Ctr*., No. 1:15 CV 98 ACL, 2016 WL 7474988, at *6 (E.D. Mo. Dec. 29, 2016).
[98] 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.

> of physician instruction, poor shared decision-making, or ethical compromises (e.g. difficulty obtaining informed consent; [citation omitted]).[99]

The cost of these barriers can be deadly. As we found in a study we commissioned in 2010, patients lost their lives and suffered irreparable harm due to language barriers and the failure to provide appropriate language services.[100]

Due to the nature and importance of health care and the consequences that can result from language barriers, the current regulations appropriately include specific requirements to ensure that covered entities understand their obligations to ensure meaningful access and have clear instructions on how to comply with those obligations. We support this approach as it builds on yet is consistent with Title VI and existing HHS LEP Guidance and offer additional recommendations. We also emphasize that, consistent with the current rule, discrimination on the basis of national origin, including limited English proficiency (LEP), creates unequal access to health. LEP is often compounded with the "cumulative effects of race and ethnicity, citizenship status, low education, and poverty," resulting in more barriers to access.[101]

Visiting health care facilities and agencies that administer health programs and activities are often uncomfortable for individuals with LEP who are "unfamiliar with [the system's] cultural norms, vocabulary, and procedures."[102] Unfamiliarity with the health care system often results in inaction that could compromise a basic standard of living for individuals and families. Furthermore, the lack of language assistance services negatively impacts communities at large, not just LEP individuals. When interpreter services are inadequate, children often serve as language brokers for their parents.[103]

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[99] 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, at 17, (2002), available at http://www.nationalacademies.org/hmd/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx.

[100] National Health Law Program, *The High Costs of Language Barriers in Medical Malpractice,* https://healthlaw.org/resource/the-high-costs-of-language-barriers-in-medical-malpractice/.

[101] Kaiser Family Foundation, *Overview of Health Coverage for Individuals with Limited English Proficiency*, at 3, http://kff.org/disparities-policy/fact-sheet/overview-of-health-coverage-for-individuals-with/.

[102] Vikki Katz, *Children as Brokers of their Immigrant Families' Healthcare Connections*, at 24 (2014), https://academic.oup.com/socpro/article-abstract/61/2/194/1672037?redirectedFrom=fulltext.

[103] *Id.* at 31.

The cost of these barriers can be deadly. As we found in a study we commissioned in 2010, patients lost their lives and suffered irreparable harm due to language barriers and the failure to provide appropriate language services.[104] Examples of patient experiences that have resulted in malpractice claims are documented in *The High Costs of Language Barriers in Medical Malpractice*, a joint publication by the National Health Law Program and University of California, Berkeley, School of Public Health.[105]

Our specific comments on the proposed revisions are outlined below.

a. § 92.101(a) – Obligation

We appreciate that the proposed rule properly makes clear that language assistance services required under paragraph (a) must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency. These provisions are consistent with longstanding Supreme Court precedent holding 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.[106] At least one court has recognized that Section 1557 incorporates this concept of meaningful access.[107] All too often, individuals with limited English proficiency do not understand their rights, and will not know their new rights under Section 1557, and thus believe they have to bring their own interpreter or use a child, other patient, or unqualified individual to interpret. The responsibility for informing individuals must reside with the covered entity. And covered entities should be required to document that this information is provided or it would be assumed the individual with limited English proficiency did not get the information and the covered entity would be not in compliance with Section 1557.

We oppose, however, the proposal in § 92.101(a) to inappropriately switch the emphasis from "each individual with limited English proficiency" as provided in the 2016 Final Rule to the covered entity's program or activities. In Section 1557, Congress declared "an *individual* shall not" be subject to discrimination (emphasis added). Section 1557 regulations cannot offer less protection than the statute that authorizes such

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[104] National Health Law Program, *The High Costs of Language Barriers in Medical Malpractice* (2010) https://healthlaw.org/resource/the-high-costs-of-language-barriers-in-medical-malpractice/.

[105] *Id.*

[106] *See Lau v. Nichols*, 414 U.S. 563, 568 (1974).

[107] *See Esparza v. Univ. Med. Ctr. Mgmt. Corp*., No. CV 17-4803, 2017 WL 4791185, at *17 (E.D. La. Oct. 24, 2017).

regulations. Therefore, the correct emphasis in the 1557 regulations must be on each individual and not programs. As such, this NPRM would weaken meaningful access and runs counter to Congressional intent and the thorough administrative record supporting the 2016 Final Rule. We oppose these changes.

b. § 92.101(b)(1) – Specific applications -- Enforcement Discretion

As recognized in the current regulation, the enforcement standards balance two core principles critical in effectuating Section 1557's prohibition of national origin discrimination. The first principle, as outlined in HHS' 2003 LEP Guidance, is that the Department must "ensure that [health programs and activities] aimed at the American public do not leave some behind simply because they face challenges communicating in English."[108] Safe and quality health care requires an exchange of information between health care provider and patient for purposes of the diagnoses, treatment options, the proper use of medications, obtaining informed consent, and insured coverage of health-related services. This exchange of information is jeopardized when the provider and the patient speak different languages, which may result in adverse health consequences and even death. Indeed, as recognized in the original Section 1557 NPRM, the provision of health care services, by its "very nature[,] requires the establishment of a close relationship with the client or patient that is based on sympathy, confidence and mutual trust."[109] Provider-patient communication is essential to the concept of patient centeredness, which is a core component of quality health care and has been shown to improve patients' health and health care.

The second principle is that the level, type and manner of language assistance services required should vary based on the relevant facts, which may include the operations and capacity of the covered entity. For these reasons, current regulations provide factors that the Director will evaluate to determine whether a covered entity has met the requirement in paragraph (a). Current § 92.201(b)(1) requires the Director to consider, and give substantial weight to, the nature and importance of the health program or activity, including the particular communication at issue. Both Title VI and Section 1557 prohibit national origin discrimination against each person, not based on the total

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[108] *Policy Guidance Document: Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Individuals* (HHS LEP Guidance), 68 Fed. Reg. 47312 (Aug. 8, 2003), https://www.govinfo.gov/content/pkg/FR-2003-08-08/pdf/03-20179.pdf.

[109] *Notice of Proposed Rulemaking: Nondiscrimination in Health Programs and Activities*, 80 Fed. Reg. 54183 (Sep. 8 2015), https://www.govinfo.gov/content/pkg/FR-2015-09-08/pdf/2015-22043.pdf.

number of people. Neither Title VI nor Section 1557 protections are conditioned on the number of people who experience discrimination, and thus utilizing the four factors is insufficient both for entities to determine how to comply with Title VI and Section 1557 and also for HHS to evaluate compliance.

The proposed regulations would change the mandatory "two factor" mandatory test into a "four factor" optional test. We strongly oppose these changes, which are not consistent with Section 1557's intent. The current regulation at § 92.201(b) provides a modified version of the pre-existing four-factor balancing test, first focusing on the existing factor of the "nature and importance of the health program or activity" and requires that the Director evaluate and give substantial weight to that factor. We support beginning the fact-dependent inquiry of what type of meaningful access must be provided by starting with and giving substantial weight to the nature and importance of the health program or activity and the communication at issue. Beginning the inquiry with this factor properly balances Title VI and Section 1557 obligations to ensure LEP persons are meaningfully served by health programs or activities. This approach is consistent with an understanding of the consequences that can result in lack of access to services or information in the health care setting by individuals with LEP, as intended by Congress when it enacted the ACA.

In evaluating comments submitted on the Section 1557 proposed rule in 2015, HHS revised the final Section 1557 regulation (the regulations currently in place) to eliminate the illustrative four factors and to articulate only one factor: whether a covered entity has developed and implemented an effective written language access plan appropriate to its circumstances. HHS stated that it agreed with commenters' concerns that including multiple illustrative factors – such as the four factors – in the regulatory text may create the erroneous impression that the Director will not consider relevant factors absent from § 92.201(b)(2).

In 2016, HHS also demonstrated that the two-factor test imposes no new burden on covered entities. As it stated in the preamble to the final Section 1557 regulations:

> This is because, with regard to recipients of Federal financial assistance, the proposed rule adopted recipients' existing obligations under Title VI to take reasonable steps to provide meaningful access to individuals with limited English proficiency and codified standards consistent with long-standing principles from the HHS LEP Guidance regarding the provision of oral interpretation and written translation services. . .Thus, we do not believe this rule will impose a greater

> burden regarding the costs of language assistance services than exist under Title VI.[110]

Further, HHS specifically addressed why it chose to provide implementing regulations for Section 1557 on the national origin prong in light of Title VI:

> OCR considered remaining silent on covered entities' obligations to comply with Section 1557's prohibition of national origin discrimination as it affects individuals with limited English proficiency. We rejected this approach because we were concerned that OCR's silence would create ambiguity about covered entity's obligations to individuals with limited English proficiency and could jeopardize the access of individuals with limited English proficiency to covered entities' health programs and activities. Clearly explaining the standards also promotes compliance and reduces enforcement costs."[111]

As clearly stated in these quotes, HHS has already considered and rejected using the four-factor test in evaluating compliance with Section 1557 because the four-factor test failed to adequately implement Section 1557's protections against discrimination on the basis of national origin. Now in the NPRM, HHS fails to adequately explain why it is moving away from the two-factor test and back to the four-factor test. It also fails to explain why it would make the four-factor test optional – the Director "*may* assess how such entity balances the following four factors" (emphasis added) – rather than mandatory as under the current regulations.

The proposed rule fails to recognize that flexibility covered entities have under Section 1557 is not be an assessment of *whether* to provide meaningful access, but *how* to provide such language assistance. Because "meaningful access" is already a subjective standard, adding the four factors as an optional enforcement discretion adds an excessive layer of ambiguity and therefore makes meaningful language access all the more remote for individuals with LEP. As HHS has previously reiterated from the Department of Justice's LEP Guidance, Title VI policies advance the longstanding principle that "federally assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English."[112] This regulation must do the same yet the proposed changes fail to recognize this important principle.

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[110] 81 Fed. Reg. 31453-4.
[111] *Id.* at 31461-2.
[112] HHS LEP Guidance, 68 Fed. Reg. 47312.

Further, the proposed section deletes a specific reference to those "eligible to be served" by an entity. The shift again moves away from an individual assessment to a program/activity assessment. Yet both Title VI and Section 1557 require that covered entities not discriminate against any individual. Thus, if an entity determined, using the four factors that it did not have to provide language services it would indeed be in violation of both Title VI and Section 1557. Further, it is insufficient for an entity to only provide language services to those who actually walk in its door (or call its office). Instead, a covered entity must be prepared to provide language services to all those eligible to be served, as has been recognized at least since HHS' 2003 LEP Guidance. That guidance states:

> Ordinarily, persons ''eligible to be served, or likely to be directly affected, by'' a recipient's program or activity are those who are served or encountered in the eligible service population . . . . In certain circumstances, it is important in conducting this analysis to include language minority populations that are eligible for their programs or activities but may be underserved because of existing language barriers.[113]

Unfortunately, by changing the focus from each individual eligible to be served to focus instead on meaningful access to the program or activity, a covered entity may unintentionally discriminate against individuals with LEP.[114] Eligible clients/patients will not go to a covered entity if the client/patient perceives the entity is not prepared to assist the client/patient in his/her language. For example, if a hospital is located in an area with a large Hmong population (e.g. in parts of Minnesota), the hospital likely should have the availability of language services in Hmong. Without having materials and services available, it will be discriminating against Hmong patients who reside in its service area, are eligible to be served, but are not yet actually served.

Further, many who have used the four-factor test incorrectly believe that each factor is weighed equally in evaluating compliance. This misinterpretation will arise again with the rescinding of the existing regulations. For example, some covered entities have used the resources and costs factor as a defense to providing language services to a less frequently encountered language group. Indeed the reverse is true; entities must do something but what they must do is determined on a case-by-case basis, a determination supported by the current regulations. For example, if a covered entity has a small number of patients/clients of a less frequently encountered language, an entity may erroneously think it does not have to provide oral interpreting services. While there

[113] *Id.* at 47314.

[114] *Compare* 45 C.F.R. § 92.201(a) with proposed 45 C.F.R. § 92.101(a), 84 Fed. Reg. 27892.

may be some particular dialects or languages which are so infrequently encountered that over-the-phone interpreters are not readily available, advance planning would ensure a covered entity can meet the needs of most LEP individuals.

It is often difficult if not impossible to ascertain when a seemingly "routine" doctor's visit may turn into one that affects an individual's day-to-day existence. How many individuals go to the doctor thinking that they may have high blood pressure, diabetes, cancer, or heart disease? Only by the ability to effectively communicate with a provider and having a provider take a full health history from a patient is it likely that the provider will gather all the information necessary to actually determine if a patient may have a condition that could affect his day-to-day existence. Thus the importance of even a seemingly "routine" healthcare visit in diagnosing potentially life-threatening conditions should weigh heavily in favor of the provision of language services and likely outweigh any concerns about costs and resources, particularly when over-the-phone interpreting services can offer a wide variety of languages at a relatively low cost.

Perhaps most importantly, cost-benefit analyses fail to evaluate how professional and industry or agency culture contribute to racial disparities in health care.[115] Because language assistance services can be measured in cost or resources—money, time, staffing—the cost-benefit analysis is skewed towards the quantifiable and does not capture the immeasurable benefits of language access, increased access and participation in underserved communities, improved health outcomes, and compliance with anti-discrimination laws. The cost-benefit analysis also does not explicitly account for the costs to a consumer who is denied or delayed language assistance.

We also oppose the deletion of consideration of a language access plan from this section. Current regulations do not require development of a language access plan but rather require HHS to take into account whether a covered entity has developed and implemented an effective written language access plan. Many covered entities are already required to evaluate the type of language services they are obligated to provide based on the current HHS LEP Guidance. Doing so ensures that covered entities understand the scope of the populations they serve, the prevalence of specific language groups in their service areas, the likelihood of those language groups coming in contact with or eligible to be served by the program, activity or service, the nature and importance of the communications provided and the cost and resources available. Depending on an entity's size and scope, advance planning need not be exhaustive but is used to balance meaningful access with the obligations on the entity.

[115] Ikemoto, L. C., *Symposium: Racial Disparities in Health Care and Cultural Competency*, 48 St. Louis L.J. 75, 119 (2003).

Our experience is that entities are in a better position to meet their obligations to provide language assistance services in a timely manner when those entities identify, in advance, the types and levels of services available in each of the contexts in which the covered entity encounters individuals who are LEP. The current regulations are also consistent with the encouragement of covered entities to create a language access plan from the HHS LEP Guidance.[116] HHS' 2003 LEP Guidance included elements of an effective language access plan.[117] And as noted in the Preamble to the original Section 1557 NPRM, many organizations already develop such plans based on the model described in HHS LEP Guidance. Doing so need not be burdensome and the size and scope of the plan may vary depending on whether the covered entity is a small provider or a Qualified Health Plan issuer.

Given the longstanding recognition of the benefits of creating a language access plan, we oppose the rescission of § 92.101(b)(2) and recommend that the provision remain as an element OCR can consider in evaluating compliance.

c. § 92.101(b)(2) – Language assistance services requirements

As noted above, we oppose using the four-factor test to determine whether language services must be provided. Oral interpreting services should **not** be subject to the four-factor test but rather be available as needed and free of charge. It may be reasonable for an entity to determine whether to provide in-person or phone or video interpreting based on a variety of factors but under Section 1557 a covered entity may not deny language services altogether, as implied by the proposed rule. The proposed language for interpreter services does not meet even the minimum existing standards required by Section 1557, and currently stated under Title VI and HHS LEP Guidance. As HHS LEP Guidance notes, oral interpreting "can range from on-site interpreters for critical services provided to a high volume of LEP persons, to access through commercially-available telephonic interpretation services."[118] In addition, covered entities may, depending on when interpreting is needed and what is reasonable, provide interpretation through: hiring bilingual staff, hiring staff interpreters, contracting for interpreters, using a telephonic interpreter line, using community volunteers or other persons, in limited circumstances.

[116] 80 Fed. Reg. 54185.
[117] 68 Fed. Reg. 47319-21.
[118] HHS LEP Guidance, 68 Fed. Reg. 47311 (Aug. 8, 2003).

Oral interpreting services must be provided in **all** cases where requested or needed to comply with Section 1557 (and Title VI) although the manner of providing these services (in-person, telephonic, video) may differ depending on the entity. Thus, consistent with HHS LEP Guidance, covered entities may provide oral interpreting services through the range of options that are available and evaluate the type and manner using a fact-dependent inquiry. This avoids an overly prescriptive approach, but provides clarity that some form of oral interpreting services must be provided in all cases where needed to constitute meaningful access. This approach provides a reasonable balance and provides covered entities with needed flexibility by adopting existing standards that are already required for some entities. For example, many smaller covered entities may find that contracting with a telephonic interpreter line, such as that required by the Health Insurance Marketplaces and Qualified Health Plans, can provide meaningful access in some cases, while contracting with interpreters or employing staff interpreters may be necessary where communications are likely to affect the health and well-being of an individual and where the covered entity frequently interacts with LEP persons, such as in a hospital. Lastly, in all circumstances when information cannot be translated into multiple languages, taglines should be used to notify limited English proficient individuals that information is available to be interpreted in their primary language.

d. § 92.101(3) – Specific requirements for interpreter and translation services

We appreciate having specific requirements for interpreter and translation services. It is important to specify the particular knowledge, skills and abilities required of interpreters. We note, however, that § 92.101(b)(2)(ii) refers to the need for a "qualified interpreter" and "qualified bilingual or multilingual staff" yet § 92.101(3) fails to replicate the use of the term "qualified." The inclusion of "qualified" in § 92.101(3) is necessary to reiterate the importance of having trained and competent individuals providing language services and also to reinforce § 92.101(4), and to effectuate Congress's intent to protect LEP individuals from discrimination.

We oppose the removal of technical and training requirements for the use of video remote interpreting services for spoken language interpreting. The type of interpreting during a health care visit should not depend on whether the encounter uses telephonic or video connections. In particular, interpreting for trauma, mental health, or death are often inappropriate for telephonic interpreting. Additionally, an interpreter may miss non-verbal cues via telephone. Even with the higher cost in equipment and training, video interpreting has saved costs from in person interpreting as there are no minimums, travel time, or cancellation risks. Keeping the current standard allows providers to determine which technology is appropriate and when an entity uses video, that it is high quality and without lagging. HHS should not set up a dichotomy between video

interpreting for sign language interpreters and video interpreting for foreign language interpreting; once video interpreting is used, the same standards should apply. That is, while a particular entity may determine whether to provide audio or video interpreting, once video interpreting is selected, the same standards should apply to both sign language and foreign language interpreters. We oppose the proposed changes and support continuation of the current requirements.

e. § 92.101(4) – Restricted use of certain persons to interpret or facilitate communication

We support the provision that restricts covered entities from: 1) requiring individuals with limited English proficiency to provide their own interpreter; and 2) relying on an adult accompanying an individual with limited English proficiency to interpret except in emergency situations or where the individual specifically requests for that adult to interpret. We also strongly support the provision that prevents minor children from interpreting or facilitating communications except in emergency situations involving imminent danger. Research has shown that the ability of a provider to accurately diagnose a patient's condition can be jeopardized by untrained interpreters, such as family and friends, especially minor children, who are prone to omissions, additions, substitutions, volunteered opinions, semantic errors, and other problematic practices.

Further, covered entities should be required to document that it provided information about free interpreting is provided and that individuals with LEP do not have to use family members, friends or other ad hoc interpreters. Otherwise, it would be assumed the individual with limited English proficiency did not get the information and the covered entity would be not in compliance with Section 1557. As we noted in our report on malpractice and language access,

> Physicians are taught that if an activity is not documented in the medical record, it did not happen. In reliance on this practice, if the medical chart did not show that a professional interpreter was used, this report concluded that none was used.[119]

The same concept should apply with regards to covered entities documenting compliance with Section 1557. Covered entities must be required to document the

[119] National Health Law Program and University of California, Berkeley School of Public Health, *The High Costs of Language Barriers in Medical Malpractice* (2010) at p. 3, fn. 11, http://www.healthlaw.org/publications/search-publications/the-high-costs-of-language-barriers-in-medical-malpractice#.Vie5GytFpSE.

provision of language services and an individual's decision to use an accompanying adult or it should be presumed not to have happened.

§ 92.102 Effective communication for individuals with disabilities

NHeLP supports HHS' proposal to retain the provisions of 45 C.F.R. § 92.202 (redesignated § 92.102), regarding effective communication for individuals with disabilities. Effective communication is a critical component of accessing and receiving quality health care. We often hear about entities refusing to provide effective communication or relying on communication methods that are the preference of the entity rather than the choice of the individual. Therefore, we commend HHS for holding all covered entities to the higher ADA Title II standards found at 28 C.F.R. §§ 35.160–35.164. Giving primary consideration to the choice of aid or service requested by the individual with a disability helps to ensure actual effective communication and thus equal opportunity in the health care setting.

We are, however, concerned with HHS' proposed changes to the definitions relating to the effective communication regulation. First, we object generally to the deletion of the definitions section at 45 C.F.R. § 92.4. The elimination of this section will cause confusion for covered entities and risk inconsistency among the various Section 1557 regulations. It also makes it more difficult to amend definitions as needed, which is especially important in the context of effective communication, as auxiliary aid technologies are constantly evolving. Second, while we appreciate HHS' efforts to incorporate many of the current ADA definitions, including the definitions of disability, auxiliary aids and services, qualified interpreter, and video remote interpreting, we note that HHS has erred in tracking the language of these longstanding definitions. The problems we have identified are as follows:

- The definition of auxiliary aids and services at proposed § 92.102(b)(1) excludes "acquisition or modification of equipment and devices" and "[o]ther similar services and actions," despite these two items being found in the ADA definition at 28 C.F.R. § 35.104 and the current Section 1557 definition at 45 C.F.R. § 92.4. HHS states in its NPRM that "[t]he list of auxiliary aids and services from 28 CFR 35.104 is incorporated into the proposed rule at § 92.102(b)(1)" and in general that "[t]hese provisions are drawn from regulations implementing Title II of the Americans with Disabilities."[120] This list is incomplete and HHS' statements are misleading. Parts of 28 C.F.R. § 35.104 are incorporated into the NPRM, but the above-quoted language regarding the "acquisition or modification of equipment

[120] 84 Fed. Reg. 27866, 27867, n. 123.

and devices" and "other similar services and actions" is missing. This deletion alters what was an open-ended functional definition, and takes what is clearly a list of examples of auxiliary aids and services in the current regulations and turns it into an exhaustive list in the proposed regulation. Moreover, to the extent that HHS claims it seeks to eliminate inconsistent applications of the law, such as change is neither prudent nor consistent with the law. We strongly oppose these deletions.

- The definition of auxiliary aids and services at proposed § 92.102(b)(1) also excludes the term "Qualified" before "Interpreters" in subsection (i) and before "Readers" in subsection (ii), despite this critical adjective being found in the ADA definition at 28 C.F.R. § 35.104 and the current Section 1557 definition at 45 C.F.R. § 92.4. While we appreciate that HHS does track the content of the ADA definition of *qualified* interpreters at proposed § 92.102(b)(2)–(3), we believe it will enable greater clarity and consistency with the ADA regulations to keep the term "Qualified interpreters" in the auxiliary aids definition at proposed § 92.102(b)(1)(i). Moreover, the word "Qualified" has also been deleted from "readers" in proposed § 92.102(b)(1)(ii), yet the proposal fails to incorporate the ADA definition of qualified readers. We strongly encourage HHS to both include the word "Qualified" in proposed § 92.102(b)(1)(ii), and incorporate the ADA definition of this term, *see* 28 C.F.R. § 351.04 ("Qualified reader means a person who is able to read effectively, accurately, and impartially using any necessary specialized vocabulary."). The change here is not merely theoretical. Covered entities should not, for example, be free to assign the task of reading personal information about healthcare status, medical procedures, and bills to a high school student hired to help with receptionist duties over the summer. The requirement for a defined "qualified reader" helps to ensure effective communication and healthcare for people with disabilities.

NHeLP is also concerned with the narrowing of the "free of charge" and "timely manner" provision at proposed § 92.102(b)(2). The current Section 1557 regulations provide that a covered entity must provide appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner . . ."[121] This language echoes the ADA Title II regulations, which provide that covered entities "may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program

[121] 45 C.F.R. § 92.8.

accessibility... "[122] In proposed § 92.102(b)(2), HHS significantly narrows this provision by only stating that "*interpreting service* shall be provided to individuals free of charge and in a timely manner" (emphasis added). We strongly oppose this change and encourage HHS to replace the words "interpreting service" with "auxiliary aids and services" to be consistent with the ADA and prevent unnecessary confusion over the requirement. Covered health care entities may not legally charge for *any* auxiliary aid provided; this pre-existing legal requirement should be made clear.

Finally, HHS requests comment on whether it should add an exemption from the effective communication requirements for covered entities with fewer than 15 employees.[123] NHeLP strongly opposes this exemption. HHS has not applied such an exemption in nearly 20 years and to apply it now would roll back the clock on the enforcement of effective communication for people with disabilities. To be clear, effective communication requirements profoundly impact threshold access to and the quality of health care that a person with a disability receives. Breakdowns in communication between a health care provider and a patient with a disability are reported across all types of disabilities,[124] and the lack of accurate and effective communication can lead to misdiagnosis, erroneous treatment, and ultimately a negative impact on the health of the patient.[125] The lack of positive health care communication experiences can also lead to a loss of trust or fear of health care providers, leading some people with disabilities to feel as if they have no choice but to rely upon self-diagnosis and treatment.[126] The provision of appropriate auxiliary aids and services can help remedy some of these health care disparities. For example, the provision of ASL interpreters to Deaf patients preferring this type of communication

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[122] 28 C.F.R. § 35.130(f).

[123] *See* 84 Fed. Reg. 27867.

[124] *See, e.g.*, Thilo Kroll, et al., *Primary Care Satisfaction Among Adults with Physical Disabilities: The Role of Patient-Provider Communication*, 11 MANAGED CARE Q., no. 1, 11–19 (2003); Melinda Neri & Thilo Kroll, *Understanding the Consequences of Access Barriers to Health Care: Experiences of Adults with Disabilities*, 25 DISABILITY & REHAB., no. 2, 85–96 (2003); Sara Bachman, et al., *Provider Perceptions of Their Capacity to Offer Accessible Health Care For People With Disabilities,* 17 J. DISABILITY POL'Y STUD., no. 3, 130–36 (2006); Elizabeth H. Morrison, et al., *Primary Care for Adults with Physical Disabilities: Perceptions from Consumer and Provider Focus Groups*, 40 FAM MED., no. 9, 645–51 (2008).

[125] *See* Silvia Yee, Mary Lou Breslin, et al., *Compounded Disparities: Health Equity at the Intersection of Disability, Race, and Ethnicity*, NAT'L ACADS. SCI., ENG'G, & MED. (2017), *available at* http://nationalacademies.org/hmd/Activities/SelectPops/HealthDisparities/Commissioned-Papers/Compounded-Disparities, at 43–44 (summarizing and analyzing the abundance of research on this point).

[126] *Id.*

accommodation has been linked with significantly higher utilization rates of preventative care, including cholesterol screens, colonoscopy, and influenza vaccines.[127] While there are still many improvements to be made, requiring all covered entities to provide effective communication is a vital first step towards ensuring health care equity.

Provider offices with fewer than 15 employees should not be exempted from this basic civil rights requirement. People with disabilities often obtain their health care from local providers or specialists with only a few employees. This is especially true in rural areas, where providers are more likely to have smaller practices, and there may only be one appropriate specialist within a reasonable distance. This exemption could thus function to exclude many people with disabilities from accessing the health care they need. The American Medical Association's (AMA's) Physician Practice Benchmark Survey in the period from 2012-16 found that a majority of physicians still work in small practices, with 57.8% in practices of 10 or fewer physicians, and 37.9% working in practices with fewer than 5 physicians in 2016.[128] Physicians in single specialty practices were even more likely to be in smaller practices. A practice with 10 physicians may or may not have 15 or fewer employees, but a practice with 5 physicians is very likely to have fewer than 15 employees. Exempting these small practices means that people with disabilities will have significantly more difficulty obtaining effective communication from both general and specialty physicians, and sends the message that HHS's latest healthcare-specific civil rights regulations make it harder for people with communication disabilities to obtain needed healthcare. Congress surely did not intend such a result in enacting the ACA and Section 1557.

Moreover, in practice, this exemption would make little sense because public accommodations (including hospitals and provider offices) of any size are already required to provide effective communication under Title III of the ADA. Even HHS, when it originally announced that the 15-employee exemption does not apply to entities receiving HHS funds, recognized this reality:

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[127] Michael M. McKee, et al., *Impact of Communication on Preventive Services Among Deaf American Sign Language Users*, 41 AM. J. PREVENTATIVE MED., no. 1, 75–79 (2011).
[128] Carol K. Cane, *Updated Data on Physician Practice Arrangements: Physician Ownership Drops Below 50 Percent*, Policy Research Perspectives 4-5, AMA (2017), *available at* 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.

> This is not a new requirement; Title III of the Americans with Disabilities Act (ADA) already requires public accommodations of all sizes to provide auxiliary aids and services to persons with disabilities where necessary to ensure effective communication and Title II of the ADA extends the same requirement to state and local government entities. The vast majority of entities that receive federal financial assistance from HHS thus are already required to provide auxiliary aids and services to persons with disabilities where necessary to ensure effective communication.[129]

If HHS intends to protect small entities from costs, then the appropriate mechanisms to do so is already in 45 C.F.R. § 92.202, which incorporates the ADA Title II exemptions found in 28 C.F.R. § 35.164 by explicit reference.[130] Adding an exemption for small entities will harm people with disabilities and is not the proper solution.

In summary, HHS should clarify that the list of auxiliary aids and services in proposed § 92.102(b)(1) is not exhaustive by adding the following after subsection (ii):

> (iii) Acquisition or modification of equipment and devices; and
> (iv) Other similar services and actions.

HHS should also put back the term “Qualified” before “Interpreters” in proposed § 92.102(b)(1)(i) and before “Readers” in proposed § 92.102(b)(1)(ii), and it should incorporate the definition of “Qualified readers” found at 28 C.F.R. § 35.104. The requirement to provide services “free of charge and in a timely manner” in proposed § 92.102(b)(2) should be applied to all “auxiliary aids and services,” not just “interpreter services.” Last, no exemption should be added for covered entities with fewer than 15 employees.

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[129] HHS OCR, *Section 504 of the Rehabilitation Act of 1973; Notice of Exercise of Authority Under 45 CFR 84.52(d)(2) Regarding Recipients With Fewer Than Fifteen Employees*, 65 Fed. Reg. 79368 (Dec. 19, 2000).

[130] 28 C.F.R. § 35.164 (“This subpart does not require a public entity to take any action that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens. In those circumstances where personnel of the public entity believe that the proposed action would fundamentally alter the service, program, or activity or would result in undue financial and administrative burdens, a public entity has the burden of proving that compliance with this subpart would result in such alteration or burdens.”).

§ 92.103 Accessibility standards for buildings and facilities

NHeLP supports HHS' proposal to retain the provisions of 45 C.F.R. § 92.203 (redesignated § 92.103), regarding accessibility standards for buildings and facilities. We agree that the 2010 ADA Standards for Accessible Design ("2010 Standards") are the appropriate architectural standards for any facility or part of a facility in which health programs or activities are conducted that is constructed or altered by or on behalf of, or for the use of, a recipient or State Exchange. We appreciate HHS' continued commitment to ensuring that health care facilities and provider offices are physically accessible for people with disabilities.

HHS requests comment on the appropriateness of applying the 2010 ADA Standards' definition of "public building or facility" (i.e., the ADA Title II standards) to all entities covered under Section 1557, specifically with respect to multistory building elevators and text telephone ("TTY") requirements.[131] It is indeed appropriate and *necessary* to hold all health programs and activities that receive federal financial assistance to these standards, and we strongly oppose importing the private multistory building exception found at Section 206.2.3 of the 2010 Standards and the private entity TTY standard found at Section 217.4.3 of the 2010 Standards into Section 1557.

First, by virtue of accepting federal financial assistance from HHS, it is entirely appropriate to hold all covered health programs and activities, including private entities, to the Title II standards. If we look at the ADA in a vacuum, a private entity that operates as a place of public accommodation would only be subject to the lower Title III architectural standards. However, here, the ADA standards function in relation to Section 1557, which notably references and incorporates the grounds of discrimination of Section 504, not the ADA. Section 504 covers programs and activities receiving federal financial assistance. So, in this context, some private health care practices, for example, would be on the hook for not only being a public accommodation under Title III, but also an entity that avails itself to nondiscrimination law (Section 504 and Section 1557) by virtue of choosing to accept federal financial assistance from HHS. This distinction justifies holding private health care entities to a higher standard, which HHS itself recognized in its 2015 NPRM:

> [The] entities covered under the proposed rule are health programs and activities that either receive Federal financial assistance from HHS or are conducted directly by HHS. Although OCR could apply Title II standards to States and local entities and Title III standards to private entities, we believe it is appropriate to

[131] *See* 84 Fed. Reg. 27846, 27867.

> hold all recipients of Federal financial assistance from HHS to the higher Title II standards as a condition of their receipt of that assistance.[132]

Additionally, it is important to consider the context of the buildings and facilities at issue under Section 1557. While we affirm that architectural access is essential in all contexts, we note that it is particularly crucial for people with disabilities to have equal access to health programs and activities. People with disabilities already face significant barriers in accessing needed health care.[133] Exempting a health insurance enrollment center or plan benefit counselor from having an elevator or a small health care practice from providing TTY, for example, will only serve to widen the disparities in health access. By choosing to operate a business that is critical to an individual's health and life, and then by choosing to accept HHS funds, private health entities have also assumed a duty to ensure that their buildings and facilities are accessible for all. These are also obligations that are inevitably included in the contracts that health entities enter when they agree to function as a plan or provider with Medicaid, Medicare, or through an Exchange. Watering down this responsibility is unacceptable and unlawful. It will function to reward those few construction or alteration projects that did not have the foresight to take account of the needs of healthcare consumers with disabilities.

As to the two exemptions that HHS specifically requests comment on, NHeLP strongly opposes them both. Section 206.2.3 of the 2010 Standards provides, in relevant part, that "[i]n private buildings or facilities that are less than three stories or that have less than 3000 square feet (279 m^2) per story, an accessible route shall not be required to connect stories provided that the building or facility is not . . . the professional office of a health care provider . . . or another type of facility as determined by the Attorney General." This private elevator exemption dates back to the 1991 ADA Standards for Accessible Design, a time period in which the concept of widespread architectural accessibility was still relatively recent and when the construction or addition of accessible elevators was still considered extremely burdensome and costly. Today, private entities have had over 50 years to adjust their architectural designs and consider the needs of people with disabilities.[134] Requiring a multi-story building or facility to have

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[132] HHS, *Nondiscrimination in Health Programs and Activities; Proposed Rule*, 80 Fed. Reg. 54172, 54186 (Sept. 8, 2015).

[133] *See, e.g.*, Yee, et al., *supra* note 125; H. Stephen Kaye, *Disability-Related Disparities in Access to Health Care Before (2008–2010) and After (2015–2017) the Affordable Care Act*, 109 AM. J. PUB. HEALTH, no. 7, 1015–21 (July 2019).

[134] The Architectural Barriers Act, the first federal law requiring that facilities designed, constructed, altered, or leased with certain federal funds be accessible for people with disabilities, was signed into law in 1968. *See* 42 U.S.C. §§ 4151–57.

an elevator is no longer the foreign concept or perceived burden it once was. Instead, it is required by the law. Rolling back the standards for having an elevator in private health buildings will only serve to erect a new, additional barrier for individuals with disabilities to access needed health programs.

We also oppose lowering the private entity TTY standard. Section 217.4.3 of the 2010 Standards provides, in relevant part, that "[w]here at least one public pay telephone is provided in a *public building*, at least one public TTY shall be provided in the building" (§ 217.4.3.1) and "[w]here four or more public pay telephones are provided in a *private building*, at least one public TTY shall be provided in the building" (§ 217.4.3.2). The lower 4:1 TTY standard for private entities, which originated 15 years ago,[135] is now outdated given the current widespread availability and affordability of the technology. It takes little effort or cost for covered entities to provide 1:1 TTY, yet the benefits offered to people who are Deaf or have hearing impairments are significant. It enables people with disabilities to communicate with health care providers, their insurance companies, and other similar entities. HHS should not lower the 1:1 TTY standard that has already been in place for three years.

HHS should continue to apply the 2010 ADA Standards' definition of "public building or facility" to all entities covered under Section 1557. HHS should not incorporate the private multistory building elevator exemption or the private entity TTY standard into Section 1557 regulations.

§ 92.104 Accessibility of information and communication technology

NHeLP supports HHS' proposal to retain the provisions of 45 C.F.R. § 92.204 (redesignated § 92.104), regarding information and communication technology ("ICT") for individuals with disabilities. Like effective communication, access to information, communication, and electronic technologies is important to guaranteeing people with disabilities equal access to health care services—and this fact is even more true as U.S. society increasingly relies on digital and web-based communications. Health care providers and health insurance plans are rapidly developing interactive websites, moving their medical recordkeeping online, and communicating with patients through electronic means. We commend HHS' efforts to ensure that people with disabilities are not left behind as technologies evolve.

[135] The 4:1 private TTY standard was first adopted in the 2004 ADA Accessibility Guidelines ("ADAAG").

HHS also requests comment on whether it should cross-reference Section 508 and its applicable implementing regulations in proposed § 92.104. NHeLP supports this proposal. Cross-referencing Section 508 and its regulations will help ensure that the Section 1557 stay up-to-date as the Section 508 regulations are amended, and it will ensure consistency across the civil rights laws.

§ 92.105 Requirement to make reasonable modifications

The proposed text of 45 C.F.R. § 92.105 mirrors the current text of 45 C.F.R. § 92.205 and retains the requirement to make reasonable modifications to policies, practices, or procedures. We support this language. This language of "reasonable modification" conforms to other non-discrimination regulations that apply to state and local government, and therefore is consistent with other regulatory schemes applicable to entities subject to 1557.[136] The 2016 Final Rule specifically applies the definition of "reasonable modification" from Title II of the ADA (state and local governments), which continues to be the appropriate standard for recipients of federal financial assistance, programs established under Title I of the ACA, and programs administered by HHS. The concept of "reasonable modification" is not burdensome. The concept has long applied to a broad swath of entities, whether public or private, and therefore it is clear and familiar to most entities covered by Section 1557.[137] There is no reason to make any changes to this language, nor to import unrelated concepts from other regulatory schemes.

HHS has requested comment on whether the following language should be substituted for the proposed 45 C.F.R. § 92.105: covered entities shall make "reasonable accommodation to known physical or mental limits of an otherwise qualified" individual with a disability. HHS also asks whether an exemption for "undue hardship" should be imported from 45 C.F.R. § 84.12 and 28 C.F.R. § 92.205 into proposed § 92.105. The substitute language is from regulations related to employment, and is unnecessary, ill-

[136] 45 C.F.R. § 92.205.

[137] *See, e.g.,* 28 C.F.R. § 35.130(b)(7)("A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.")(Title II of the ADA). Title III also incorporates a requirement that covered entities make "reasonable modifications in policies, practices, or procedures, when the modifications are necessary to afford goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the public accommodation can demonstrate that making the modifications would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations." 28 C.F.R. § 36.302(a) (Title III).

fitting, and inappropriate for a health care context. The answer to both questions is no. HHS should not make any changes to the language at current 45 C.F.R. § 92.205.

As a preliminary matter, in asking about the imported language, HHS states that the language is taken from HHS Section 504 regulations and the "Department of Justice's Section 504 coordinating regulation."[138] However, both citations to the DOJ Section 504 coordinating regulations are to a non-existent portion of the Code of Federal Regulations.[139] These incorrect citations makes it impossible for public to know with certainty what HHS is proposing, nor does it allow the public to analyze the context of proposed imported, or any case law interpreting such, language.[140] Public comment requires transparency, and the source of any imported language is an integral part of transparency.

Furthermore, new exemptions are unnecessary and contrary to Section 1557. The concept of a "reasonable modification" is not boundless—it is already well-defined by regulation and decades of case law. In fact, the definition of "reasonable modification" is so clear that HHS declined to provide additional explanation of the term in the 2016 Final Rules.[141] The 2016 final regulations track Title II of the ADA, requiring covered entities to make a reasonable modification "unless the covered entity can demonstrate that making the modifications would fundamentally alter the nature of the health program or activity."[142] Continuing to apply the "reasonable modification" analysis to Section 1557 promotes consistency with pre-existing civil rights statutes, one of HHS' stated goals of their proposed rules.[143] Neither Section 504 nor Title II of the ADA would

[138] 84 Fed. Reg. 27868.
[139] *See* 84 Fed. Reg. 27868, citing to 28 C.F.R. § 92.205 two separate times. 28 C.F.R. Part 92 contains regulations regarding the "Office of Community Oriented Policing Services (COPS)," and does not contain a section 92.205.
[140] It appears that HHS seeks to import DOJ's rules for the implementation of Executive Order 12250. *See* 28 C.F.R. § 41.53. It is also possible that HHS intends to refer to DOJ's rules for reasonable accommodation in employment in federally assisted programs pursuant to Section 504. *See* 28 C.F.R. § 42.511. Either way, it is incumbent on HHS to accurately explain the source of any regulations it seeks to substitute.
[141] *See* 81 Fed. Reg. 31382 ("OCR believes that defining the terms ''reasonable modification'' and ''accessibility'' in this rule is unnecessary, given the meaning that these terms have acquired in the long history of enforcement of Section 504 and the ADA in the courts and administratively. We intend to interpret both terms consistent with the way that we have interpreted these terms in our enforcement of Section 504 and the Age and so decline to add these definitions to the final rule").
[142] 45 C.F.R. § 92.205.
[143] 84 Fed. Reg. 27848.

permit an exemption for “undue hardship” in this context, and it is inappropriate to import such an exemption into Section 1557 where none exists in the statute itself.

As noted above, the suggested imported language of “reasonable accommodation,” “known physical or mental limitation,” and “undue hardship” stems directly from employment-related regulations. Such concepts are ill-fitting in the health care context and cannot be applied under Section 1557. For example, the definition of “undue hardship” makes little sense when divorced from the employment context, as it requires consideration of factors often irrelevant to the health care context, such as “(1) The overall size of the recipient's program or activity with respect to number of employees, number and type of facilities, and size of budget; (2) The type of the recipient's operation, including the composition and structure of the recipient's workforce; and (3) The nature and cost of the accommodation needed.”[144] These factors make sense in an employment context; they do not when applied to health care. For example, the composition and structure of a workforce and the number of employees is relevant to common employment-related accommodations, such as changes in job duties or schedules. These factors are much less likely to have bearing on common health care modifications, which may more commonly include requests for alternative evacuation plans for individuals who cannot use stairs, additional training for health care staff on how to provide services to certain individuals, ensuring lab referrals are made to accessible entities when necessary, or altering a policy to allow an individual to remain in a wheelchair and avoid unnecessary transferring while receiving some treatments such as dental care. Because the factors used to analyze “undue hardship” are more appropriate for the employment context, we believe that the appropriate approach is to retain the “reasonable modification” language, which is taken from Title II of the ADA, already applies to many entities subject to Section 1557, and has a clear definition that is flexible enough to provide guidance to health care entities.

We specifically object to the importation of the concept of “known physical or mental limitation” because it could introduce confusion, suggest that covered entities' obligations are limited, and unduly focuses on measures entities must take in response to requests for modifications. Disability discrimination encompasses not just inappropriate responses to requests for modifications, but also a failure of covered entities to take affirmative steps to prevent discrimination. Taken in conjunction with the proposed deletion of Section 92.101 (defining discriminatory actions prohibited), importing the language regarding "known physical or mental limitation" could be read to limit covered entities' obligations. Nothing in Section 1557 permits such limitations, and such a reading would be contrary to the language of Section 1557 and the larger

[144] 45 C.F.R. § 84.12.

Act within which it sits. Nor has HHS provided an explanation of how this concept, which heretofore has been largely limited to the employment context, would be applied in the health care context. Such an application would undermine HHS' stated purpose of the proposed rule, which is to promote consistency in the application of rules and to adhere to the enforcement mechanisms available in the underlying statutes.[145]

Furthermore, while we disagree with HHS' statement that Congress only intended to permit disparate impact claims if such claims were permissible prior to 1557, HHS admits that many courts have permitted disparate impact claims under Section 504.[146] Importing language regarding "known" limitations could be interpreted as limiting plaintiffs' ability to bring systemic disparate impact claims, or other substantive claims. If HHS intends to create such a limitation, it must be explicit about its intent, and do so via a transparent rulemaking process. HHS should retain the language in proposed 45 C.F.R. § 92.105.

For the reasons stated above, we urge HHS to retain the language proposed in Section 92.105 as drafted, and not to import any new exemptions or language regarding "reasonable accommodations for known physical and mental impairments."

§§ 92.102 through 92.105

In these four sections, HHS asks broadly whether it has struck the "appropriate balance" with respect to Section 504 rights and obligations imposed on the "regulated community." We agree generally that to the extent that HHS has retained protections from the 2016 Final Regulations, such protections are appropriate. More broadly, however, the question should not be "whether the benefits of these provisions exceeds the burdens imposed by them." Such a balancing exercise is not called for by the statute, and inserts an inappropriate regulatory finesse on a remedial scheme created by Congress and intended to be interpreted broadly and to correct decades of harm.[147] The task of the agency is to interpret and implement the statute. The proposed balancing of interests may be an appropriate role for Congress, but not for the administrative branch.

[145] 84 Fed. Reg. 27849-51.
[146] *See, e.g., McWright v. Alexander*, 982 F.2d 222, 229 (7th Cir. 1992); *Smith v. Barton*, 914 F.2d 1330, 1340 (9th Cir. 1990).
[147] *See, e.g.* 42 U.S.C. § 12101 (ADA findings and purposes). The ADA built upon Section 504, and Section 1557 follows in their footsteps.

Although we disagree with the premise of the question, we do note that the harm that people with disabilities would suffer if Section 1557 and the current regulatory scheme were not upheld is immense.[148] People with disabilities already experience significant disparities in health outcomes and access to health care.[149] For example, adults with disabilities are 58% more likely to experience obesity, three times more likely to be diagnosed with diabetes, and nearly four times more likely to have early-onset cardiovascular disease.[150] Moreover, they are nearly three times more likely to have not accessed needed health care because of cost and twice as likely to have unmet mental health needs.[151] The ACA's reforms worked to reduce some of these disparities by, for example, reducing the uninsurance rate and increasing the likelihood of a person with a disability having a regular health care provider.[152] However, there are still large gaps in health access.[153] Persistent attitudinal and programmatic barriers to care are ongoing.[154] Section 1557 provides an avenue through which people with disabilities can identify and challenge discriminatory policies.

HHS also asks generally whether regulations for Section 1557 are consistent with the regulatory scheme for entities that are not covered by Section 1557 regulations, such as human services grantees, or whether underlying regulations for other civil rights statutes need to be modified. In general, we have commented on contexts where it is inappropriate to import regulations created for the employment into Section 1557's regulatory scheme. While there are clearly other areas of nondiscrimination law where importing or exporting other regulatory regimes would be inappropriate, HHS has not provided sufficient clarity in both the questions and the context to allow us to provide additional meaningful comment outside of the comments raised above.

To propose changes in existing regulations, HHS must provide its own justification for the changes. Given that the public must be provided an opportunity to comment on HHS' alleged explanations and rationale for these proposed changes, HHS' attempt to

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[148] *See generally, e.g*. Valarie K. Blake, *An Opening for Civil Rights in Health Insurance After the Affordable Care Act*, 36 B.C. J.L. & SOC. JUST. 235 (2016) (describing pre-ACA health insurance discrimination and how the ACA addressed those issues).
[149] *See, e.g.*, Yee, et al., supra note 125.
[150] *Id.* at 32.
[151] *Id.* at 31.
[152] Kaye, supra note 133 at 1015–21 (July 2019); Gloria L. Krahn, *Drilling Deeper on the Impact of the Affordable Care Act on Disability-Related Health Care Access Disparities*, 109 AM. J. PUB. HEALTH, no. 7, 956–58 (July 2019).
[153] *See* Kaye, *supra* note 133, at 1019–21 (for example, across the population of people with disabilities, there has been "much greater delayed or forgone care" post-ACA).
[154] *See id.*; Yee, et al., *supra* note 125, at 31–32; 39–44.

solicit feedback on unspecified underlying regulations that it may then use to promulgate unanticipated changes in a final rule violates requirements of public notice and comment as required by the Administrative Procedures Act. These issues would be more appropriate to inform agency decisions prior to issuing an NPRM, such as through a Request for Information, than in response to an NPRM. We thus decline to provide additional feedback on the question of whether Section 1557 is generally aligned with underlying but unspecified regulations, but have provided our explanations, justifications and evidence supporting our comments in the sections above.

III.B. Current Section 1557 Regulations Proposed for Repeal

§ 92.4 Definitions

HHS proposes to eliminate the definitions section of the current regulations and to drastically limit the scope of Section 1557's protections. We strongly oppose these changes. (See also the discussion above on §§ 92.2 Nondiscrimination Requirements & 92.3 Scope of Application).

The scope of Section 1557's protected classes and characteristics extend broadly. The plain text of Section 1557 and the current implementing regulations establish the broad scope of its nondiscrimination protections. This is consistent with Congress's intent that Section 1557 build and expand upon existing civil rights laws, while providing broad protection against discrimination in health care. However, the proposed rule eliminates key definitions describing who is protected under Section 1557 and ignores HHS' own findings in the 2016 Final Rule on the harms of discrimination in health programs or activities. We oppose these proposed changes which seem to be based more on animus than fact or law.

a. Protections based upon gender identity

Twenty-nine percent of transgender individuals were refused to be seen by a health care provider on the basis of their perceived or actual gender identity and the same percent experienced unwanted physical contact from a health care provider.[155]

[155] 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.

Additionally, the 2015 U.S. Transgender Survey found that twenty-three percent of respondents did not see a provider for needed health care because of fears of mistreatment or discrimination.[156]

Under current law and regulations, Section 1557 prohibits discrimination on the basis of sex, including someone's gender identity.[157] In addition, current regulations expressly prohibit coverage exclusions for gender-affirming care, and prohibit plans from imposing limits or restrictions on health services provided to transgender persons, for services traditionally provided to persons of one sex.[158]

Despite the stark need for protection against discrimination on the basis of gender identity, however, the proposed rule completely eliminates gender identity as part of the definition of sex discrimination. It also removes sections of the existing regulations that prohibit health plans from excluding gender-affirming care.

HHS argues that gender identity protections and the prohibition of coverage exclusions imposes a new and costly burden for plans. However, issuers have been on notice since 2012 that they are obliged to follow Section 1557's protections against gender identity discrimination.[159] In any case, the 2016 Final Rule did not establish any new obligations that exist separate from Section 1557.

As explained above, HHS provides no rationale for relying on the preliminary injunction issued in *Franciscan Alliance* as the justification for eliminating regulatory protections against discrimination based upon gender identity. In addition, HHS fails to address numerous other court decisions finding that Section 1557's gender identity protections are statutory, instead cherry picking a handful of cases to the contrary. Discrimination based on gender identity, gender expression, gender transition, transgender status, or sex-based stereotypes is necessarily a form of sex discrimination.[160] Numerous federal

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[156] Nat'l Ctr. for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* 5 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[157] 45 C.F.R. § 92.4.

[158] 45 C.F.R. §§ 92.206, 92.207(b)(3)-(5). See, *e.g.*, Rebekah Rollston, MD, MPH, PROMOTING CERVICAL CANCER SCREENING AMONG FEMALE-TO-MALE TRANSMASCULINE PATIENTS, The Fenway Institute (May 22, 2019), https://fenwayhealth.org/wp-content/uploads/TFIP-28_TransMenCervicalCancerScreeningBrief_web.pdf.

[159] 81 Fed. Reg. 31387, citing Letter from Leon Rodriguez, Director, U.S. Dep't of Health & Human Servs., Office for Civil Rights, to Maya Rupert, Federal Policy Director, National Center for Lesbian Rights (Jul. 12, 2012), https://www.nachc.com/client/OCRLetterJuly2012.pdf.

[160] *See, e.g.*, *EEOC v. R.G. & G.R. Harris Funeral Homes*, No. 16-2424 (6th Cir. Mar. 7, 2018); *Whitaker v. Kenosha Unified Sch. Dist.*, 858 F.3d 1034 (7th Cir. 2017) (Title IX and Equal

courts have found that federal sex discrimination statutes reach these forms of gender-based discrimination.[161] Moreover, the scope of sex discrimination in Title VII is currently pending before the Supreme Court.[162] It is premature to change the regulations now before the Supreme Court has spoken to this precise interpretive issue.

Regardless, it is clear that discrimination based on gender identity or transgender status is sex discrimination because it treats people differently from otherwise similarly situated people based on their transition from one gender to another, because it treats them

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Protection Clause); Doddsv. U.S. Dep't of Educ., 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); Smith v. City of Salem, 378 F.3d 566 (6th Cir. 2004) (Title VII); *Rosa v. Park West Bank & Trust Co*., 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *A.H. ex rel. Handling v. Minersville Area School District*, 3:17-CV-391, 2017 WL 5632662 (M.D. Pa. Nov. 22, 2017) (Title IX and Equal Protection Clause); *Stone v. Trump*, ---F.Supp.3d ---, No. 17–2459 (D. Md. Nov. 21, 2017) (Equal Protection Clause); Doe v. Trump, ---F.Supp.3d ---, 2017 WL 4873042 (D.D.C. Oct. 30, 2017) (Equal Protection Clause); *Prescott v. Rady Children's Hospital-San Diego*, ---F.Supp.3d ---, 2017 WL 4310756 (S.D. Cal. Sept. 27, 2017) (Section 1557); *E.E.O.C. v. Rent-a-Center East, Inc*., ---F.Supp.3d ---, 2017 WL 4021130 (C.D. Ill. Sept. 8, 2017) (Title VII); *Brown v. Dept. of Health and Hum. Serv.*, No. 8:16DCV569, 2017 WL 2414567 (D. Neb. June 2, 2017) (Equal Protection Clause); *Smith v. Avanti*, 249 F.Supp.3d 1194 (D. Colo. 2017) (Fair Housing Act); *Students & Parents for Privacy v. U.S. Dep't of Educ.*, No. 16-cv-4945, 2016 WL 6134121 (N.D. Ill. Oct. 18, 2016) (Title IX); *Mickens v. Gen. Elec. Co.* No. 16-603, 2016 WL 7015665 (W.D. Ky. Nov. 29, 2016) (Title VII); *Fabian v. Hosp. of Cent. Conn*., 172 F.Supp.3d 509 (D. Conn. 2016) (Title VII); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. Jul. 5, 2016) (Section 1557); *Doe v. State of Ariz*., No. CV-15-02399-PHX-DGC, 2016 WL 1089743 (D. Ariz. Mar. 21, 2016) (Title VII); *Dawson v. H&H Elec., Inc.*, No. 4:14CV00583 SWW, 2015 WL 5437101 (E.D. Ark. Sept. 15, 2015) (Title VII); *U.S. v. S.E. Okla. State Univ*., No. CIV–15–324–C, 2015 WL 4606079 (W.D. Okla. 2015) (Title VII); *Rumble v. Fairview Health Serv.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (Section 1557); *Finkle v. Howard Cty*., 12 F.Supp.3d 780 (D. Md. 2014) (Title VII); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); *Lopez v. River Oaks Imaging & Diagnostic Grp*., Inc., 542 F.Supp.2d 653 (S.D. Tex. 2008) (Title VII); *Mitchell v. Axcan Scandipharm,* Inc., No. Civ.A. 05-243, 2006 WL 456173 (W.D. Pa. 2006) (Title VII); *Tronettiv. Healthnet Lakeshore Hosp*., No. 03–CV–0375E, 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003) (Title VII).

[161] *See, e.g*., *Smith v. City of Salem*, 378 F.3d 566, 572-75 (6th Cir. 2004); *Rosa v. Park West Bank & Trust Co*., 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act). *See also* Statement of Interest of the United States at 14, *Jamal v. Saks*, No. 4:14-cv-02782 (S.D. Tex. Jan. 26, 2015).

[162] *See Altitude Exp., Inc. v. Zarda*, 139 S. Ct. 1599 (2019); *R.G. & G.R. Harris Funeral Homes*, Inc. v. E.E.O.C., 139 S. Ct. 1599 (2019).

differently based on sex stereotypes, and because it treats them differently based on gender identity and transgender status. The First, Sixth, Seventh, Ninth, and Eleventh Circuits have found transgender individuals to be protected by Title VII and other federal sex discrimination laws.[163] Numerous district courts have also held that gender identity discrimination is prohibited by Title VII, either as *per se* sex discrimination because it is based on sex stereotypes, or because it is based on their gender transition.[164] Numerous agency administrative decisions and regulations have also made clear that "sex" includes gender identity and transgender status.[165]

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[163] *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, No. 16-3522, 2017 WL 2331751, at *9 (7th Cir. May 30, 2017); *Chavez v. Credit Nation Auto Sales, LLC*, 641 F. App'x 883, 884 (11th Cir. 2016); *Chavez v. Credit Nation Auto Sales, LLC*, 641 F. App'x 883, 884 (11th Cir. 2016); *Barnes v. City of Cincinnati*, 401 F.3d 729, 737 (6th Cir. 2005); *Smith v. City of Salem, Ohio*, 378 F.3d 566, 575 (6th Cir. 2004); *Schwenk v. Hartford*, 204 F.3d 1187, 1201-02 (9th Cir. 2000); *Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213, 215 (1st Cir. 2000).

[164] *Evancho v. Pine-Richland Sch. Dist.*, 2017 WL 770619, at *13 (W.D. Pa. Feb. 27, 2017); *Smith v. Avanti*, 2017 WL 1284723, at *4 (D. Colo. Apr. 5, 2017); *Valentine Ge v. Dun & Bradstreet, Inc.*, 2017 WL 347582, at *4 (M.D. Fla. Jan. 24, 2017); *Baker v. Aetna Life Ins.*, 228 F. Supp. 3d 764, 771 (N.D. Tex. Jan. 13, 2017); *Roberts v. Clark Cty. Sch. Dist.*, 215 F. Supp. 3d 1001, 1011, 1015 (D. Nev. 2016); *Bd. of Educ. of the Highland Local Sch. Dist. v. United States Dep't of Educ.*, 208 F. Supp. 3d 850, 869 (S.D. Ohio 2016); *Mickens v. General Electric Co.*, 2016 WL 7015665, at *3 (W.D. Ky. Nov. 29, 2016); *Fabian v. Hosp. of Cent. Connecticut*, 172 F. Supp. 3d 509, 526-27 (D. Conn. 2016); *Doe v. Ariz.*, 2016 WL 1089743, at *2 (D. Ariz. Mar. 21, 2016); *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015); *E.E.O.C. v. R.G. & G.R. Harris Funeral Homes, Inc.*, 100 F. Supp. 3d 594, 603 (E.D. Mich. 2015); *Rumble v. Fairview Health Servs.*, 2015 WL 1197415, at *2 (D. Minn. Mar. 16, 2015); *Finkle v. Howard Cty.*, Md., 12 F. Supp.3d 780, 788 (D. Md. 2014); *Parris v. Keystone Foods*, 959 F. Supp. 2d 1291, 1303 (N.D. Ala. 2013), *appeal dismissed*, No. 13-14495-D (11th Cir. Dec. 26, 2013); *Radtke v. Miscellaneous Drivers & Helpers Union Local #638 Health, Welfare, Eye, & Dental Fund*, 867 F. Supp. 2d 1023, 1031 (D. Minn. 2012); *Lopez v. River Oaks Imaging & Diagnostic Grp., Inc.*, 542 F. Supp. 2d 653, 660 (S.D. Tex. 2008); *Schroer v. Billington*, 577 F. Supp. 2d 293, 305 (D.D.C. 2008); *Mitchell v. Axcan Scandipharm, Inc.*, 2006 WL 456173, at *2 (W.D. Pa. Feb. 17, 2006); *Tronetti v. TLC HealthNet Lakeshore Hosp.*, 2003 WL 22757935, at *4 (W.D.N.Y. Sept. 26, 2003).

[165] See*, e.g.*, *Lusardi v. Dep't of the Army*, 2015 WL 1607756, at *11 (E.E.O.C. Apr. 1, 2015); *Macy v. Holder*, 2012 WL 1435995, *10 (E.E.O.C. Apr. 20, 2012) ("Thus, we conclude that intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination 'based on . . . sex,' and such discrimination therefore violates Title VII."); U.S. Department of Education - 34 C.F.R. § 270.7 ("Sex desegregation means the assignment of students to public schools … without regard to their sex (including transgender status; gender identity; sex stereotypes, such as treating a person differently because he or she does not conform to sex-role expectations because he or she is attracted to or is in a

There is a split of authority whether the rationale of the Title VII cases discussed above extends to the context of Title IX. Courts generally hold that the sex discrimination provisions of Title IX protect transgender individuals from discrimination.[166]

For example, in *M.A.B. v. Board of Education of Talbot County*, a transgender male student was required to use "neutral" locker rooms to change his clothes for activities requiring it.[167] Deciding the student's claim under Title IX, the court considered and relied upon Title VII precedents because the operative language is the same in both statutes. The neutral locker room did not have the same amenities as the boys' locker rooms though including a lack of showers and benches. Additionally, the student was the only student in the school that had to use the designated locker room causing embarrassment as other students gave him odd looks when he went to use his designated locker room. Discrimination based on gender identity had to incorporate consideration of the student's biological sex and stereotypes associated with the student's particular biological sex, so gender identity discrimination is unlawful sex discrimination.

HHS acknowledges other cases in which federal courts have upheld gender identity protections under § 1557, but characterizes them as "pending."[168] The court in *Prescott v. Rady Children's Hosp.*, concluded: "Because Title VII, and by extension Title IX,

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relationship with a person of the same sex; …)…."); U.S. Department of Health and Human Services - 45 C.F.R. § 92.4 ("On the basis of sex includes, but is not limited to, discrimination on the basis of . . . sex stereotyping, and gender identity.").

[166] See *Whitaker v. Kenosha Unified Sch. Dist. No. 1*, 858 F.3d 1034, 1049 (7th Cir. 2017) (granting a preliminary injunction and holding that the plaintiff had established a likelihood of success under Title IX where the school denied a transgender boy access to the boy's restroom); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1099 (S.D. Cal. 2017). In *G.G. ex rel. Grimm v. Gloucester Cty. Sch. Bd.*, 822 F.3d 709, 723 (4th Cir.), the Fourth Circuit reversed a district court ruling interpreting Title IX narrowly in contravention of properly-adopted regulations, remanding the case to the district court for the application of proper deference. The United States Supreme Court vacated and remanded the Fourth Circuit's decision, however, 137 S. Ct. 1239, 197 L. Ed. 2d 460 (2017), with instructions to consider the matter further "in light of the guidance document issued by the Department of Education and Department of Justice on February 22, 2017."

[167] 1:16-cv-02622-GLR (D. Md. March 12, 2018).

[168] 84 Fed. Reg. 27855.

recognize that discrimination on the basis of transgender identity is discrimination on the basis of sex, the Court interprets the ACA to afford the same protections."[169]

In *Flack* v. *Wis. Dept of Health Servs.,* the court held that Wisconsin's coverage exclusions for gender affirming care in Medicaid is "text-book discrimination based on sex." The court explained: "the Challenged Exclusion prevents the [plaintiffs] from getting medically necessary treatments on the basis of both their natal sex and transgender status, which surely amounts to discrimination on the basis of sex in violation of the ACA."[170]

HHS mischaracterized the status of *Flack* in the NPRM, claiming the petition for class certification is still pending.[171] The court granted class certification on April 23, 2019, nearly two months before HHS published its NPRM.[172]

In *Boyden v. Conlin,* the court similarly held: "Whether because of differential treatment based on natal sex, or because of a form of sex stereotyping where an individual is required effectively to maintain his or her natal sex characteristics, the Exclusion on its face treats transgender individuals differently on the basis of sex, thus triggering the protections of… the ACA's anti-discrimination provision."[173]

HHS also misrepresents the current status of *Boyden* in the NPRM. HHS claims the case is still pending appeal with the 7th Circuit.[174] This is false. The U.S. Court of Appeals for the 7th Circuit dismissed the case on March 26, 2019, three months before HHS published its NPRM.[175]

In *Tovar v. Essentia Health*, the court concluded: "Because Title VII, and by extension Title IX, recognize that sex discrimination encompasses gender-identity discrimination, the Court concludes that Section 1557 also prohibits discrimination on the basis of gender identity."[176]

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[169] 265 F. Supp. 3d 1090, 1099 (S.D. Cal. 2017). See also *Rumble v. Fairview Health Servs*., No. 14-CV-2037 (SRN/FLN), 2017 WL 401940, at *2 (D. Minn. Jan. 30, 2017) ("Section 1557 protects plaintiffs who allege discrimination based on gender identity").
[170] 328 F. Supp. 3d 931 (W.D. Wis. 2018).
[171] 84 Fed. Reg. 27855.
[172] *Flack v. Wis. Dept of Health Servs*., 2019 WL 1772403 (2019).
[173] 341 F. Supp. 3d 979, 997 (W.D. Wis. 2018).
[174] 84 Fed. Reg. 27855.
[175] Order to Dismiss, *Boyden v. Conlin* Nos. 18-3408, 18-3485 (7th Cir.) (March 26, 2019).
[176] 2018 U.S. Dist. LEXIS 16065 (D. Minn., Sept. 20, 2018)

The fact that HHS acknowledges these cases, but ignores these courts' conclusions, brings into question the rigor of the agency's analysis and undermines the very premise upon which HHS bases this regulatory rollback. Furthermore, HHS misstates the status of these important federal court cases that upheld Section 1557 protections against discrimination based upon someone's gender identity, which shows that HHS' proposed revision and elimination of current regulations is not based upon fact or law. HHS should not finalize these proposals.

b. Protections against discrimination based on sex stereotyping

According to one survey, eight percent of lesbian, gay, and bisexual individuals had an experience within the year prior to the survey where a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation and seven percent experienced unwanted physical contact and violence from a health care provider.[177] The study *When Health Care Isn't Caring* found that fifty-six percent of LGB people reported experiencing discrimination from health care providers – including refusals of care, harsh language, or even physical abuse – because of their sexual orientation.[178] HHS' Healthy People 2020 initiative recognizes, "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[179]

Current Section 1557 regulations protect against discrimination based on sex stereotypes.[180] While regulations do not expressly include discrimination on the basis of sexual orientation, HHS stated that Section 1557's prohibition of discrimination on the basis of sex includes, at a minimum, sex discrimination related to an individual's sexual

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[177] 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.

[178] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV,* 5 (2010), http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf.

[179] *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.

[180] 45 C.F.R. § 92.4.

orientation where the evidence establishes that the discrimination is based on sex stereotypes. The definition of sex stereotypes includes 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.[181] Sex stereotypes also include gendered expectations related to the appropriate roles of a certain sex.[182]

Moreover, it is well-established that sex discrimination encompasses discrimination based on sex stereotypes. Three decades ago, the Supreme Court held that Title VII prohibits discrimination against workers for their failure to conform to sex-based stereotypes in *Price Waterhouse v. Hopkins*.[183] In cases since then, courts have concluded that Title VII's nondiscrimination protections based upon sex stereotyping applies to sexual orientation.

In *Oncale v. Sundowner Offshore Services,* the Court recognized that same-sex sexual harassment can constitute discrimination because of sex and thus violate Title VII.[184] The Court focused on differential treatment of similarly situated men and women, and away from the specific goals of Congress in passing Title VII. *Oncale* has been read to preclude courts from creating their own exceptions to Title VII coverage based on speculation about the primary intent of Congress in passing the legislation. The Court in *Oncale* observed that "[S]tatutory prohibitions often go beyond the principal evil to cover reasonably comparable evils, and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed."[185] According to the Court, whatever evidentiary route a plaintiff chooses, so long as a plaintiff's claim "meets the statutory requirements" – i.e., is "discrimination because of sex" – the claim is cognizable.[186]

Since 2015, the Equal Employment Opportunity Commission ("EEOC") has opined that "[s]exual orientation discrimination is sex discrimination because it necessarily entails

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[181] *Id*.
[182] *Id*.
[183] 490 U.S. 228, 251 (1989) ("As for the legal relevance of sex stereotyping, we are beyond the day when an employer could evaluate employees by assuming or insisting that they match the stereotype associated with their group.")
[184] 523 U.S. 75 (1998).
[185] *Id.* at 79.
[186] *Id.* at 80.

treating an employee less favorably because of the employee's sex."[187] Numerous federal district courts have agreed.[188]

However, the proposed rule eliminates sex stereotyping from the definitions section of the current regulations.[189] It goes even further, by purging references to "sexual orientation" appearing in other HHS regulations, including those preventing discrimination in Essential Health Benefits, Qualified Health Plan marketing and design, outreach and enrollment activities, as well as Medicaid managed care and Programs for All-inclusive Care of the Elderly (PACE).[190]

Deleting sex stereotyping and other definitions may set the stage for HHS to refuse to enforce these important nondiscrimination protections. However, the proposed rule cannot eliminate thirty years of case law finding that sex stereotyping is part of nondiscrimination protections based on sex. We urge HHS to maintain current definitions for Section 1557, including sex stereotyping.

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[187] *Baldwin v. Department of Transportation* (Federal Aviation Administration), EEOC Appeal No. 0120133080 (July 15, 2015), 2015 WL 4397641, at 5, 10.

[188] See *Burnett v. Union R.R. Co.*, No. CV 17-101, 2017 WL 2731284, at *4 (W.D. Pa. June 26, 2017); *Philpott v. N.Y.*, 2017 WL 1750398, at *2 (S.D.N.Y. May 3, 2017); *Smith v. Avanti*, No. 2017 WL 1284723, at *4 (D. Colo. Apr. 5, 2017); *Smith v. Avanti*, No., 2017 WL 1284723, at *4 (D. Colo. Apr. 5, 2017); *U.S. Equal Employment Opportunity Comm'n v. Scott Med. Health Ctr., P.C.*, 217 F. Supp. 3d 834, 841 (W.D. Pa. 2016); *Tinory v. Autozoners,* No. CV 13-11477-DPW, 2016 WL 320108, at *5 (D. Mass. Jan. 26, 2016); *Boutillier v. Hartford Pub. Sch.*, 221 F. Supp. 3d 255, 268 (D. Conn. 2016); *U.S. Equal Employment Opportunity Comm'n v. Scott Med. Health Ctr., P.C.*, 217 F. Supp. 3d 834, 841 (W.D. Pa. 2016); *Videckis v. Pepperdine Univ.*, 150 F. Supp. 3d 1151, 1160 (C.D. Cal. 2015); *Isaacs v. Felder Servs.,* LLC, 143 F. Supp. 3d 1190, 1194 (M.D. Ala. 2015); *Hall v. BNSF Ry. Co.*, 2014 WL 4719007, at *3 (W.D. Wash. Sept. 22, 2014); *Koren v. Ohio Bell Tel. Co.*, 894 F. Supp. 2d 1032, 1038 (N.D. Ohio 2012); *Perry v. Schwarzenegger*, 704 F. Supp. 2d 921, 996 (N.D. Cal. 2010); *Heller v. Edgewater Country Club*, 195 F. Supp. 2d 1212, 1223 (D. Or. 2002); *Terveer v. Billington*, 34 F. Supp. 3d 100, 114 (D.D.C. 2014); *Centola v. Potter*, 183 F. Supp. 2d 403, 410 (D. Mass. 2002).

[189] 84 Fed. Reg. 27855, 27869

[190] 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).

c. Protections against sex discrimination, including pregnancy and 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 a diagnosis and treatment 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 sex discrimination for women of color may be compounded by other forms of discrimination they face, including racial discrimination and discrimination based on limited English language proficiency.

Before the ACA, women experienced pervasive discrimination in health care settings and by insurers. For example, women paid more than men for their insurance and were often unable to find coverage for necessary services, such as maternity care. In 2011, one year before qualified health plans were available in the ACA insurance marketplaces, sixty-two percent of individuals with individual market plans did not have maternity care coverage.[191]

Section 1557 prohibits discrimination on the basis of sex, including pregnancy status, termination of pregnancy, childbirth and related medical conditions, gender identity, and sex stereotyping. Any discrimination on the basis of pregnancy is specifically prohibited in Title IX regulations, and Section 1557 adopted these same restrictions.[192] Moreover, the 2016 final regulations implementing Section 1557 made clear that Section 1557 did not displace existing federal refusal laws and did not include new refusals.[193]

The proposed rule attempts to roll back these protections. Although HHS acknowledges in the preamble to the 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 rescind 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

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[191] Sarah Lueck, Ctr. on Budget & Policy Priorities, *If Essential Health Benefit Standards Are Repealed, Health Plans Would Cover Little*, (Mar. 23, 2017), https://www.cbpp.org/blog/if-essential-health-benefits-standards-are-repealed-health-plans-would-cover-little.

[192] See 45 C.F.R. § 86.40(b) (prohibiting discrimination on the basis of "pregnancy, childbirth, false pregnancy, termination of pregnancy, or recovery therefrom").

[193] 45 C.F.R. § 92.2(b)(2).

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.[194] 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 on abortion access 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 disparities in care and provider discrimination during pregnancy.

The impact of these changes could directly harm many people of color. For example, pregnancy-related complications remain one of the ten leading causes of death for Black women aged 15-34 years.[195] Black women are three-to-four times more likely to die from pregnancy related complications than white women. Rescinding portions of the 2016 final rule that expressly define and prohibit sex discrimination based on pregnancy status could put Black women at increased risk of pregnancy-related complications. Similarly, Asian American and Pacific Islander ("AAPI") women could be denied access to crucial services such as emergency contraceptives and prenatal care. AAPI women already face challenges accessing culturally and linguistically appropriate reproductive health care. Some studies show that AAPI women use less effective, but more easily accessible contraceptive methods at higher rates compared to women of other races and ethnicities, placing AAPI women at greater risk of unintended pregnancy.[196] Disparities also exist among AAPI women regarding utilization of prenatal care; Laotian and Cambodian women are less likely than other racial and ethnic groups to receive early and adequate prenatal care.[197] One study found AAPI women are twice as likely to

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[194] Proposed 45 C.F.R. §86.18 (codifying the abortion exemption in Title IX and "relevant laws" including laws cited in *Franciscan Alliance*, RFRA, the Weldon Amendment, Coats-Snowe, and the Church Amendments).

[195] 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/.

[196] Jo Jones, et al., U.S. Dep't of Health & Human Servs., *Current Contraceptive Use in the United States, 2006-2010, and Changes in Patterns of Use Since 1995*, 60 Nat'l Health Statistics Report 1, 5 (Oct. 18, 2012), https://www.cdc.gov/nchs/data/nhsr/nhsr060.pdf.

[197] Lora Jo Foo, The Ford Found., Asian American Women: Issues, Concerns, and Responsive Human and Civil Rights Advocacy 106 (2002).

die from pregnancy-related causes, including embolism and pregnancy-related hypertension.[198] For the Latina and Latinx population, lack of access to comprehensive, affordable insurance coverage means sporadic, if not non-existent, access to desperately needed treatment and services. Due to this and other factors, Latinas experience disproportionately high rates of unintended pregnancy, sexually transmitted infections including HIV, diabetes, asthma, and other health issues. Latinas have the highest incidence of cervical cancer; and Latinas are diagnosed with cervical cancer at nearly twice the rate of non-Latina white women. Immigrant Latinas also experience inequities because they have fewer employment opportunities that provide insurance coverage, may be ineligible for federally funded health coverage, face extreme poverty, and lack culturally and linguistically appropriate health care providers and services. The proposed rule also has the potential to place Native American women at risk of being denied treatment because of illegal pregnancy-based discrimination. According to one study of geographically diverse urban areas, Native American women are already 4.5 times more likely to die during or immediately after pregnancy than non-Hispanic white women.[199] Instead of rolling back nondiscrimination protections that will create more barriers to care, the Trump-Pence Administration should be creating policies that ensure Native women receive all of the pregnancy-related care they need.

We strongly oppose HHS proposal to rollback nondiscrimination protections based on sex, including pregnancy status and termination of pregnancy. This proposal is not consistent with Section 1557.

d. Other Definitions

HHS requested comment on whether definitions should be included in the regulatory text.[200] We are concerned about the elimination of an overarching definition section as well as the elimination of specific definitions. Having one section that provides all the relevant definitions for the proposed rule makes it easier for entities and the public to identify relevant definitions rather than having to find definitions within each section. This is especially the case in sections where definitions are not the first subsection of

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[198] Marcus T. Smith, *Fact Sheet: The State of Asian American Women in the United States*, Ctr. for Am. Progress (Nov. 7, 2013, 5:33 PM), https://www.americanprogress.org/issues/race/reports/2013/11/07/79182/fact-sheet-the-state-of-asian-american-women-in-the-united-states/.

[199] Adrian Dominguez, et al., Urban Indian Health Inst., Seattle Indian Health Bd., Community Health Profile: National Aggregate of Urban Indian Health Program Service Areas 37 (2016), http://www.uihi.org/wp-content/uploads/2017/08/UIHI_CHP_2016_Electronic_20170825.pdf.

[200] 84 Fed. Reg. 27860-1.

the proposed regulation (e.g. definition of qualified interpreter/translator in § 92.101 and definition of qualified interpreter for individuals with disabilities as well as the definition of auxiliary aids and services in § 92.102).

In particular, we oppose the elimination of the following definitions from the current regulations:

- Covered entity;
- Electronic and information technology;
- Employee health benefit program;
- Federal financial assistance;
- Individual with a disability;
- Individual with LEP;
- National origin;
- Qualified bilingual/multilingual staff;
- Qualified individual with a disability; and
- Recipient.

HHS says that it eliminates some terms and will interpret them "naturally and consistent" with the Final Rule. This includes "individual with limited English proficiency," "qualified bilingual/multilingual staff," and "individual with a disability." We disagree with this conclusion because it is the very lack of definitions for covered entities that often leads to erroneous determinations about what type of services are required or who can provide those services. For example, in the language access context, we continue to hear about unqualified bilingual/multilingual staff attempting to provide interpreting services or services directly in a non-English language. In our report, *The High Costs of Language Barriers in Medical Malpractice*, we described numerous examples of individuals who believed they had sufficient language skills to communicate with LEP patients but the resulting ineffective communication led to serious patient harm.[201] In one case detailed in the report:

> the patient was a Spanish-speaking pregnant woman in her second trimester who died from complications caused by pork tapeworms. Her neurologist testified that he did not require the use of an interpreter. He admitted that while his Spanish was "somewhat limited," he said that he spoke "medical Spanish" and could take a medical/neurological history in Spanish. He spoke with the patient in Spanish and asked all of his questions in Spanish. Notwithstanding the

[201] *See* https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/09/Language-Access-and-Malpractice.pdf.

> neurologist's self-assessment of his Spanish-proficiency, Mrs. Garcia still complained that she was unable to effectively communicate her condition to the treating physicians because they did not provide her with an interpreter.[202]

An individual may self-assess sufficient fluency in a non-English language to provide services in that language but more often than not, that individual does not have the sufficient fluency for interacting in health care encounters let alone the requisite knowledge of specialized medical terminology essential. Given the goal of Section 1557 to prohibit discrimination and a major goal of the ACA is to reduce disparities, having a definition that clarifies when someone who identifies as bilingual or multilingual can actually provide services directly in a non-English language is critical.

The same reasons support having a definition of individual with a disability, qualified individual with a disability, individual with limited English proficiency and qualified individual with limited English proficiency. Covered entities need to understand the full scope of individuals protected by Section 1557 and for whom assistance in the form of language services or auxiliary aids and services must be provided.

We also support including the definition of "electronic and information technology." Given that the underlying civil rights statutes on which Section 1557 builds were all enacted prior to adoption of much of today's electronic and information technology, we believe it is important that regulations proposed in response to a statute adopted in the 2000's include specific reference to this technology.

Finally, HHS specifically requested comment on whether it should define "recipient'' according to the current rule or by incorporation by reference to definitions in the underlying statutes, and whether such a definition of recipient should include subrecipients. We strongly recommend that HHS should define the term recipient and subrecipient according to the covered rule. As we have discussed throughout these comments, Section 1557 has broader applicability than the underlying civil rights statutes on which it builds. Therefore, new entities are subject to Section 1557 and need to understand the full scope of expectations for compliance.

§ 92.7 Designation of responsible employee and adoption of grievance procedures

We oppose the deletion of requirements related to designation of a responsible employee and adoption of grievance procedures. We believe that the requirements for a

[202] *Id.* at 14.

responsible employee and adoption of a grievance procedure is very important to holding covered entities responsible for the protections provided by § 1557. Without a designated employee and defined grievance procedure, many individuals protected by Section 1557 may not receive the information needed to prevent discrimination or seek redress for discrimination faced. Other federal civil rights laws require designation of a responsible employee and creation of grievance procedures so many covered entities will already have processes in place; expanding them to cover Section 1557 discrimination should be an easy process and HHS could also determine that processes in place to support Section 1557 are evidence of compliance with other pre-existing requirements.

§ 92.8 Notice Requirements

We strongly support the notice and tagline requirements in current regulations that ensure 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. The proposed changes are inconsistent with Section 1557 and should not be finalized.

a. Notices

The elimination of notices is problematic on many levels. The importance of this notice is in part due to Section 1557's recognition of the intersectionality of individuals and the discrimination they may face. Prior to Section 1557, an individual facing discrimination could have different rights and remedies based on the relevant underlying civil rights law covering that discrimination. For example, a woman who is limited English proficient would not have any redress for sex discrimination and would likely only have an ability to file an administrative complaint to address national origin discrimination. One of the goals of Section 1557 was to provide the same rights and remedies to all individuals facing discrimination, whether the discrimination be due to race, color, national origin, sex, disability or age. Having one notice covering all the rights under Section 1557 is critical in informing individuals who may face discrimination due to multiple factors of all their rights in one place and notice.

The proposed elimination of notices compromises and diminishes the primacy of the non-discrimination message of Section 1557. To clearly communicate a covered entity's non-discrimination obligations and consumers' right to access services, a notice must be posted in physical locations, on websites and sent with significant documents as the current regulations provide.

The current required elements of the notice cover a broad range of requirements for compliance with Section 1557. The notice requirement ensures that each covered entity notifies beneficiaries, enrollees, applicants and members of the public of the following:

(1) The covered entity does not discriminate on the basis covered by Section 1557;
(2) The covered entity provides auxiliary aids and services for people with disabilities;
(3) The covered entity provides language assistance services for individuals with LEP;
(4) How to obtain auxiliary aids and services;
(5) How to obtain language services;
(6) The availability of the grievance procedure; and
(7) How to file a discrimination complaint with OCR.[203]

Second, the notice requirements under Section 1557 are not duplicative of any other requirements, especially Section 504 or Title VI. The notice requirements in the current regulations are explicit and designed to adequately inform individuals of the scope of their rights under Section 1557. By not fully explaining why repeal of the notices is necessary, HHS fails to justify the repeal. Further, HHS recognizes that eliminating the notice requirement will result in some individuals not knowing of their rights and how to enforce them. Since the Section 1557 notice is more comprehensive than other requirements, HHS has previously determined that the Section 1557 notice would satisfy the Title VI notice requirement as outlined in 45 C.F.R. § 80.6(d) so that these notices are not duplicative. It has also done so for other required notices as long as the combined notice clearly informs individuals of their rights under Section 1557.[204] That is, the current notice requirements provides the most comprehensive yet concise summary of an individual's rights under Section 1557, building on Section 504, Title VI, Title IX and the Age Discrimination Act such that the Section 1557 notice is more comprehensive but not duplicative of other notices.

The notice requirement is also important because Section 1557 applies to a broader array of covered entities than the civil rights laws on which it builds. Section 1557 applies specifically to federally administered programs and activities as well as entities created under Title I of the Affordable Care Act. By eliminating the notice requirements, HHS has effectively exempted a large swath of covered entities from informing individuals about their rights under Section 1557.

[203] 45 C.F.R. § 92.8.
[204] 45 C.F.R. § 92.8(h).

Further, the costs of providing this notice are not prohibitive for covered entities. HHS provided a sample notice and translated it into 64 languages, alleviating covered entities of the responsibility and cost of developing one on their own.[205] Any burdens of wall space and use of information technology staff and resources to post the notice and include it on a website are greatly outweighed by the benefit of having the notice visible and conspicuous so that consumers may see and access the services promised in the notice.

While we recognize that some covered entities have raised concern about how often they have to send this notice (as well as taglines) with significant documents, the wholesale elimination of the notice is not justified by these concerns. Rather, HHS could consider a variety of options including an explanation of what constitutes significant documents or how often a covered entity has to send a notice if the covered entity sends multiple significant documents to individuals over the course of a year. Indeed, in comments submitted by insurers and medical associations in response to the original NPRM, the overriding question was about the frequency of sending notices or taglines rather than the need to send them at all. This was reiterated during a listening session convened by HHS' Office for Civil Rights in 2017 which we attended, where insurers and provider associations did not request a repeal of tagline requirements but rather sought clarification on the frequency with which notices and taglines should be sent.

HHS did not specifically calculate the costs of providing notices or the costs and harm individuals will suffer by not knowing about their rights. 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. We thus oppose the repeal of requirements related to notices.

b. Taglines

We strongly support the existing tagline requirements and oppose their repeal. The current regulations requires that the English notice and taglines be included in "significant publications and significant communications targeted to beneficiaries, enrollees, applicants or members of the public."[206]

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[205] Appendix A to Part 92 – Sample Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Sample Nondiscrimination Statement: Discrimination is Against the Law, *see also* OCR, Translated Resources for Covered Entities, https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html.

[206] 45 C.F.R. § 92.8(f)(1).

As HHS noted in the preamble to the final rule, taglines are important in part because HHS decided not to require translation of notices or other documents. The preamble states:

> Given that we are not requiring covered entities to post notices in non-English languages, having taglines available in multiple languages is even more important to provide notice to individuals with limited English proficiency of the availability of language assistance services.[207]

HHS also considered alternatives to the tagline requirements. HHS declined to adopt these alternatives, stating "We decline to eliminate the tagline requirement because such an approach would not provide adequate notice of language assistance services."[208] It specifically noted that the mere **availability** of language services or auxiliary aids and services does not provide adequate **notice** about the availability of services, how to request services or file a complaint.[209]

Tagline requirements also exist in other regulations so many of those entities that raised cost concerns with the taglines in the Section 1557 regulations will likely still have to comply with tagline requirements elsewhere. For example, marketplace regulations require taglines on documents and websites.[210] Qualified health plan issuers must comply with tagline requirements applicable to group health plans and issuers which requires taglines on certain notices and the Summary of Benefits and Coverage.[211]

While the Preamble and Regulatory Impact Analysis (RIA) attempt to provide a cost justification for repealing the tagline requirements, much of the data HHS relies on is old and irrelevant. In addition, HHS does not explain the methodology it used to draw these conclusions based on information provided by only a few entities. To the extent we can infer the methodology used by HHS to reach its conclusions, that methodology appears flawed. Additional information provided by a handful of insurers and pharmacy benefit managers cannot be extrapolated to the entire health care system since different entities have different interpretations of what a "significant" document is. Indeed, rather than consider any alternatives – such as clarifying the definition of "significant document" or examining whether taglines could be included in fewer documents if the

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[207] 81 Fed. Reg. 31398.
[208] *Id.*
[209] *Id.*
[210] 45 C.F.R. § 155.205(c)(2)(iii)(A).
[211] 45 C.F.R. § 147.136€(2)(iii), (e)(3); 29 C.F.R. §2590.715-2719(e)(2)(iii), (3).

same document is sent multiple times a year – HHS instead concluded that the costs outweighed any benefit. The repeal of taglines considered in connection with HHS' adoption of the four-factor test for evaluating compliance (which includes consideration of costs) leaves us even more concerned that HHS' enforcement activities will regularly but erroneously conclude that covered entities may not have to provide any language services.

Some of the examples provided to the Office of Management and Budget by entities complaining about the costs of taglines, and which HHS relied on in the RIA, actually go far beyond the expectations and requirements of the Section 1557 regulations. For example, HHS' sample English tagline consists of 19 words (including TTY information in the word count). Some of the taglines provided to OMB and HHS were much longer than HHS' sample and included in many more languages than the 15 expected in the current regulations. The following chart includes the information provided to OMB, extrapolated on the assumption that the length of the tagline would stay relatively similar in different languages (or that the variances would result in similar results across the examples):[212]

Source	**Tagline Length**	**Language**	**Number of Taglines**	**Estimated Total Words[213]**
§ 1557 Final Rule[214]	19	English	15	285
Example 1[215]	31	Spanish	65	2015
Example 2	85	English	18	1530
Example 3	11	English	66	726
Example 4	36	Spanish	15	540

[212] Completed 18166 Meeting, Rin 0945-AA11, May 9, 2018, Handout #1, *available at* https://www.reginfo.gov/public/do/viewEO12866Meeting?viewRule=false&rin=0945-AA11&meetingId=3184&acronym=0945-HHS/OCR.

[213] Please note that this total is a rough extrapolation as different languages will use more or less words than an English or Spanish tagline. However, we believe it is useful as a guide given the estimates HHS relied on are much longer than what is expected under current Section 1557 regulations.

[214] This estimate uses the length of HHS' sample tagline included in the Section 1557 final regulation.

[215] These examples are taken from the information submitted to OMB, https://www.reginfo.gov/public/do/viewEO12866Meeting?viewRule=false&rin=0945-AA11&meetingId=3184&acronym=0945-HHS/OCR.

Even with this rough estimate, the examples provided consist of two to seven times the number of words expected under the Section 1557 current rule. Thus any cost estimates using those examples would vastly overestimate the costs of providing taglines. While we certainly appreciate the inclusion of a longer, more descriptive tagline in more languages, HHS cannot rely on inflated costs from an extremely small sample as justification to repeal this provision. In the only examples provided, the costs end up inflated because the added length and number of taglines increases the costs to covered entities beyond what HHS originally contemplated. If instead the covered entities utilized a shorter tagline and only provided the tagline in the top 15 languages in the state (which a covered entity likely could do by tailoring notices per state rather than aggregating languages among multiple states), the costs of compliance would be significantly less. It does not seem that HHS conducted any analysis of the costs of using its shorter tagline in only 15 languages.

Additionally, HHS estimates the cost using the current application of the tagline requirement. While we oppose the NPRM's proposed limitations on the scope of Section 1557 as outlined in proposed § 92.2, limiting the number of covered entities, particularly by reducing the number of insurers or products covered, would further reduce the expected costs of providing notices and taglines. That is, HHS currently proposes that only insurers providing health plans in the marketplaces would be covered by Section 1557, excluding these insurer's non-marketplace products (including short-term limited duration plans and employer-sponsored plans). Thus, many fewer entities would be subject to providing taglines to fewer enrollees, further reducing the likely costs.

The combination of inflated costs for providing longer taglines and notices, the reduction in covered entities, and the lack of an independent analysis results in a failure of HHS to accurately estimate and assess the costs and costs savings in proposing to eliminate taglines (as well as notices). As noted by the Center for American Progress, HHS relies solely on selected data provided by insurers and pharmacy benefit managers to make these changes, yet the survey results provided do not contain any information about the reaction individuals with LEP had to the taglines or the impact on this population. In the proposed rule, HHS never mentions receiving input from individuals with LEP and entirely relies on insurance company and pharmacy benefit managers' analyses to determine that notices are not necessary.[216] HHS's methods are not sound.

[216] Center for American Progress, *Attack on the ACA: Undermining Protections for LGBTQ Patients and Language Accessibility Requirements* (July 19, 2019), https://www.americanprogress.org/issues/lgbt/news/2019/07/19/472332/attack-on-the-aca/.

By completely repealing the tagline requirements, HHS failed to consider any alternatives that could balance the potential costs with the need for individuals to be informed about their rights. As HHS noted in the preamble to the final Section 1557 regulations, not having taglines "would not provide adequate notice of language assistance services"[217] and thus would not ensure entities comply with the statutory nondiscrimination requirements of Section 1557. Yet HHS did not consider the costs to individuals with LEP of the loss of taglines or all individuals covered by the protections of Section 1557 who will suffer by the elimination of notices.

As HHS recognized in the Preamble to the Section 1557 final regulations, tagline requirements

> may impose some limited burdens on covered entities. However, these burdens are outweighed by the benefits . . . for individuals with limited English proficiency by making them aware, in their own languages, of the availability of language assistance services. Notifying individuals of their rights under Section 1557 and this part, including the availability of language assistance services for individuals with limited English proficiency and the availability of auxiliary aids and services for persons with disabilities, is critical to providing an equal opportunity to access health care and health coverage.[218]

As we mentioned above regarding notices, comments submitted by insurers and medical associations in response to the original NPRM did not generally dispute the tagline requirement but the overriding question was about the frequency of sending notices or taglines. This was reiterated during a listening session convened by HHS' Office for Civil Rights in 2017 which we attended, insurers and provider associations did not request a repeal of tagline requirements but rather sought clarification on the frequency with which notices and taglines should be sent.

HHS has also failed to explain why completely eliminating tagline requirements is justified given the prior analysis HHS has already undertaken in adopting these requirements just a few short years ago.

§ 92.101 Discrimination Prohibited

HHS proposes to delete § 92.101 of the current rule, claiming it will be replaced by "provisions addressing Section 1557's purpose, nondiscrimination requirements, scope

[217] *Id.*

[218] 81 Fed. Reg. 31401.

of application, enforcement mechanisms, relationship to other laws, and meaningful access for LEP individuals."[219] However, § 92.101 contains important prohibitions on discrimination that the NPRM now fails to incorporate.

In the preamble to the current final regulations, HHS noted:

> We considered harmonizing each of the specific discriminatory actions prohibited across each civil rights law addressed by Section 1557. We noted that although harmonization could reduce redundancy in the specific discriminatory actions incorporated that are similar to one another, harmonization would likely lead to confusion and unintended differences in interpretation that are subtle yet significant. We therefore proposed that paragraphs (b)(1)–(4) incorporate the specific discriminatory actions prohibited under each civil rights law on which Section 1557 is grounded.[220]

Yet the deletion of this section in the current NPRM will cause the very result HHS has previously determined untenable. Both the overall deletion and the deletion of specific protections of each protected class will result in a murkier understanding of Section 1557's scope as well as the protections afforded each protected class.

By deleting § 92.101(b)(1), HHS deletes references to important regulatory definitions of discrimination on the basis of race, color and national origin. For example, the current regulation states that "Each covered entity must comply with the regulation implementing Title VI, at § 80.3(b)(1) through (6) of this chapter."[221] The regulations prohibit discrimination on the basis of race, color or national origin such as: denying or providing different services; restricting access or subjecting an individual to segregation or separate treatment; or treating an individual differently than others for the purposes of admission, enrollment, eligibility, membership or other requirement/condition needed to receive a service or other benefit.

The current regulations also provide that no covered entity may aid or perpetuate discrimination against any person by providing significant assistance to any entity/person that discriminates on the basis of race, color or national origin in providing any aid, benefit or service to beneficiaries.[222] Given that many covered entities fail to understand the requirements of Title VI, it is important to reiterate those requirements in

[219] 84 Fed Reg. 27856, 27860.
[220] 81 Fed. Reg. 31404.
[221] 45 C.F.R. § 92.101(b)(1)(i).
[222] 45 C.F.R. §92.101(b)(1)(ii).

this regulation, given that many entities have paid more attention to implementation of the ACA than with complying with longstanding civil rights laws. Thus, having these provisions in the current regulations can bring much needed attention to the pre-existing provisions on which Section 1557 is built.

HHS deletes § 92.101(b)(2) which references important regulatory definitions of disability discrimination, and incorporates the relevant provisions of 504 implementing regulations for federal assisted and federally administered programs and activities.[223] For example, the current regulation states that "Each recipient and State-based Marketplace[SM] must comply with the regulation implementing Section 504, at §§ 84.4(b), 84.21 through 84.23(b), 84.31, 84.34, 84.37, 84.38, and 84.41 through 84.52(c) and 84.53 through 84.55 of this subchapter."[224] It also states that

> [t]he Department, including the Federally-facilitated Marketplaces, must comply with the regulation implementing Section 504, at §§ 85.21(b), 85.41 through 85.42, and 85.44 through 85.51 of this subchapter.[225]

These cross-references clarify that covered entities have an affirmative obligation to ensure that their health care is accessible to individuals with disabilities in a myriad of ways that are not captured in other sections of the NPRM. For example, sections 84.4(b) and § 85.21(b) prohibit discrimination by a variety of factors. These include:

- denying an individual with a disability the opportunity to participate in or benefit from the aid, service, or benefit;
- affording an individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;
- providing an individual with a disability a less effective aid, benefit or service;
- providing an individual with a disability different or separate aids, benefits, or services;
- otherwise limiting a person with a disability in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service.[226]

[223] 81 Fed. Reg. 31404.
[224] 45 C.F.R. § 92.101(b) (2) (i).
[225] 45 C.F.R. § 92.101(b)(2)(ii).
[226] 45 C.F.R. §§ 84.4(b), 85.21(b).

It also prohibits covered entities from:

> utiliz[ing] criteria or methods of administration (i) that have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap, (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program or activity with respect to handicapped persons, or (iii) that perpetuate the discrimination of another recipient if both recipients are subject to common administrative control or are agencies of the same State."[227]

In short, without the inclusion of § 92.101, the NPRM's description of prohibited discrimination under Section 504 is incomplete. It is also contrary to the statutory language and intent of Section 1557, which explicitly specifies that the grounds for discrimination are defined by reference to Section 504 and other civil rights laws.

HHS also proposes deleting § 92.101(b)(3), which references to important regulatory definitions of sex discrimination. For example, the current regulation states that "Each covered entity must comply with the regulation implementing Title IX, at § 86.31(b)(1) through (8) of this chapter."[228] These regulatory sections outline the specific prohibitions of Title IX, including:

- Treating a person differently in determining whether a person satisfies any requirement or condition for receiving aid, benefit or service;
- Providing different aid, benefits or services (or providing them in a different manner);
- Denying any aid, benefit or service;
- Subjecting any person to separate or different rules of behavior, sanctions, or other treatment;
- Discriminating against any person in the application of any rules of appearance;
- Applying any rule concerning the domicile/residence of a student/applicant, including eligibility for in-state fees and tuition;
- Aiding or perpetuating discrimination against any person by providing significant assistance to any agency, organization, or person which discriminates on the basis of sex in providing any aid, benefit or service to students or employees;
- Otherwise limiting any person in the enjoyment of any right, privilege, advantage, or opportunity.[229]

[227] 45 C.F.R. § 84.4(b); 45 C.F.R. § 85.21(b).
[228] 45 C.F.R. § 92.101(b)(3)(i).
[229] 45 C.F.R. § 86.31(b)(1)-(8).

It also states that

> a covered entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration that have the effect of subjecting individuals to discrimination on the basis of sex, or have the effect of defeating or substantially impairing accomplishments of the objectives of the program with respect to individuals on the basis of sex.[230]

Additional subsections specify that site location may not exclude individuals on the basis of sex and that sex-specific health programs or activities may only be permitted if there is an "exceedingly persuasive" justification.[231] These provisions clarify that covered entities have an affirmative obligation to ensure that their health care is accessible regardless of one's sex (or sex stereotypes or gender identity, per the definition of "on the basis of sex" in the current regulations) in a myriad of ways that is not captured in other sections of the NPRM. Given the fact that sex discrimination is only newly prohibited in health care by Section 1557, since Title IX had only applied to educational contexts, it is extremely important to provide information to health care providers about the scope of Title IX's protections and how to prevent sex discrimination.

By deleting these provisions, the NPRM's description of prohibited discrimination under Title IX, and thereby Section 1557, is incomplete. These provisions are necessary to the statutory language and intent of Section 1557, which explicitly specifies that the grounds for discrimination are defined by reference to Title IX and other civil rights laws.

And by deleting § 92.101(b)(4), HHS deletes references to important regulatory definitions of age discrimination. For example, the current regulation states that "Each covered entity must comply with the regulation implementing the Age Discrimination Act, at § 91.11 of this subchapter."[232] This provision outlines the general rule for protecting against age discrimination as well as specific rules such as not using age to deny benefits or subject an individual to discrimination under any program/activity receiving federal financial assistance and denying or limiting the ability to participate in any program/activity receiving federal financial assistance. In its NPRM, HHS fails to provide any specific information about complying with the Age Discrimination Act and its implementing regulations. Indeed, the only way HHS attempts to recognize the relevance of the Age Discrimination Act for the purposes of Section 1557 is to limit

[230] 45 C.F.R. § 92.101(b)(3)(ii).
[231] 45 C.F.R. § 92.101(b)(3)(iii), (iv).
[232] 45 C.F.R. § 92.101(b)(4)(i).

enforcement mechanisms rather than recognize any additional or new requirements for covered entities. The elimination of these provisions is not consistent with Section 1557 and is likely to create confusion.

The current section also contains important information with regard to applicable and non-applicable exceptions as well as how to adopt other regulations' terminology to the context of Section 1557.[233] These important clarifications have helped covered entities to understand the depth and breadth of Section 1557's application, both where it parallels pre-existing civil rights laws on which it builds but also more importantly where it departs and has a broader application. Eliminating this explicit information leaves covered entities without guidance as to the scope of Section 1557, which is likely to cause confusion, and result in entities engaging in prohibited discrimination. The current provisions are consistent with Section 1557 and should be retained.

§ 92.207 Nondiscrimination in health-related insurance and other health-related coverage

Section 1557 and the 2016 implementing regulations prohibit health insurance companies from discriminating through marketing practices and benefit design. These protections are especially important for people with disabilities and those with other serious or chronic conditions. The proposed rule seeks to exempt most health insurance plans from Section 1557's nondiscrimination protections and eliminates, without explanation, the regulation prohibiting discriminatory benefit design and marketing. This proposed change is contrary to Section 1557's express language and intent.

Before the ACA, health insurers routinely discriminated against people with HIV/AIDS and other serious or chronic conditions by charging them exorbitant premiums, excluding coverage for their conditions, or refusing to provide health coverage at all. Although the ACA ended these practices, some insurers still sought ways to discourage people with significant health needs from enrolling in their plans.

For example, the National Health Law Program and The AIDS Institute filed a complaint with HHS Office for Civil Rights (OCR) charging that four Florida health insurers discriminated against persons living with HIV/AIDS by placing all drugs used in the treatment of HIV, including generics, in the highest cost sharing tiers.[234] Researchers at

[233] 45 C.F.R. § 92.101(c), (d).
[234] 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 Harvard School of Public Health found that the practice of placing HIV drugs in the highest cost sharing tier, which they called "adverse tiering," to be widespread.[235] The Pharmaceutical Research and Manufacturers Association (PhRMA) contracted for an analysis of the formularies for 123 silver-level Marketplace plans and found similar problems regarding medications for multiple sclerosis and cancer. PhRMA concluded that there was a "lack of adequate formulary scrutiny on the part of state and federal regulators" because "[r]equiring high cost sharing for all medicines in a class is exactly the type of practice the ACA was designed to prevent."[236]

Section 1557 was passed as part of the ACA to specifically address discrimination in benefit design. As an integral component of these reforms, Congress mandated comprehensive health benefit coverage and explicitly prohibited discriminatory practices in the content of those plan designs. Most pertinent, it prohibited limitations or exclusions of benefits based on pre-existing conditions; it mandated coverage, on a nondiscriminatory basis, of ten categories of essential health benefits ("EHBs"); and it prohibited QHP "marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs," among other protections.[237]

Section 1557 of the ACA is the key to enforcing these statutory mandates. Section 1557 prohibits discrimination, including discrimination in the design of a benefit package, in health programs or activities receiving federal financial assistance.[238] By statute, it creates a private right of action for individuals to enforce their civil rights in the health care context.[239] The scope of actionable discrimination under Section 1557 logically covers discrimination in enrollment, equal access to benefits, and benefit design.[240]

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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/.

[235] Douglas B. Jacobs, ScB, and Benjamin D. Sommers, MD, PhD, *Using Drugs to Discriminate — Adverse Selection in the Insurance Marketplace*, N ENGL J MED 2015; 372:399-402 (Jan. 29, 2015).

[236] PhRMA, Coverage Without Access: An Analysis of Exchange Plan Benefits for Certain Medicines, http://www.phrma.org/affordable-care-act/coverage-without-access-an-analysis-of-exchange-plan-benefits-for-certain-medicines#sthash.o0bB3Xh0.pdf.

[237] 42 U.S.C. §§ 300gg-3(b)(1), 18022, 18031(c)(1)(A).

[238] *See* 42 U.S.C. § 18116(a).

[239] See*, e.g.*, *Rumble v. Fairview Health Servs.*, No. 14-cv-2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (finding that Section 1557 creates a private right of action).

[240] See*, e.g.*, 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/.

Recognizing this statutory requirement, the 2016 final rule reiterates that Section 1557 prohibits "marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age, or disability in a health-related insurance plan or policy."[241] In guidance, HHS provided examples of practices that would contravene Section 1557 and this regulation. Plans that, for example, "cover bariatric surgery in adults but exclude such coverage for adults with particular developmental disabilities place[e] most or all drugs that treat a specific condition on the highest cost tiers or exclude bone marrow transplants regardless of medical necessity would run afoul of Section 1557, HHS explained.[242]

HHS' 2016 regulation logically follows the letter and intent of the ACA. Without explicit acknowledgement of, and a resulting prohibition on, discriminatory benefit design, Section 1557's nondiscrimination protections would be rendered illusory. By not reaching the structure of a benefit package, a health insurer could always manipulate their benefit design to elude discrimination law, despite maintaining the same discriminatory effects.

For illustration, consider cancer benefits. Without the ACA reaching benefit designs, a health insurer could not deny an individual with cancer enrollment in a QHP or equal access to the treatments, services, and prescription drugs the plan chooses to cover; however, it could exclude from its coverage all cancer-related surgery, chemotherapy, radiation, and post-treatment drugs. It could also limit beneficiaries to provider networks that fail to include key oncology specialists, thus avoiding coverage of the expensive treatments they may prescribe. For a person with cancer, access to a health plan would be deemed virtually meaningless in the absence of cancer-related coverage. The effect of these exclusions would be the same as an outright denial of enrollment. Elimination of the benefit design regulation perversely encourages this result. It incentivizes insurers to find roundabout ways to deter people with pre-existing conditions from their plans. This is impermissible under Section 1557 of the ACA and Section 504 of the Rehabilitation Act.[243]

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[241] 45 C.F.R. § 92.207.

[242] HHS Nondiscrimination in Health Programs and Activities; Final Rule, 81 Fed. Reg. 31,376, 31,429 (May 18, 2016); *HHS Notice of Benefit and Payment Parameters for 2016*, 80 Fed. Reg. 10,750, 10,822 (Feb. 17, 2015); CMS CCIIO, QHP Master Review Tools for 2015, Non-Discrimination in Benefit Design (2015), http://insurance.ohio.gov/Company/Documents/2015_Non-Discriminatory_Benefit_Design_QHP_Standards.pdf.

[243] *See* 29 U.S.C. § 794; 42 U.S.C. §§ 18116(a), 18031(c)(1)(A); 45 C.F.R. § 92.207(b)(2).

The proposed rule removes the current prohibition on discriminatory plan benefit design and marketing in the Section 1557 regulations at 45 C.F.R. § 92.207. These protections are especially important for people with disabilities and those with serious or chronic conditions. This could result in health insurers excluding important benefits, designing their prescription drug formularies in a way that limits access to medically necessary care, or cherry-picking healthier enrollees through marketing practices. Eliminating these regulatory provisions may make it harder for people who experience discrimination to enforce their rights through administrative and judicial complaints.

However, HHS fails to provide any explanation regarding the elimination of these regulatory protections. Therefore, we are unable to adequately comment and strongly oppose HHS' proposed action.

§ 92.208 Employer liability for discrimination in employee health benefit programs

We oppose the repeal of this provision. HHS has not provided any reason or explanation as to why it seeks to repeal this provision. To justify proposed changes in existing regulations, HHS must provide its own explanation and rationale for the changes, documenting a need for these changes based not on an opposition to the policy undergirding a particular regulation but based on reason and data. Given that the public must be provided an opportunity to comment on HHS' alleged justifications for these proposed changes, HHS' attempt to repeal this provision is legally insufficient and violates requirements of public notice and comment as required by the Administrative Procedures Act.

§ 92.209 Nondiscrimination on the basis of association

Current regulations expressly prohibit discrimination on the basis of association with a protected class.[244] Without explanation, the proposed rule eliminates this provision. Congress intended Section 1557 to protect against discrimination by association, and these provisions should be retained.

In the 2016 Final Rule, HHS explains that the statute does not restrict "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

[244] 45 C.F.R. § 92.209.

discrimination is a characteristic of the harmed individual or an individual who is associated with the harmed individual.[245]

The current regulation's language mirrors that of Title I and Title III of the ADA, which protect against discrimination based on association or relationship with a person with a disability.[246] Congress intended that Section 1557 provide at least the same protections for patients and provider entities. In accord with the ADA, the current regulation recognizes this 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.[247]

For example, an individual in an interracial marriage who experiences discrimination would be protected under Section 1557 because of the individual's association with a protected class.[248] Similarly, a HIV-negative person in a sero-discordant relationship could not be denied access to pre-exposure prophylaxis (PrEP) to prevent HIV infection.[249] Denying access to this treatment or other health care services would be prohibited associational discrimination, and would adversely affect vulnerable, highest risk populations including gay and bisexual men.

By eliminating regulatory provisions expressly prohibiting discrimination on the basis of association, HHS will create uncertainty and confusion regarding the responsibilities of

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[245] 81 Fed. Reg. 31439.

[246] 42 U.S.C. §§ 12112, 12182 (2012).

[247] 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").

[248] *Id*., citing *Parr v. Woodmen of the World Life Ins*., 791 F.2d 888, 892 (11th Cir. 1986).

[249] Press Release, FDA Approves First Drug for Reducing the Risk of Sexually Acquired HIV Infection, FOOD & DRUG ADMIN. (July 16, 2012), https://wayback.archive-it.org/7993/20170112032741/http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm312210.htm. *Pre-exposure Prophylaxis (PrEP) for HIV Prevention*, CTRS. FOR DISEASE CONTROL AND PREVENTION 1 (May 2014), https://www.cdc.gov/hiv/pdf/PrEP_fact_sheet_final.pdf; *PrEP*, CTRS. FOR DISEASE CONTROL AND PREVENTION (March 23, 2018), https://www.cdc.gov/hiv/basics/prep.html. While a generic version of Truvada was approved by the FDA in 2017, it appears likely that it will not become commercially available until 2021, when Gilead's patent on emtricitabine (one of the two HIV antiretroviral drugs Truvada is composed of) expires. See *The FDA Has Approved Generic PrEP – but Access May Remain Difficult*, PROJECT INFORM (June 16, 2017), https://www.projectinform.org/hiv-news/the-fda-has-approved-generic-prep-but-access-may-remain-difficult/.

providers and the rights of persons who experience discrimination. However, because HHS provides no explanation of its reasons for removing 45 C.F.R. § 92.209, we cannot adequately comment, and urge HHS to retain the current regulatory protections.

§ 92.302 Procedures for health programs and activities conducted by recipients and State-based marketplaces &
§ 92.303 Procedures for health programs and activities administered by the Department

We oppose the repeal of these provisions as discussed above in section II.A.2.

IV. Need for Conforming Amendments

NHeLP opposes the proposed amendments to:

- 45 C.F.R. §§ 155.120(c)(1)(ii), 155.220(j)(2) (nondiscrimination provisions concerning how States and Exchanges carry out PPACA requirements and how agents or brokers market to individuals they assist with Exchange enrollment or related applications);
- § 147.104(e) (nondiscrimination provision concerning marketing or benefit design practices of health insurance issuers under the PPACA);
- §§ 156.200(e), 156.1230(b)(3) (nondiscrimination provision concerning the administration of QHPs by issuers and concerning marketing and other conduct by QHP issuers engaged in direct enrollment);
- 42 C.F.R. §§ 460.98(b)(3), 460.112(a) (nondiscrimination provisions for organizations operating Programs for All-inclusive Care of the Elderly (PACE) programs and participants receiving PACE services under Medicare); and
- §§ 438.3(d)(4), 438.206(c)(2), 440.262 (nondiscrimination provisions concerning Medicaid beneficiary enrollment, and promotion and delivery of access and services).

These amendments would remove sexual orientation and gender identity as enumerated prohibited bases of discrimination. HHS's attempt to stylize these amendments as necessary to conform these provisions to HHS' new interpretation of Section 1557 and the civil rights laws referenced in it is incorrect. As a preliminary matter, the scope of sex discrimination in Title VII is currently pending before the

Supreme Court.[250] It is premature to change the regulations now before the Supreme Court has spoken to this precise interpretive issue.

For several of the proposed provisions, the regulations listed above were promulgated under a statutory basis other than, or in addition to, Section 1557, as requiring protection against discrimination on the basis of gender identity and sexual orientation.[251] HHS completely fails to address the statutory grounds or these provisions outside of Section 1557. In fact, those statutes independently provide for prohibitions against discrimination on the basis of gender identity and sexual orientation. HHS may not finalize the proposed revisions to these regulations.

As discussed in more detail above (*supra* Section III.B), the plain language of Section 1557 provides for protection from discrimination based on gender identity. The majority of courts to consider the question have found that the statutory language of Section 1557 prohibits discrimination based on gender identity.[252] As one court has explained: "discriminating on the basis that an individual was going to, had, or was in the process of changing their sex — or the most pronounced physical characteristics of their sex — is still discrimination based on sex."[253] Discrimination on the basis of gender identity is prohibited by 1557. Removing the words "gender identity" from the various regulations listed will not change that fact, but will serve to confuse the entities covered by those regulations, and the stakeholders entitled to protection under them, as to the scope of their legal obligations and rights. This confusion will likely lead to more complaints and litigation over gender identity-based discrimination. HHS should not adopt the proposed changes to these sections.

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[250] *See Altitude Exp., Inc. v. Zarda*, 139 S. Ct. 1599 (2019); *R.G. & G.R. Harris Funeral Homes*, Inc. v. E.E.O.C., 139 S. Ct. 1599 (2019).

[251] Specifically, 45 C.F.R. § 155.120(c)(1)(ii) was promulgated pursuant to ACA section 1321(a)(1)(A). *See Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans*, 76 Fed. Reg. 41865, 41897 (2011). 45 § 156.200(e) was promulgated pursuant to ACA section 1321(a)(1)(B). *See Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans*, 76 Fed. Reg. 41865, 41897 (2011). The protections at 42 C.F.R §§ 438.3(d)(4), 438.206(c)(2), 440.262 are based on Social Security Act §§ 1902(a)(19) and 1902(a)(4). *Medicaid and Children's Health Insurance Program (CHIP) Programs*, 81 Fed. Reg. 27498, 27538 (2016).

[252] *See, e.g., Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 953 (D. Minn. 2018); *Boyden v. Conlin*, 341 F. Supp. 3d 979, 997 (W.D. Wis. 2018); *Flack v. Wis. Dep't of Health Servs*., 328 F. Supp. 3d 931, 951 (W.D. Wis. 2018); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090, 1098-1100 (S.D. Cal. 2017); *Rumble v. Fairview Health Servs*., No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at *18 (D. Minn. Mar. 16, 2015).

[253] *Flack v. Wis. Dept. of Health Servs*., 328 F. Supp. 3d 931, 949 (W.D. Wis. 2018).

In addition, as discussed above (*supra* Section III.B), section 1557 prohibits discrimination based on sexual orientation. To date, no court has specifically addressed whether sexual orientation discrimination is encompassed under section 1557's prohibition against discrimination on the basis of sex. Numerous courts, however, have held that sexual orientation discrimination is a type of sex discrimination, both because it is based on the sex of the individuals to whom a person is attracted, and because it relies on sex stereotypes about romantic pairings and attraction.[254] For the same reason, Section 1557 prohibits discrimination on the basis of sexual orientation. Removing the words "sexual orientation" from the listed regulations will not change the statutory text of Section 1557 or other statutory non-discrimination provisions such that sexual orientation discrimination is allowed, but, as described above, it will serve to confuse the entities covered by those regulations, and the stakeholders entitled to protection under them, as to the scope of their legal obligations and rights. This confusion will likely lead to more complaints and litigation over sexual orientation-based discrimination. HHS should not adopt the proposed changes to these sections.

V. Interim Treatment of Subregulatory Guidance

We oppose HHS' suspension of all subregulatory guidance related to Section 1557 while the rulemaking is in process, and in particular the preamble to the current Section 1557 regulation. HHS is bound by the Administrative Procedures Act to provide justification for its proposed changes and cannot change current regulations without going through the notice and comment period, considering those comments, and then providing justification for its changes in a new final regulation. Particularly with respect to the preamble to the current regulations, the information provided helps covered entities understand the parameters of the regulations, how to comply, and what HHS considered in evaluating comments. Rescinding the subregulatory guidance while the current regulations remain will only sow confusion for covered entities as well as

[254] *See, e.g., Zarda v. Altitude Express, Inc.*, 883 F.3d 100, 119 (2d Cir. 2018), *cert. granted sub nom. Altitude Exp., Inc. v. Zarda*, 139 S. Ct. 1599, 203 L. Ed. 2d 754 (2019); *Christiansen v. Omnicom Grp., Inc*., 852 F.3d 195, 201 (2d Cir. 2017); *Hively v. Ivy Tech Cmty. Coll. of Indiana*, 853 F.3d 339, 345 (7th Cir. 2017); *Spencer v. Town of Bedford*, No. 6:18-CV-31, 2018 WL 5983572, at *5 (W.D. Va. Nov. 2, 2018); *Boutillier v. Hartford Pub. Sch*., 221 F.Supp.3d 255, 269 (D. Conn. 2016); *Videckis v. Pepperdine Univ*., 150 F.Supp.3d 1151, 1160 (C.D. Cal. 2015); *Terveer v. Billington*, 34 F.Supp.3d 100, 116 (D.D.C. 2014); *Centola v. Potter*, 183 F.Supp.2d 403, 410 (D. Mass. 2002); *Heller v. Columbia Edgewater Country Club*, 195 F.Supp.2d 1212, 1224 (D. Or. 2002).

individuals protected by Section 1557. The harm of suspending the guidance and the preamble greatly outweighs any benefit.

HHS cites to the Attorney General's memorandums of November 16, 2017 and January 25, 2018 as justification for the suspension. While HHS states that Department of Justice litigators cannot use ***noncompliance*** with guidance documents as the basis for proving violations, the guidance can certainly be used by covered entities to help ensure ***compliance*** with Section 1557. It can also be used by the courts to understand HHS' intent in promulgating the current regulations. Suspending this guidance, especially while the current regulations remain in effect, will cause confusion amongst covered entities who have been relying on this guidance and the preamble for a number of years.

Given the time it will take for HHS to proceed through the required steps to finalize revisions, and that the current Section 1557 regulation remains in effect until that process is completed, HHS should not suspend any existing guidance that offers information on interpreting and applying Section 1557.

VI. Regulatory Impact Analysis

a. The Regulatory Impact Analysis (RIA) is insufficient and fails to justify the proposed changes

The NPRM provides a RIA that is wholly insufficient to justify the extensive scope of the proposed changes to language access and entirely fails to identify and to quantify costs to protected individuals. As we discussed above, we believe the cost estimates considered by HHS as justification for the proposed changes are outdated, overestimated and fail to consider the cost and harm to individuals covered by Section 1557. In general, HHS fails to provide the underlying data or methodology that would support its claims.

HHS's estimate of the burden to covered entities for compliance with the nondiscrimination notice and tagline requirements is based on voluntary actions by covered entities. HHS based the elimination of the notice and taglines on these estimates, but did not consider whether alternatives, such as further clarification about the requirements, was warranted in the form of FAQs or other guidance. That is, HHS failed to consider alternatives to a complete repeal of notices and taglines that could have appropriately balanced the need to inform individuals of their rights while recognizing the 2016 Final Rule may not have been clear in its expectations.

Similarly, the majority of the costs are associated with the provision of a single type of document -- the Explanation of Benefits (EOB). HHS did not consider alternatives as to how it would consider enforcement and interpretation of the "significant document" standard with respect to the provision of multiple EOBs sent during a coverage year.

HHS states it has received little evidence that more beneficiaries are seeking language assistance and uses this claim as a justification to remove the notice and taglines. This claim, which relies on reports from health plans, is insufficient to justify the repeal of these important requirements. The regulation has been in effect for three years in which HHS, by its own admission, has had limited resources to conduct public outreach. Second, the protections guaranteed by Section 1557 are both continuing and expanded, warranting a public effort to conduct outreach. Third, the notices and taglines were specifically selected as to balance the needs of LEP individuals against requiring covered entities to translate large numbers of documents. Fourth, LEP persons are uniquely at risk of facing barriers to knowing and asserting their rights. Lack of uptake of services raises questions about the extent to which the public knows its rights and what covered entities are doing to communicate those rights, as opposed to justifying elimination of notices and taglines.

More broadly, however, we take issue with HHS' evaluation of costs to covered entities. The question should not be "whether the benefits of these provisions exceeds the burdens imposed by them." Such a balancing exercise is not called for by the statute, and inserts an inappropriate regulatory finesse on a remedial scheme created by Congress and intended to be interpreted broadly and to correct decades of harm.[255] The task of the agency is to interpret and implement the statute. The proposed balancing of interests may be an appropriate role for Congress, but not for the administrative branch.

b. Language Access Requirements in the 2016 final rule are justified by need

HHS has provided no tangible analysis of the costs and burdens of repealing the notice and tagline requirement. Instead, HHS provides only acknowledgment that repeal "may impose costs, such as decreasing access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services."[256] HHS perfunctorily labels the impact as "negligible" while providing no evidentiary basis.[257]

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[255] *See, e.g.* 42 U.S.C. § 12101 (ADA findings and purposes). The ADA builds upon Section 504, and Section 1557 follows in their footsteps.
[256] 84 Fed. Reg. 27882.
[257] *Id.*

The costs are not only reduced awareness of language services by individuals with LEP, but also reduced awareness by the general public about their rights as protected by 1557, especially regarding the notices which include information about the broader nondiscrimination requirements of Section 1557. HHS's only acknowledgement of this impact is one statement about the "unknown number of persons are likely not aware of their right to file complaints."[258]

Discrimination of all kinds creates unequal access to health care. HHS' proposed changes fly in the face of the letter and spirit of Section 1557 and its RIA fails to provide any legal justification for these changes.

See also our discussion above regarding § 92.8 about the repeal of provisions related to notices and taglines.

IX. Request For Comment

HHS provides an extensive list of issues on which it solicits comments, in addition to seeking comment on all issues raised by the proposed regulation. The list of issues in Section IX, however, provides insufficient clarity in both the questions and the context such that we do not think we can provide meaningful comment outside of the comments we are providing elsewhere.

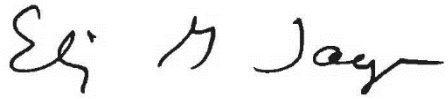
To justify proposed changes in existing regulations, HHS must provide its own explanation and rationale for the changes, documenting a need for these changes based not on an opposition to the policy undergirding a particular regulation but based on reason and data. Given that the public must be provided an opportunity to comment on HHS' alleged justifications for these proposed changes, HHS' attempt to solicit feedback on a list of additional issues that it may then use to promulgate unanticipated changes in a final rule violates requirements of public notice and comment as required by the Administrative Procedures Act. These issues would be more appropriate to inform agency decisions prior to issuing an NPRM, such as through a Request for Information, than in response to an NPRM. We thus decline to provide feedback on these issues in Section IX but have provided our explanations, justifications and evidence supporting our comments in the sections above.

[258] 84 Fed. Reg. 27883.

Conclusion

We appreciate the opportunity to provide comments on the NPRM. We oppose all the proposed changes and instead urge HHS not to finalize its proposals but instead to leave the current regulations, as well as subregulatory guidance, in place. If you have any questions, please contact us at (202) 289-7661 or via email -- Mara Youdelman (youdelman@healthlaw.org), Wayne Turner (turner@healthlaw.org) or Jennifer Lav (lav@healthlaw.org).

Sincerely,



Elizabeth G. Taylor
Executive Director

August 13, 2019

Office for Civil Rights
Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue, SW
Washington, D.C. 20201

Submitted Electronically

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

Dear Secretary Azar,

The National Women's Law Center ("the Center") is writing to comment on the Department of Health and Human Services' ("the Department") Office for Civil Rights' ("OCR") proposed rule "Nondiscrimination in Health and Health Education in Programs or Activities" ("Proposed Rule").[1] Since 1972, the Center has worked to protect and advance the progress of women and their families in core aspects of their lives, including income security, employment, education, and reproductive rights and health, with an emphasis on the needs of low-income women and those who face multiple and intersecting forms of discrimination. To that end, the Center has long worked to end sex discrimination and to ensure all people have equal access to the full range of health care, including abortion and birth control, regardless of income, age, race, sex, sexual orientation, gender identity, ethnicity, geographic location, or type of insurance coverage.

Section 1557 of the Affordable Care Act (ACA) provides broad federal protection against sex discrimination in health care and health insurance. The prohibition on sex discrimination is properly understood to include discrimination based on gender identity, sexual orientation, sex stereotypes, and pregnancy, including termination of pregnancy. Section 1557 also importantly expands existing protections against health care discrimination based on race, color, national origin, age, and disability.

In 2016, after considerable public comment and deliberate consideration, including numerous meetings with stakeholders and two comment periods with over 25,000 comments, the Department issued strong and effective regulations implementing and enforcing Section 1557 of the ACA.[2] Now, the Department seeks to repudiate the 2016 Final Rule by deleting most of

[1] Nondiscrimination in Health and Health Education in Programs or Activities, 84 Fed. Reg. 27,846 (proposed June 14, 2019) (to be codified at 42 C.F.R. pts. 428, 440, & 460) [hereinafter *Proposed Rule*]
[2] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,375 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92) [hereinafter *Final Rule*].

the substantive provisions, adding unlawful exemptions, and dramatically narrowing the scope of Section 1557's regulations in direct opposition to what is required by the statute itself.

For the reasons outlined in this comment letter, the Proposed Rule is illegal, harmful, and discriminatory and must be rescinded in its entirety.

I. Section 1557 has gone a long way to address discrimination in health care and health insurance.

Section 1557 was intended to provide robust protections for people who face discrimination in health care because of their race, color, national origin, age, disability, or sex, including gender identity, sex stereotyping, pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth, or related medical conditions. In enacting this provision, Congress sought to "remedy the shameful history of invidious discrimination and the stark disparities in outcomes in our health care system based on traditionally protected factors such as race and gender."[3]

The rampant sex discrimination women faced in the insurance market was a particular area of concern for Congress.[4] As the Center documented, prior to the ACA, insurance companies rejected women for health coverage for a variety of "pre-existing conditions" that were unique to them, such as having had a Cesarean delivery, prior pregnancy, or breast or cervical cancer, or receiving medical treatment for domestic or sexual violence.[5] Plans also charged women more than men for the same coverage, a practice known as gender rating. According to the Center's research, before the ACA took effect, gender rating was rampant in the individual market: 92% of best-selling plans on the individual market practiced gender rating - costing women approximately $1 billion a year.[6] Plans also refused to cover women's major health needs; for example, in 2008, only 12% of individual market plans covered maternity services.[7]

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[3] 156 Cong. Rec. S1842 (daily ed. Mar. 23, 2010) (Sen. Leahy).

[4] *E.g.*, 156 CONG. REC. H1632-04 (daily ed. March 18, 2010) (statement of Rep. Lee) ("While health care reform is essential for everyone, women are in particularly dire need for major changes to our health care system. Too many women are locked out of the health care system because they face discriminatory insurance practices and cannot afford the necessary care for themselves and for their children."); 156 CONG. REC. H1891-01 (daily ed. March 21, 2010) (statement of Rep. Pelosi) ("It's personal for women. After we pass this bill, being a woman will no longer be a preexisting medical condition."); 155 CONG. REC. S12,026 (daily ed. Oct. 8, 2009) (statements of Sen. Mikulski) ("[H]ealth care is a women's issue, health care reform is a must-do women's issue, and health insurance reform is a must-change women's issue because . . . when it comes to health insurance, we women pay more and get less."); 155 CONG. REC. S10,262-01 (daily ed. Oct. 8, 2009) (statement of Sen. Boxer) ("Women have even more at stake. Why? Because they are discriminated against by insurance companies, and that must stop, and it will stop when we pass insurance reform."); 156 CONG. REC. H1854-02 (daily ed. March 21, 2010) (statement of Rep. Maloney) ("Finally, these reforms will do more for women's health . . . than any other legislation in my career.").

[5] Nat'l Women's Law Ctr., *Nowhere to Turn: How the Individual Health Insurance Market Fails Women* (2008) (on file with NWLC).

[6] NAT'L WOMEN'S LAW CTR., TURNING TO FAIRNESS: INSURANCE DISCRIMINATION AGAINST WOMEN TODAY AND THE AFFORDABLE CARE ACT (March 2012), https://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf.

[7] *See* NAT'L WOMEN'S LAW CTR., *supra* note 6 at 4.

Several important ACA provisions were enacted specifically to correct these insurer practices that discriminated against women either on their face or in their effect,[8] and Section 1557 was put into place alongside these specific provisions as an important backstop against discrimination. In other words, a primary purpose of the ACA was to end health care and health insurance practices that in their intent or in their effect resulted in gender-based discrimination.

By its terms, Section 1557 accomplishes its aims of addressing discrimination in health care by specifically referencing the bases protected by existing laws, namely Title VI, Title IX, the Americans with Disabilities Act, and the Age Discrimination Act. The 2016 Final Rule correctly drew upon the long-standing civil rights principles in the referenced statutes to define the scope of what it means to ban discrimination based on the protected characteristics and to guide enforcement. However, the 2016 Final Rule did not include the specific exceptions to those bans, because Congress spoke clearly as to the exceptions that apply to the ban on discrimination in health care in the text of Section 1557.

Importantly, Section 1557 also intended to remedy the problem of varying levels of protections and enforcement mechanisms depending on an individual's protected characteristics. This means that it recognizes that people can hold multiple identities that might be a basis for discrimination. For example, an immigrant woman seeking reproductive health care could face harassment because she is a woman and has limited English proficiency (LEP). Similarly, a provider could discriminate against a Black woman because of both her race and gender.

Since its passage, Section 1557 has been used to ensure that people on their parents' insurance plans could no longer be denied maternity coverage,[9] health plans could no longer exclude coverage of transition-related care for transgender individuals,[10] an individual could not be denied fertility services because of their age,[11] and health insurance companies would have to provide information about their services in the language a person speaks, not just English.[12]

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[8] 42 U.S.C. 300gg(a) (2012) (allowing rating based only on family size, tobacco use, geographic area, and age but not based on gender, thereby eliminating a long standing discriminatory practice); 42 U.S.C. 300gg-3 (2012) (prohibiting preexisting condition exclusions which were often used to discriminate against women in part because several of the conditions excluded by insurers primarily affect women and because women are more likely than men to suffer from chronic conditions); 45 C.F.R. § 147.104(e) (2015) (prohibiting discrimination in marketing and benefit design, including on the basis of sex).

[9] *See* Press Release, Nat'l Women's Law Ctr., *Victory in Sex Discrimination Complaints Brought by NWLC: After Investigation by HHS, Employers Change Policies* (Jan. 26, 2017), https://nwlc.org/press-releases/victory-in-sex-discrimination-complaints-brought-by-nwlc-after-investigation-by-hhs-employers-change-policies/.

[10] *See Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018) (holding that a health plan containing a categorical exclusion for all services related to gender transition violated section 1557).

[11] *See* Dania Palanker, *Connecticut Ends Discriminatory Limit on Infertility Coverage*, NAT'L WOMEN'S LAW CTR BLOG (Aug. 14, 2015), https://nwlc.org/blog/connecticut-ends-discriminatory-limit-infertility-coverage/.

[12] *See* Office of Civil Rights, *Enforcement Success Stories Involving Persons with Limited English Proficiency*, HHS.GOV https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/examples/limited-english-proficiency/index.html.

The Proposed Rule not only threatens these gains – it is a deliberate attempt to reverse them.

II. The Proposed Rule is an unlawful attempt to undermine Section 1557 and permit discrimination in health care.

The Proposed Rule is an unjustified and unlawful attack on core civil rights protections that will open the door to discrimination in health care.

The Proposed Rule:

- Specifically targets sex discrimination protections by unlawfully attempting to add a religious exemption, attempting to incorporate Title IX's abortion provision, and explicitly deleting language that protects against discrimination on the basis of sex stereotyping and gender identity; and
- Attempts to unlawfully allow certain entities to discriminate by narrowing the number of insurance plans covered by Section 1557 and exempting many of the Department's own programs.

The Proposed Rule deletes most of the 2016 Final Rule's substantive provisions, including:

- All of the regulations detailing what forms of discrimination are prohibited under Section 1557;
- All of the regulations specifically detailing what practices constitute discrimination by health insurance issuers;
- Provisions making clear that Section 1557 prohibits actions that have the effect of discriminating in health care.
- The requirement that covered entities provide notice that they do not discriminate on the basis of race, color, national origin, sex, age, or disability;
- The requirement that covered entities make reasonable accommodations to avoid disability discrimination;
- The requirement that covered entities provide equal access to programs on the basis of sex;
- The prohibition against covered entities discriminating against someone because of their relationship to someone in one of the protected classes;
- The prohibition against covered entities providing significant assistance to those who discriminate;
- Provisions making clear that covered entities may be required to take remedial action to overcome the effects of past discrimination and that covered entities may voluntarily take remedial actions on their own;
- The requirement that covered entities designate someone to be responsible for ensuring that the entity is not in violation of Section 1557.

Importantly, the 2016 Final Rule correctly drew upon long-standing civil-rights principles from the underlying statutes to interpret Section 1557's substantive ban and to ensure common enforcement against discrimination in health care. Instead of incorporating the regulations from the referenced statutes wholesale, as the Proposed Rule attempts to do, the 2016 Final

Rule only incorporated those regulations that were consistent with the goals and plain language of Section 1557 and the Affordable Care Act. The 2016 Final Rule did not incorporate any exceptions or other regulations that are particular to the context of the underlying statutes, such as regulations from Title IX that only make sense in the educational context, or that are inconsistent with Section 1557 or the ACA. The 2016 Final Rule also added regulations to ensure consistent protections and enforcement mechanisms for all the protected characteristics and regulations that address discrimination by health insurance issuers, something Section 1557 was specifically intended to eliminate.

The Proposed Rule, in contrast, deletes most of these regulations and attempts to incorporate by reference the regulations for Title VI, Title IX, the Age Act, and Section 504, even those that are contrary to Section 1557's plain language and Congressional intent. It justifies this by claiming that Section 1557 only imposed "the pre-existing understanding of the underlying obligations" of the "civil rights laws referenced by Section 1557."[13] But this is an improper attempt to narrow Section 1557's scope in a way that is not permitted by the statute. And it will create precisely what Section 1557 was intended to remedy—varying levels of protections and enforcement remedies depending on an individual's protected characteristics. Section 1557 only incorporates the referenced statutes' underlying bases against discrimination and their enforcement mechanisms, not any other parts of those laws.

In order to justify this arbitrary and capricious reversal of policy implemented a mere three years ago, the Department has ignored court precedent, cherry picked facts and ignored the costs that the Proposed Rule would have on public health while improperly amplifying the costs of the 2016 Final Rule to covered entities.[14]

The Proposed Rule's reversal in policy is an unlawful, unjustified, arbitrary and capricious attempt to allow discrimination in health care.[15] The Department must withdraw the Proposed Rule in its entirety and fully enforce Section 1557, including the provisions of the 2016 Final Rule.

a. The Proposed Rule Unlawfully Rolls Back the Sex Discrimination Protections in Section 1557

The 2016 Final Rule provides for robust protections against sex discrimination as required by Section 1557's plain language. The Department now attempts to undo these regulations by

[13] *Proposed Rule*, 84 Fed. Reg. at 27,874.

[14] The 2016 Final Rule was developed over the course of six years and following one request for information and one notice of proposed rulemaking, with over 25,000 comments from stakeholders. Comments overwhelmingly supported the provisions included in the 2016 rule.

[15] A "change [to] existing policies," requires "a reasoned explanation for the change." *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016). At minimum, an agency must "'display awareness that it is changing position' and 'show that there are good reasons for the new policy.'" *Id.* at 2126 (quoting *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009)). Where an agency's "new policy rests upon factual findings that contradict those which underlay its prior policy" or "its prior policy has engendered serious reliance interests," a "detailed justification" for the new position is required. *Fox*, 556 U.S. at 515.

deleting all of the sex specific protections. Instead, the Proposed Rule unlawfully restricts sex discrimination protections to those available under Title IX rather than simply referencing Title IX for the grounds on which it prohibits discrimination. In doing so, the Proposed Rule unlawfully attempts to include provisions specific to Title IX that cannot be applied to Section 1557, including Title IX's religious exemption and abortion provision. The Proposed Rule also eliminates the specific prohibition against discrimination on the basis of sex stereotyping and gender identity that were explicitly protected by the 2016 Final Rule.

In order to justify this arbitrary and capricious policy reversal, the Proposed Rule claims that *Franciscan Alliance, Inc. et al. v. Burwell et al.*, 227 F. Supp. 3d 660 (N.D. Tex. 2016) requires the Department to remove the 2016 Final Rule's definition of "sex" from the 1557 regulations and incorporate Title IX's religious exemption and abortion provisions. In so doing, the Department ignores decades of court precedent interpreting both Title IX's and Title VII's sex discrimination provisions, other court interpretations of Section 1557, Congressional intent, and how the Department's own decision not to defend the 2016 Final Rule in *Franciscan Alliance* predetermined the outcome of the case.[16]

i. The Proposed Rule Unlawfully Attempts to Add a Religious Exemption to Section 1557's Prohibition on Sex Discrimination.

The Administration's attempt to incorporate Title IX's religious exemption[17] into Section 1557 is unlawful, contrary to the very purpose of Section 1557, and opens the door to allowing personal beliefs to dictate patient care.

Incorporating a religious exemption into Section 1557's prohibition on sex discrimination is contrary to law. The plain language of Section 1557 makes clear that it is unlawful to incorporate, explicitly or by reference, any exemptions to the non-discrimination protections. Section 1557 references Title VI, Title IX, Section 504, and the Age Act solely for the grounds on which they prohibit discrimination and for their enforcement mechanisms. Section 1557's ban against discrimination in health programs or activities includes a single exception – that it applies "[e]xcept as otherwise provided" in Title I of the ACA. Congress' decision to include "[e]xcept as otherwise provided" makes clear that no other exceptions were intended. In 2016, the Department explicitly declined to incorporate Title IX's religious exemption to Section 1557's implementing regulations.[18]

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[16] The Department's decision not to appeal the preliminary injunction and then not to defend the regulations at all was, in and of itself, a policy decision that cannot be used now as justification for the Proposed Rule.

[17] In the preamble, the Department explains that the intent of the provision of the proposed rule at issue here (§ 92.6(b)) is to "incorporate by reference statutory exemptions and protections concerning religious and abortion exemptions." 84 Fed. Reg. at 27,864. For clarity, we are mirroring the Department's language in our discussion of § 92.6(b) throughout our comments.

[18] Instead, the Department reiterated that the 2016 Final Rule "would not displace" the application of federal refusal laws. *Final Rule*, 81 Fed. Reg. 31,379.

Section 1557 does not by its terms import any exceptions from Title IX or from any other statute.[19] In addition, as discussed above, several important ACA provisions, including Section 1557, were enacted specifically to correct practices that discriminated on the basis of sex either on their face or in their effect.[20] Incorporating a religious exemption that undermines only Section 1557's protections against sex discrimination has the potential to undermine this purpose and violate the Equal Protection Clause of the United States Constitution.[21]

In addition to being unlawful, it is non-sensical and impractical to incorporate Title IX's religious exemption into Section 1557. Title IX's religious exemption is narrowly focused on educational institutions.[22] As the Department noted in the 2016 Final Rule, "there are significant differences between the educational and health care contexts that warrant different approaches."[23] Importantly, individuals in either the educational or health care setting may not know whether their school or health care entity has religious objections. Moreover, even if an individual is aware of the religious objections, they may not understand the significant harm such objections could have on them. However, the difference between the two contexts is that an entity's religious objections in the health care setting could mean life or death for a patient. This difference means that applying Title IX's religious exemption has the potential to do even greater harm in the health context, and thus warrants "different approaches" as the 2016 Final Rule concluded.[24]

Moreover, the Department unlawfully attempts to subordinate Section 1557 to any regulations implementing federal refusal of care laws, including the Department's recent federal refusal rule. Not only does the Department not have statutory authority to do this, but the refusal of

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[19] The Proposed Rule is vague and seemingly could be read to incorporate by reference additional religious exemptions, such as the limited exemptions included in Title VII and the ADA. Incorporating these provisions is not only unlawful, it makes no sense in the statutory scheme of Section 1557 or in the health care context.

[20] *See supra* note 8 (citing 42 U.S.C. 300gg(a) (2012); 42 U.S.C. 300gg-3 (2012); 45 C.F.R. § 147.104(e) (2015)).

[21] By creating a religious exemption only to Section 1557's protections against sex discrimination that has the purpose and effect of cherry picking people who have had or are seeking abortions, transgender individuals, and gender nonconforming people from the law's protections, the Proposed Rule creates impermissible classifications based on sex and the exercise of a fundamental right that cannot withstand the exacting scrutiny required by the Equal Protection guarantee of the Fifth Amendment of the U.S. Constitution.

[22] *See* Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,173. Title IX's exceptions for social fraternities or sororities, scholarship awards in beauty pageants, and Girls State conferences, for example, are irrelevant at best in the context of Section 1557. *See* 20 U.S.C. § 1681(a)(6), (7), (9).

[23] *Final Rule*, 81 Fed. Reg. at 31,380.

[24] Further, the Department of Education is currently attempting to alter Title IX's religious exemption regulations by removing the requirement that funding recipients notify the Department of Education in writing and identify which Title IX provisions conflict with their religious beliefs. *See* Nondiscrimination on the Basis of Sex in Education Programs and Activities Receiving Federal Financial Assistance, 83 Fed. Reg. 61,462, 61,496 (Nov. 29, 2018) (to be codified at 34 C.F.R. pt. 106.12(b)). This proposed change would allow schools to conceal their intent to discriminate and expose students to harm. If the same no-prior-notice rule would apply in the health care context, the consequences of allowing hospitals concealing the intent to discriminate against patients seeking treatment could be far more severe, and a matter of life or death.

care rule is itself currently being challenged in court by numerous stakeholders as illegal and discriminatory.[25]

The potential harm of a religious exemption cannot be overstated. Providers have invoked personal beliefs to deny access to health insurance and an increasingly broad range of health care services, including birth control,[26] sterilization,[27] certain fertility treatments,[28] abortion,[29] transition-related care for transgender individuals,[30] and end of life care.[31] For example, one woman experiencing pregnancy complications was 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.[32] A transgender man was denied gender affirming surgery at a religiously-affiliated hospital that refused to provide him a hysterectomy.[33] A woman called an ambulance after experiencing abdominal pain, but the ambulance driver refused to take her to get the care she needed at an abortion clinic.[34] Women of color – and black women in particular – are at higher risk since they are more likely than white women to seek reproductive health care and pregnancy-related care at religious-affiliated medical institutions,[35] and more likely to experience pregnancy-related complications that require services or procedures prohibited in certain religiously-affiliated health care institutions.[36]

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[25] *See New York et al. v. U.S. Dep't Health & Human Servs.*, No. 1:19-cv-4676-PAE (S.D.N.Y.); *Planned Parenthood Federation of America, Inc. et al. v. Azar*, No. 1:19-cv-5433-PAE (S.D.N.Y.); *National Family Planning and Reproductive Health Assoc. et al. v. Azar*, No. 1:19-cv-5435-PAE (S.D.N.Y.); *California v. Azar*, 3:19-cv-02769-WHA (N.D. Cal.); *City & County. of San Francisco v. Azar*, No. 3:19-cv-2405-WHA (N.D. Cal.); *County. of Santa Clara et al.* v. *U.S. Dep't Health & Human Servs.*, No. 5:19-cv-2916-WHA (N.D. Cal.); *Washington v. Azar*, No. 2:19-cv-00183-SAB (E.D. Wash.); *Mayor & City Council of Baltimore v. Azar*, 1:19-cv-01672-GLR (D. Md.).

[26] Nat'l Women's Law Ctr., *Health Care Refusals Harm Patients: The Threat to Reproductive Health Care* (May 2014), http://www.nwlc.org/sites/default/files/pdfs/refusals_harm_patients_repro_factsheet_5-30-14.pdf.

[27] *See* Nat'l Women's Law Ctr., *supra* note 26.

[28] *See* Nat'l Women's Law Ctr., *supra* note 26.

[29] *See* Nat'l Women's Law Ctr., *supra* note 26.

[30] Nat'l Women's Law Ctr., *Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS* (May 2014), http://www.nwlc.org/sites/default/files/pdfs/lgbt_refusals_factsheet_05-09-14.pdf.

[31] U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services,* (5th ed. 2009) (directive 24 denies respect for advance medical directives), http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf.

[32] *See* Nat'l Women's Law Ctr., *supra* note 26.

[33] *See* Complaint for Declaratory, Compensatory, and Injunctive Relief, *Conforti v. St. Joseph's Healthcare System*, No. 2:17-CV-00050 (D.N.J. Jan. 5, 2017).

[34] Nat'l Women's Law Ctr., *Put Patient Health First* (August 2017), https://nwlc.org/resources/continued-efforts-to-undermine-womens-access-to-health-care/.

[35] *See* Kira Shepherd et al., *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, PUBLIC RIGHTS/PRIVATE CONSCIENCE PROJECT (Nov. 9. 2019), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

[36] For example, Black women experience complications such as preeclampsia, fibroids, eclampsia, embolisms, fetal death, and miscarriage at a higher rate than white women. *See* NAT'L PARTNERSHIP FOR WOMEN AND FAMILIES, BLACK WOMEN'S MATERNAL HEALTH (Apr. 2018), http://www.nationalpartnership.org/our-work/health/reports/black-womens-maternal-health.html. In some cases, ending the pregnancy might be the best way to preserve a woman's

Indeed, as the Department acknowledged in the 2016 Final Rule, a religious exemption "could result in a denial or delay in the provision of health care to individuals and in discouraging individuals from seeking necessary care, with serious and, in some cases, life threatening results."[37] Yet, the Department now is unlawfully reversing course without providing any analysis on the potential impact of a religious exemption on health care or coverage or any reasoning that would alter the conclusion made in 2016 that it will cause substantial harm. This failure is both arbitrary and capricious and raises serious Establishment Clause concerns.[38] Moreover, the Department fails entirely to address the arguments it put forth in the 2016 Final Rule to justify this reversal of policy. The Administration points to *Franciscan Alliance* but, as discussed above, the Department cannot abdicate its legal duties under the Administrative Procedure Act and the Constitution to one judicial decision that stands in stark contrast to other court interpretations of the law, particularly after failing to defend the 2016 Final Rule in court.[39]

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life, health, or future fertility. Yet, as found in one study some doctors at Catholic hospitals have reported being required to deny medically-indicated uterine evacuations or abortion care even during emergencies, either transferring patients to another hospital while they are unstable or waiting until their medical condition becomes critical. *See* Shepherd et al., *supra* note 35; Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals,* 98,10 AM. J. PUBLIC HEALTH 1774 (2008) (stating, "[t]he experiences of physicians in our study indicate that uterine evacuation may not be approved during miscarriage by [a Catholic hospitals'] ethics committee if fetal heart tones are present and the pregnant woman is not yet ill, in effect delaying care until fetal heart tones cease, the pregnant woman becomes ill, or the patient is transported to a non–Catholic owned facility for the procedure"). The study further found that other doctors felt limited in their ability to appropriately treat patients with risky tubal/ectopic pregnancies; according to at least one provider at a Catholic hospital, such refusals have led to tubal rupture.

[37] *Final Rule*, 81 Fed. Reg. at 31,380. *See also* Shepherd et al., *supra* note 35. Additionally, patients described being discharged from the emergency room without treatment while miscarrying and being forced to continue a nonviable pregnancy.

[38] The Establishment Clause of the First Amendment requires the government to adequately account for just these sorts of consequences when considering whether to grant religious exemptions and, in fact, bars granting an exemption when it would detrimentally affect any third party. *See* U.S. Const. amend. I; *Cutter v. Wilkinson*. 554 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).

[39] The Administration also points to several so-called "exceptions" in the 2016 Final Rule in an attempt to justify this decision. But, the so-called "exceptions" from Title VI, Section 504, and the Age Act set out at 45 C.F.R. §§ 80.3(d), 84.4(c), 85.21(c), 91.12-.15, 91.17-.18 (2015), incorporated into the 2016 Final Rule and cited in the Proposed Rule by and large do not actually set out exceptions from the relevant antidiscrimination mandates. Rather, they clarify that certain programs targeted to meet the particular needs of specific protected groups within the protected class are not properly considered discrimination. This is different in kind from creating a sweeping exemption that could allow a large number of religiously-affiliated hospitals and health care providers to discriminate.

ii. The Proposed Rule unlawfully targets abortion.

The Department is using the Proposed Rule to target abortion and allow discrimination against people seeking reproductive health care, contrary to the express purpose of Section 1557 to end discrimination in health care. The Department improperly purports to incorporate Title IX's so-called "abortion neutrality provision" (the Danforth Amendment)[40]—statutory language neither mirrored nor cross referenced by Section 1557. The Department's interpretation is simply not permissible given Section 1557's plain language. Once again, this attempt to cherry pick Title IX's provisions is contrary to Congress's express limitation in Section 1557, which provides that the only applicable exceptions are those "otherwise provided in Title I" of the ACA. Moreover, Section 1557 only incorporates the referenced statutes' underlying bases against discrimination (in this case "sex") and their enforcement mechanisms, not any other parts of the law. And as courts have consistently held, discrimination on the basis of sex includes discrimination because someone has had or is seeking an abortion.[41]

In addition, as the Department acknowledges, Title IX's regulations clearly and unequivocally state that discrimination on the basis of sex includes discrimination on the basis of "termination of pregnancy." At a minimum, Title IX prohibits denying someone care or harassing someone because they have had or are seeking an abortion.[42] Yet despite this prohibition in Title IX, the Department refuses to say whether it would, in fact, enforce those protections.[43] Indeed, the Department even refuses to say whether it believes that Section 1557 protects against discrimination because someone is miscarrying or seeking care after having an abortion. This could encourage health care providers to unlawfully deny someone necessary care for miscarriage or ectopic pregnancy, care that is the medical standard, or to refuse to treat someone because they have had an abortion.

Not only does the Department's refusal to commit to enforcing protections against discrimination because someone has had or is seeking an abortion or is experiencing pregnancy

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[40] The Danforth Amendment states, "[n]othing in this chapter shall be construed to require or prohibit any person, or public or private entity, to provide or pay for any benefit or service, including the use of facilities, related to an abortion. Nothing in this section shall be construed to permit a penalty to be imposed on any person or individual because such person or individual is seeking or has received any benefit or service related to a legal abortion." 20 U.S.C. § 1688 (Mar. 22, 1988) (clearly prohibiting denying someone care or harassing someone because they have had or are seeking an abortion).

[41] *See, e.g.*, *Newport News Shipbuilding and Dry Dock Co. v. E.E.O.C.*, 462 U.S. 669, 684 (1983) (holding the PDA makes it clear that "for all Title VII purposes, discrimination based on a woman's pregnancy is, on its face, discrimination because of her sex."); *Doe v. C.A.R.S. Protection Plus, Inc.*, 527 F.3d 358, 364 (3d Cir. 2008) (holding that Title VII as amended by the PDA protects women against discrimination based on their decision to have an abortion); *Turic v. Holland Hospitality, Inc.*, 85 F.3d 1211, 1214 (6th Cir. 1996) (holding that discharge of pregnant employee because she contemplated having an abortion procedure violated Title VII as amended by the PDA); *Ducharme v. Crescent City Deja Vu, L.L.C.*, No. CV 18-4484, 2019 WL 2088625, at *5 (E.D. La. May 13, 2019) (holding that abortion is protected by the pregnancy language of Title VII).

[42] The Danforth Amendment creates a carve out from Title IX's sex discrimination rule to require neutrality as to payment for abortion or provision of abortion.

[43] *Proposed Rule*, 84 Fed. Reg. 27,870, n. 159.

complications embolden this type of discrimination, but it also is in direct conflict with the purpose of the underlying statute. Moreover, by allowing providers to impede access to critical health care, including emergency care, and by interfering with patients' ability to obtain abortions necessary to preserve their health or life, the Proposed Rule runs afoul of several federal laws, including Section 1554 of the ACA, 42 U.S.C. § 18114,[44] and the Emergency Medical Treatment & Labor Act (EMTALA),[45] and the rights to privacy, liberty, and equal protection under the law enshrined in the U.S. Constitution.

iii. The Proposed Rule improperly seeks to delete the explicit prohibition against sex stereotyping and gender identity discrimination.

The Proposed Rule seeks to enshrine a definition of sex that refers merely to the biological differences between men and women by deleting the explicit protections against discrimination on the basis of gender identity and sex stereotyping from the Proposed Rule. Such an interpretation is flatly inconsistent with longstanding legal interpretations of sex discrimination and its harms. The overwhelming majority of courts that have been presented with the question of whether federal antidiscrimination laws that prohibit sex discrimination such as Section 1557 specifically prohibit anti-transgender discrimination have firmly ruled that they do.[46] By only focusing on one district court case to justify removing gender identity and sex

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[44] Section 1554 of the ACA prohibits the Department from promulgating any regulation that "(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care; (2) impedes timely access to health care services; (3) interferes with communications regarding a full range of treatment options between the patient and the provider; (4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions; (5) violates the principles of informed consent and the ethical standards of health care professionals; or (6) limits the availability of health care treatment for the full duration of a patient's medical needs." 42 U.S.C. § 18114. By empowering health care providers to restrict access to health services and discriminate in the provision of health care, the Proposed Rule is irreconcilable with the plain language of 42 U.S.C. § 18114.

[45] To the extent the Proposed Rule would allow providers to deny care in emergency situations, it is not in accordance with the Emergency Medical Treatment & Labor Act (EMTALA), which requires that a hospital treat someone experiencing an emergency complication, such as an ectopic pregnancy or other medical complication. 42 U.S.C. § 1395dd (federal law requiring hospital emergency departments to medically screen every patient who seeks emergency care and to stabilize or transfer those with medical emergencies, regardless of health insurance status or ability to pay). Yet, religiously affiliated hospitals have denied women appropriate miscarriage management or treatments for ectopic pregnancies. *See, e.g., Means v. United States Conference of Catholic Bishops*, 836 F.3d 643, 646-6477 (6th Cir. 2016) (patient experiencing severe pregnancy complications at 18 weeks sought care at a Catholic hospital and was sent home twice and told there was nothing the hospital could do even though she was in excruciating pain and terminating the pregnancy was an option and the safest course for her condition). The rule would only exacerbate the incidence of such denials of emergency care.

[46] *See, e.g., 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); *Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018) (holding that a Medicaid program's refusal to cover treatments related to gender transition is "text-book discrimination based on sex" in violation of the Affordable Care Act and the Equal Protection Clause of the Constitution); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. 2016) (holding exclusion invalid under the Medicaid Act and the Affordable Care Act); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090 (S.D. Cal. Sept. 27, 2017) (holding that discrimination against transgender patients violates the Affordable Care Act); *Tovar v. Essentia*

stereotyping from the definition of sex, the Department improperly seeks to erase 30 years of court precedent.

Since the enactment of Title VII of the Civil Rights Act of 1964, courts have shared a common understanding of discrimination on the basis of "sex" that broadly includes discrimination based on the assumptions and stereotypes about how members of a sex—or of a subset of a sex—should behave.[47] In *Price Waterhouse*, which held that Title VII prohibits discrimination against employees based on their failure to conform to a sex stereotype, the Supreme Court clarified that, even in 1989, it was "tread[ing] [a] well-worn path," not "travers[ing] new ground."[48] In so holding, the Supreme Court reaffirmed that sex stereotyping is a central harm of sex discrimination because enforcement of such stereotypes closes opportunity, depriving individuals of their essential liberty to depart from gender-based expectations. For decades, the courts have recognized prohibitions on sex discrimination include discrimination based on sex stereotypes relating to perceived personal, familial, or romantic relationships.[49] Courts have recognized, for example, that Title VII prohibits discrimination based on sex stereotypes related

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Health, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018) (holding that Section 1557 of the Affordable Care Act prohibits discrimination on the basis of gender identity); *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); *Gavin Grimm v. Glouchester Cty. Sch. Bd.*, No. 4:15-cv-00054-AWA-RJK, Docket # 229 (E.D. Va. Aug. 9. 2019) (holding school board violated Title IX and Equal Protection Clause by forcing transgender student to use bathroom inconsistent with his gender identity).

[47] *See, e.g., Sprogis v. United Air Lines, Inc.*, 444 F.2d 1194, 1197–1202 (7th Cir. 1971) (invalidating airline policy of employing only unmarried female flight attendants); *Allen v. Lovejoy*, 553 F.2d 522, 524–25 (6th Cir. 1977) (invalidating State Health Department rule requiring newly married female employees to take on their husbands' last names); *see generally, Am. Newspaper Publishers Ass'n v. Alexander*, 294 F. Supp. 1100, 1102–03 (D.D.C. 1968) (invalidating "help wanted" advertisements bifurcated into male and female sections).

[48] *See Price Waterhouse v. Hopkins*, 490 U.S. 228, 248, 259 (1989).

[49] *See, e.g., Frontiero v. Richardson*, 411 U.S. 677, 685 (1973) (Equal Protection case striking down sex classification based on assumptions about women's appropriate role in the family, decrying discrimination based on "gross, stereotyped distinctions between the sexes"); *Weinberger v. Wiesenfeld*, 420 U.S. 636, 653 (1975) (holding that gender-based classification in the Social Security Act that provided dissimilar treatment to similarly situated men and women based on a "gender-based generalization" was unconstitutional); *Califano v. Goldfarb*, 430 U.S. 199, 216-17 (1977) (holding that the differential treatment of widows and widowers based on "archaic and overbroad generalizations" was unconstitutional). Indeed, a finding to the contrary in *Price Waterhouse* would have contradicted decades of jurisprudence and EEOC guidance, rejecting courts' repeated recognition that limiting opportunities based on sex stereotypes is among the core harms of sex discrimination.

to an employee's personal and family life.[50] Title VII also protects against adverse employment decisions based on perceptions about an employee's sexual relationships.[51]

Similarly, courts have consistently held that Title IX's sex discrimination protections include protections against sex stereotyping and gender identity discrimination.[52] Congress was also specifically concerned with eradicating pernicious sex stereotyping in education when enacting Title IX. When introducing Title IX, Senator Bayh expressly recognized that sex discrimination in education is based on "stereotyped notions," like that of "women as pretty things who go to college to find a husband, go on to graduate school because they want a more interesting husband, and finally marry, have children, and never work again." [53]Title IX was therefore necessary to "change [these] operating assumptions" so as to combat the "vicious and reinforcing pattern of discrimination" based on these "myths."[54]

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[50] *See, e.g.*, *Phillips v. Martin Marietta Corp.*, 400 U.S. 542, 544 (1971) (invalidating policy of not hiring mothers of preschool-aged children); *Chadwick v. WellPoint*, 561 F.3d 38, 47 (1st Cir. 2009) (holding that a reasonable jury could infer that an employee was denied a promotion because her employer "assumed that as a *woman* with four young children, [she] would not give her all to her job"); *Back v. Hastings on Hudson Union Free Sch. Dist.*, 365 F.3d 107, 120 (2d Cir. 2004) (impermissible sex stereotyping where employer fired school psychologist based on beliefs that "a woman cannot 'be a good mother' and have a job that requires long hours," and "would not show the same level of commitment [she] had shown because [she now] had little ones at home"); *Lust v. Sealy, Inc.*, 383 F.3d 580, 583 (7th Cir. 2004) (same where employer admitted that he didn't promote the plaintiff "because she had children and he didn't think she'd want to relocate her family, though she hadn't told him that," and he had inquired as to "why [the employee's husband] wasn't going to take care of her"); *Santiago-Ramos v. Centennial P.R. Wireless Corp.*, 217 F.3d 46, 57 (1st Cir. 2000) (same where direct supervisor questioned "whether [the plaintiff] would be able to manage her work and family responsibilities").

[51] In *Parker v. Reema Consulting Servs., Inc.*, 915 F.3d 297 (4th Cir. 2019), the Fourth Circuit held that a female employee was discriminated against when she was fired based on "an unfounded, sexually-explicit rumor about her that falsely and maliciously portrayed her as having [had] a sexual relationship with a higher-ranking manager . . . in order to obtain her management position." *Id.* at 300 (internal quotations omitted).

[52] *Riccio v. New Haven Bd. of Educ.*, 467 F. Supp. 2d 219, 226 (D. Conn. 2006) (explaining that harassment claims premised on antigay epithets and plaintiff's alleged failure to conform to gender stereotypes could proceed to trial under Title IX's sex discrimination prohibition); *Montgomery v. Indep. Sch. Dist. No. 709*, 109 F. Supp. 2d 1081, 1090 (D. Minn. 2000) (holding plaintiff stated Title IX sex discrimination claim because he alleged fellow students targeted him "not only because they believed him to be gay, but also because he did not meet their stereotyped expectations of masculinity").

[53] 118 Cong. Rec. 5804 (1972) (statement of Sen. Bayh).

[54] The recognition of stereotypes as a core problem motivating sex discrimination in education also permeated the 1970 Hearings that led to the adoption of Title IX. Numerous individuals testified to the harmfulness of stereotypes—in particular, those regarding gender roles—in perpetuating inequality. *See, e.g.*, 1970 Hearings at 7 (statement of Myra Ruth Harmon, President, Nat'l Fed'n of Bus. & Prof'l Women's Clubs, Inc.) (discussing "certain sex role concepts which continue to mold our society," including in "educational institutions"); *id.* at 135 (statement of Wilma Scott Heide, Comm'r, Pa. Human Rel. Comm'n) (discussing danger of sex role stereotyping); *id.* at 436 (statement of Daisy K. Shaw, Dir. of Educ. & Vocational Guidance of N.Y.C.) (discussing how "perceptions of sex roles develop" very early in life, and what is needed to end sex discrimination is "thoroughgoing reappraisal of the education and guidance of our youth to determine what factors in our own methods of child rearing and schooling are contributing to this tragic and senseless underutilization of American women"); *id.* at 662 (statement of Frankie M. Freeman, Comm'r, U.S. Comm'n on Civil Rights) ("Because of outmoded customs and attitudes, women are denied a genuinely equal opportunity to realize their full individual potential * * *."); *id.* at 364 (statement of Pauli Murray, Professor, Brandeis Univ.) (discussing importance of treating each person as an

The Department also ignores circuit[55] and district court[56] cases throughout the country that have determined that federal sex discrimination laws prohibit discrimination on the basis of a person's gender identity or transgender status. Discrimination against transgender individuals rests in large part on sex-stereotyping—that a transgender person is not a "real man" or a "real woman" because they do not conform to stereotypes about what it means to be male or female. Further, discrimination against transgender individuals because they are transgender is inherently discrimination on the "basis of sex" because transgender people are treated differently because their gender identity and sex identified at birth do not match. Thus, for all the reasons discussed above, gender identity discrimination is sex discrimination.

In a footnote, the Department advances the transphobic—and legally erroneous—position that policies "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."[57] The Department cites *United States v. Virginia*,[58] and *Fortner v.*

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individual, and not according to a group). *See* Brief of *Amici Curiae* Nat'l Women's Law Ctr., et al., in Support of Respondent at 18-19, *Gloucester County Sch. Board v. G.G.*, 136 S.Ct. 2442 (2016).

[55] *See, e.g., EEOC v. R.G. & G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560 (6th Cir. 2018) (holding that termination of employee on the basis of transitioning or transgender status violates Title VII of the 1964 Civil Rights Act); *Whitaker v. Kenosha Unified Sch. Dist.*, 858 F.3d 1034 (7th Cir. 2017) (holding that discrimination against transgender students constitutes sex discrimination under Title IX of the Education Amendments Act of 1972 and the Equal Protection Clause of the U.S. Constitution); *Dodds v. U.S. Dep't. of Education*, 845 F.3d 217 (6th Cir. 2016) (same); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011) (holding that termination of employee based on gender transition, transgender status, and unsubstantiated "bathroom concerns" constitutions sex-based discrimination in violation of the Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (holding that termination of employee based on her gender transition constitutes sex-based discrimination under Title VII); *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004) (same); *Rose v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (holding that refusal to serve transgender customer constitutes sex-based discrimination under the Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (holding that the Gender Motivated Violence Act (GMVA) applied to targeting of a transgender person).

[56] *See, e.g., Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015); *Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018); *Cruz v. Zucker*, 195 F. Supp. 3d 554 (S.D.N.Y. 2016); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F. Supp. 3d 1090 (S.D. Cal. Sept. 27, 2017); *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018); *Boyden v. Conlin,* No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018); *Whitaker v. Kenosha Unified School District*, No. 16-3522 (7th Cir. 2017) (Title IX and Equal Protection Clause); *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal Protection Clause); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011) (Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004) (Title VII); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); *Gavin Grimm v. Glouchester Cty. Sch. Bd.*, No. 4:15-cv-00054-AWA-RJK, Docket # 229 (E.D. Va. Aug. 9. 2019) (Title IX and Equal Protection Clause); *M.A.B. v. Board of Education of Talbot County*, 286 F. Supp. 3d 704 (D. Md. March 12, 2018).

[57] *Proposed* Rule, 84 Fed. Reg. at 27,874, n.179.

[58] 518 U.S. 515 (1996) (finding that an all-male military school violated the Equal Protection Clause by refusing to admit women).

Thomas,[59] as support for its claim. Neither of these cases bear any relation to the question of whether allowing transgender individuals to use the bathrooms of their choice could create a hostile environment under Title IX. And in citing these irrelevant and inapposite cases, the Department ignores legal precedent finding that allowing transgender individuals to use private facilities that match their gender identity *does not* violate Title IX.[60]

The Department's reasoning is steeped in transphobic rhetoric that relies on faulty information and has no place in federal regulations. The Supreme Court has made clear that exclusionary policies that use a pretextual interest in protecting women or other groups instead operate principally to disadvantage the disfavored groups and are, thus, discriminatory.[61] Policies that allow transgender people to use the correct facilities and bathrooms do not legalize harassment, stalking, violence, or sexual assault as the rule claims.[62] Those behaviors are, and will continue to be, against the law for anyone, anywhere. Everyone—including transgender people—should be treated equally under the law. And there is no evidence that allowing transgender students to use bathroom facilities that correspond to their gender identity puts anyone else at risk.[63] The Department is attempting to use Section 1557 to embolden discrimination by claiming that allowing transgender individuals to use facilities that correspond to their gender identity could harm others' rights under the law. This position is not supported by the facts nor is it supported by the law. To insist that sex does not encompass gender

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[59] 983 F.2d 1024 (1993) (holding that state inmates have a constitutional right to bodily privacy).

[60] *See Doe by and through Doe v. Boyertown Area Sch. Dist.*, 897 F.3d 518, 534-35 (3d Cir. 2018) (finding that a school district's policy allowing "all students to use bathrooms and locker rooms that align with their gender identity...does not discriminate based on sex, and therefore does not offend Title IX); *cf. Cruzan v. Special Sch. Dist.*, 294 F.3d 981 (8th Cir. 2002) (finding that inclusive bathroom policy did not create a hostile work environment under Title VII). The Department also ignores the numerous cases holding that *refusing* to allow transgender individuals to use facilities that match their gender identity violates Title IX, Title VII, and the Equal Protection Clause of the U.S. Constitution. *See, e.g., Gavin Grimm v. Glouchester Cty. Sch. Bd.*, No. 4:15-cv-00054-AWA-RJK, Docket # 229 (E.D. Va. Aug. 9. 2019) (Title IX and Equal Protection Clause); *Adams v. School Board of St. Johns Cty.*, 318 F. Supp. 3d 1293 (M.D. Fla. 2018) (Title IX); *A.H. ex rel Handling v. Minersville Area Sch. Dist.*, No. 3:17-cv-391, 2017 WL 5632662 (M.D. Pa. Nov. 22, 2017) (Title IX and the Equal Protection Clause); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267 (W.D. Pa. 2017) (Equal Protection Clause); *Roberts v. Clark Cty. Sch. Dist.*, No. 2:15-cv-00388, 2016 WL 5843046 (D. Nev. Oct. 4, 2016) (Title VII); *Bd. of Ed. of Highland Local Sch. Dist. v. U.S. Dep't of Educ.*, 208 F. Supp. 3d 850 (S.D. Ohio 2016) (Title IX and Equal Protection Clause).

[61] *See Johnson Controls* 499 U.S. 187, 190 (1991); *Whole Woman's Health* v. *Hellerstedt*, 136 S. Ct. 2292, 2316 (2016) (holding that abortion laws justified as protections for women's health and safety violated women's liberty when the burdens they imposed outweighed their benefits).

[62] Letter from the Nat'l Women's Law Ctr. and 114 organizations to Roger Severino, et al. (November 1, 2018) (discussing the HHS proposal to erase transgender, non-binary, and intersex people from civil rights protections), https://nwlc.org/resources/nwlc-and-114-survivor-advocacy-organizations-writes-doj-hhs-ed-and-dol-condemning-any-proposal-to-remove-civil-rights-protections-for-transgender-people/.

[63] *See, e.g.*, Nat'l Ctr. for Transgender Equality, *What Experts Say* (citing sexual assault prevention experts asserting that protecting transgender rights does not compromise safety in restrooms), https://transequality.org/what-experts-say; Amira Hasenbush, Andrew Flores, & Jody Herman, *Gender Identity Nondiscrimination Laws in Public Accommodations: A Review of Evidence Regarding Safety and Privacy in Public Restrooms, Locker Rooms, and Changing Rooms*, SEXUALITY RESEARCH AND SOCIAL POL'Y (July 2018) (finding no link between trans-inclusive policies and bathroom safety), https://link.springer.com/article/10.1007%2Fs13178-018-0335-z.

identity is contrary to the views of the American Medical Association[64], the American Academy of Pediatrics[65], the American Psychological Association[66], the American Psychiatric Association[67], and countless doctors, counselors, psychologists, psychiatrists, and social workers across the nation. This is why in the most recent transgender rights cases briefed at the Supreme Court, more than 20 of the nation's leading medical, mental health, and health care organizations submitted amicus briefs in support of transgender employees' rights.[68] In short, the 2016 Final Rule correctly interpreted court decisions and up-to-date medical research to support a definition of sex that includes gender identity and sex stereotyping and that definition should not be altered by this Proposed Rule.

The Department has provided no justification for its effort to eliminate protections against sex stereotyping and gender identity from the regulations other than its own stated change in position and one preliminary injunction from a single district court case in Texas. But the Department cannot change the law, and the attempt to eliminate the protections from the regulations is impermissible. By removing the definition of sex and supporting the *Franciscan Alliance* court's erroneous conclusion that "sex" refers only to "the biological and anatomical differences between male and female students as determined at their birth," the Proposed Rule improperly seeks to impose a static understanding of sex discrimination that ignores not only how society has evolved and changed but also over 30 years of legal precedent.

To erase protections against sex stereotyping and gender identity discrimination willfully ignores the very real and harmful impact such discrimination has on LGBTQ individuals in this

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[64] *See* Robert Nagler Miller, *AMA Takes Several Actions Supporting Transgender Patients*, AMER. MED. ASSOC. (June 12, 2017), https://wire.ama-assn.org/ama-news/ama-takes-several-actions-supporting-transgender-patients.

[65] *See* Press Release, Amer. Acad. of Pediatrics, *AAP Policy Statement Urges Support and Care of Transgender and Gender-Diverse Children and Adolescents* (Sept. 17, 2018), https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Policy-Statement-Urges-Support-and-Care-of-Transgender-and-Gender-Diverse-Children-and-Adolescents.aspx.

[66] Nat'l LGBTQ Task Force, *American Psychiatric Association Officially Supports Equality in Transgender Health,* (last visited July 31, 2019), http://www.thetaskforce.org/american-psychiatric-association-officially-supports-equality-in-transgender-health/.

[67] Am. Psychiatric Assoc., *Help with Gender Dysphoria* (Feb. 2016), https://www.psychiatry.org/patients-families/gender-dysphoria.

[68] *E.g.*, Brief for American Psychological Association et al. as Amici Curiae in Support of the Employees, *Bostock v. Clayton Cty.* (No. 17-1618), *Altitude Express, Inc. v. Zarda* (No. 17-1623), and *R.G. & G.R. Harris Funeral Homes, Inc.* (No. 18-107) (transgender employees' rights supported by American Psychological Association, American Psychiatric Association, American Association for Marriage and Family Therapy, Georgia Psychological Association, Michigan Psychological Association, and New York State Psychological Association); Brief for American Medical Association et al. as Amici Curiae in Support of the Employees, *Bostock v. Clayton Cty.* (No. 17-1618), *Altitude Express, Inc. v. Zarda* (No. 17-1623), and *R.G. & G.R. Harris Funeral Homes, Inc.* (No. 18-107) (transgender employees' rights supported by American Medical Association, American Nurses Association, American Public Health Association, AGLP: Association of LGBTQ Psychiatrists, Association of Medical School Pediatric Department Chairs, Endocrine Society, GLMA: Health Professions Advancing LGBTQ Equality, LBGT Physician Assistant Caucus, Medical Association of Georgia, Mental Health America, Michigan State Medical Society, National Council for Behavioral Health, Pediatric Endocrine Society, Society for Physician Assistant in Pediatrics, and World Professional Association for Transgender Health).

country. LGBTQ individuals already encounter high rates of discrimination in health care. According to one survey, eight percent of lesbian, gay, bisexual, and queer individuals had an experience within the year prior to the survey where a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation and seven percent experienced unwanted physical contact and violence from a health care provider.[69] Twenty-nine percent of transgender individuals were refused to be seen by a health care provider on the basis of their perceived or actual gender identity in the previous year.[70]

The effects of discrimination on access to care are clear. In a 2016 study, over thirty percent of transgender participants delayed or did not seek needed health care due to discrimination.[71] When they were sick or injured, twenty-eight percent of respondents postponed medical care due to discrimination.[72] Among LGBTQ people who reported having experienced discrimination in the past year, over eighteen percent reported avoiding doctor's offices to avoid discrimination, nearly seven times the rate of LGBTQ people who had not experienced discrimination in the past year.[73]

Emboldening providers to deny care due to a person's gender identity will hit hardest those already experiencing the effects of racial discrimination. Lesbian, gay, bisexual, and queer people are more likely to be non-white.[74] Specifically, adults who identify as transgender are less likely to be white and more likely to be racial and ethnic minorities when compared to the U.S. general population.[75] These groups report discrimination at higher rates.[76]

The Proposed Rule's attempt to literally erase these protections will encourage more of this discrimination.

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[69] *See* 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/.

[70] *See* Mirza & Rooney, *supra* note 69.

[71] *See* K.D. Jaffee et al., *Discrimination and Delayed Health Care Among Transgender Women and Men: Implications for Improving Medical Education and Health Care Delivery*, MED. CARE, vol. 54(11), 1010 (Nov. 2016).

[72] *See* Jamie M. Grant, Ph.D. et al., *National Transgender Discrimination Survey Report on Health and Health Care* (Oct. 2010), https://cancer-network.org/wp-content/uploads/2017/02/National_Transgender_Discrimination_Survey_Report_on_health_and_health_care.pdf

[73] *See* Mirza & Rooney, *supra* note 69.

[74] *See* Frank Newport, *In U.S., Estimate of LGBT Population Rises to 4.5%*, GALLUP (May 22, 2018), https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx

[75] *See* Andrew R. Flores et al., *Race and Ethnicity of Adults Who Identify as Transgender in the United States*, UNIV. OF CAL. WILLIAMS INST. (Oct. 2016), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Race-and-Ethnicity-of-Transgender-Identified-Adults-in-the-US.pdf

[76] *See* Flores et al., *supra* note 75.

b. The Proposed Rule unlawfully tries to allow more entities to discriminate.

Despite the fact that Section 1557 was enacted to "ensure[s] that all Americans are able to reap the benefits of health insurance reform equally without discrimination,"[77] the Proposed Rule takes steps to expand discrimination in health care.

i. The Proposed Rule would allow insurers to discriminate.

The Department seeks to delete all of the provisions detailing the specific discriminatory actions prohibited by insurance companies and to unlawfully exempt most health insurance issuers from having to comply with Section 1557.

The 2016 Final Rule correctly makes clear that if a health insurance issuer receives federal financial assistance then all of the issuer's plans, including those that do not receive federal financial assistance directly, are covered by Section 1557, just as an educational institution is covered by Title IX in regard to all of its operations if it receives any federal financial assistance.[78] Thus, the 2016 Final Rule adopted the well-known—and widely-accepted—structure of the Spending Clause antidiscrimination statutes as amended by the Civil Rights Restoration Act (CRRA). It did not, as the Proposed Rule claims, expand or abrogate the CRRA.

In contrast to the 2016 Final Rule, the Proposed Rule tries to subvert both the text and purpose of the CRRA by stating that Section 1557 will only apply to the specific "operations" of a covered entity that directly receive federal financial assistance if they are "principally engaged in the business of providing health care."[79] Thus, under the Proposed Rule only those health plans that receive federal financial assistance directly—primarily plans that receive subsidies in the Health Insurance Marketplaces and Medicare HMOs—would be required to comply with Section 1557. This would exempt large numbers of health insurance plans that are currently

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[77] 156 Cong. Rec. S1842 (daily ed. Mar. 23, 2010) (emphasis added).

[78] *E.g., Williams v. Sch. Dist. of Bethlehem, Pa.*, 998 F.2d 168, 171, n. 3 (3d Cir. 1993) ("Although the School District initially argued in the district court that title IX does not apply to athletic programs that do not themselves receive federal funds, it eventually conceded, correctly, that title IX applies whenever any part of an educational program receives federal funding, which is the case here." (referencing Civil Rights Restoration Act of 1987, 20 U.S.C. § 1687 (1988)); *Horner v. Kentucky High Sch. Athletic Ass'n*, 43 F.3d 265, 271 (6th Cir. 1994) (italicizing "any part of which" and stating: "The legislative history describes the effect of the amendments, stating that the definitions of 'program or activity' and 'program' 'make clear that discrimination is prohibited throughout entire agencies or institutions if any part receives Federal financial assistance.'" (citing S.Rep. No. 64, 100th Cong., 2d Sess. 4, *reprinted in* 1988 U.S.C.C.A.N. 3, 6)); *O'Connor v. Davis*, 126 F.3d 112, 117 (2d Cir. 1997) ("Following the 1988 Amendment [of the CRRA], courts have consistently interpreted Title IX to mean that if one arm of a university or state agency receives federal funds, the entire entity is subject to Title IX's proscription against sex discrimination."); *Klinger v. Dep't of Corrections*, 107 F.3d 609, 615 (1997) ("In other words, the purpose of § 1687 [of Title IX, as amended by the CRRA] was 'to make clear that discrimination is prohibited throughout entire agencies or institutions if any part receives Federal financial assistance.'" (citing S.Rep. No. 100–64, 100th Cong., 2d Sess. 4 (1988), *reprinted in* 1988 U.S.C.C.A.N. 3, 6.)).

[79] *Proposed Rule*, 84 Fed. Reg. at 27,891 (proposed § 92.3).

covered because their issuers receive federal financial assistance even though the plan does not.

This is inconsistent with both the CRRA and Section 1557. The CRRA defines "program or activity" to include a wide variety of entities--not just those principally engaged in the business of providing health care, "any part of which is extended Federal financial assistance."[80] However, even if the Department were correct in its reading of the CRRA, it would be absurd to claim that health insurance issuers are not health programs covered by Section 1557. As part of the ACA, Section 1557 was clearly intended to reach all the operations of health insurance issuers who receive federal financial assistance. Further, courts have made clear that an entity need not be directly involved in patient care to be considered principally engaged in providing health care.[81]

In addition, by deleting the specific provisions relating to health insurance coverage,[82] the Proposed Rule will embolden discrimination. For example, covered plans would no longer be explicitly prohibited from employing discriminatory benefit designs to discourage enrollment by persons with significant health needs. This could have a profound effect on people with disabilities, chronic health conditions, people who are older, and women, who often have higher health costs. This provision has been crucial in stopping insurers from placing all or most prescription drugs used to treat a specific condition, such as HIV prescriptions, on a plan's most expensive tier.[83]

Similarly, the Proposed Rule would eliminate the regulation that prohibits issuers from using discriminatory marketing practices, such as those "designed to encourage or discourage

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[80] Civil Rights Restoration Act of 1987, Pub. L. No. 100-259, 102 Stat. 28 (1988) (codified as amended in scattered sections of 20, 29, and 42 U.S.C.). Section 1557's prohibition of discrimination in any "program or activity receiving Federal financial assistance" must be read to include the definition imported by the CRRA. These statutes thus apply, as set out in the CRRA, to any "program or activity"—defined as the types of entities listed in the CRRA—"any part of which is extended Federal financial assistance." Those entities are not limited to entities "principally engaged in the business of providing health care." *See* 20 U.S.C. § 1687(1-3) ("For the purposes of this chapter, the term 'program or activity' and 'program' mean all the operations of...a department, agency, special purpose district, or other instrumentality of a State or of a local government...a college, university, or other postsecondary institution...a local education agency...an entire corporation, partnership, or other private organization, or an entire sole proprietorship... or the entire plant or other comparable, geographically separate facility...any part of which is extended Federal financial assistance").

[81] *See, e.g., Dorer v. Quest Diagnostics Inc.*, 20 F. Supp. 2d 898, 900 (D. Md. 1998) (holding a laboratory which provided clinical diagnostic testing and received Medicare and Medicaid was principally engaged in providing health care); *Zamora-Quezada v. HealthTexas Med. Grp. of San Antonio*, 34 F. Supp. 2d 433, 444 (W.D. Tex. 1998) (explaining that a health care delivery system was fueled by the financial arrangements of an insurance company, and thus the insurance company controlled the delivery of health care and caused the discrimination patients experienced).

[82] In addition to this provision, the Proposed Rule would also delete prohibitions against insurers.

[83] 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/.

particular individuals from enrolling in certain health plans."[84] As the Department explained in the 2016 Final Rule "such practices would include, for example, any activity of a covered entity that is designed to encourage individuals to participate or enroll in the covered entity's programs or services or to discourage them from doing so, and activities that steer or attempt to steer individuals towards or away from a particular plan or certain types of plans."[85] Eliminating these regulations will encourage insurance companies to try to cut costs by engaging in these discriminatory practices. These protections have been lifesaving for many people.

ii. The Proposed Rule attempts to allow the Department to discriminate.

Section 1557 states clearly that it applies to "any program or activity that is administered by an Executive Agency." Nothing in the plain language of the statute or legislative history would permit any other reading. Yet, despite this plain language, the Department tries to claim the prohibition against discrimination by programs or activities administered by an executive agency only applies to those programs created by Title I of the ACA. The Department, thus, seeks to allow discrimination in federally run programs such as Medicare, Medicaid, the Children's Health Insurance Program, and federal research programs. But the Department cannot just decide it is no longer bound by the law in the programs it administers.

III. The Proposed Rule would sanction a host of other forms of discrimination.

By deleting the provisions of the 2016 Final Rule, the Proposed Rule opens the door to a range of discrimination against individuals in the health care context.

For example:

- The Proposed Rule would delete the explicit prohibition against discrimination based on an individual's association or relationship with someone else based on that other person's race, color, national origin, sex, age, or disability. By deleting this provision, the Department is sanctioning discrimination such as a doctor refusing to treat a newborn whose parents are lesbians,[86] an ambulance driver refusing to drive a patient to a hospital because the patient's parents do not speak English, or a receptionist refusing to book an appointment for a white woman because her husband is black.
- By removing the 2016 Final Rule's clarification that covered entities could not provide significant assistance to another entity that discriminates, the Proposed Rule would mean, for example, that a Health Insurance Marketplace could contract with navigators

[84] Musumeci et al., *supra* note 83.
[85] *Final Rule*, 81 Fed. Reg. at 31,433.
[86] *See* Mark Joseph Stern, *Anti-Gay Doctor Refuses to Treat Lesbian Parents' Six-Day-Old Baby*, SLATE (Feb. 19, 2015, 1:04 PM), https://slate.com/human-interest/2015/02/doctor-refuses-to-treat-baby-of-lesbian-parents-because-theyre-gay.html.

who refuse to assist people LGBT people or unmarried couples, something that the 2016 Final Rule made clear was prohibited.

- By eliminating the requirement that covered entities provide notice that they do not discriminate and explaining what to do if someone believes they have faced discrimination, the Proposed Rule will leave people unaware of their rights. This will be particularly harmful to people with limited English proficiency and with disabilities. Without the notice, members of the public will have limited means of knowing that language services and auxiliary aids and services are available, how to request them, what to do if they face discrimination, that they have the right to file a complaint, and how to file such a complaint.
- By eliminating the requirement that covered entities include taglines in the top fifteen languages spoken by individuals with limited English proficiency (LEP) in the state on all significant documents, the Proposed Rule would also significantly harm people who need language access services. Taglines, or short statements in various languages informing individuals of their right to language assistance and how to seek such assistance, currently must be included in significant publications, including notices of nondiscrimination. The Proposed Rule also attempts to eliminate recommendations that entities develop a language access plan.
- By eliminating critical protections for LEP individuals seeking care, the Department is making health care inaccessible for marginalized or linguistically isolated communities. These protections are crucial to minimizing the health care risks LEP individuals face in the health care system, including avoidable hospital readmissions, lower rates of outpatient follow up, limited use of preventive services, poor medication adherence, and lack of understanding discharge diagnosis and instructions. In a 2018 poll, about 6 in 10 Latinx adults reported having trouble communicating with their providers about their health care needs due to language or cultural barriers. Spanish-speaking LEP Latinx individuals are more likely to report experiencing worse health outcomes than Latinx individuals who are monolingual in English or bilingual in English and Spanish. Since Latina women are less likely than Latino men to be proficient in English,[87] the Proposed Rule's harmful changes will have a disproportionate impact on Latina women who may experience discrimination on the basis of sex, race, national origin and LEP status.

IV. The Proposed Rule unlawfully attempts to weaken the existing enforcement mechanisms and remedies.

The Proposed Rule seeks to dramatically alter the remedies and enforcement mechanisms under Section 1557 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

[87] *See* Jens Manuel Krogstad et al., *English Proficiency on the Rise Among Latinos*, PEW RESEARCH CTR. (May 12, 2015), https://www.pewhispanic.org/2015/05/12/english-proficiency-on-the-rise-among-latinos/.

limit claims of intersectional discrimination, going against the text and intent of Section 1557. For example, a pregnant Latina woman who was refused translation services and told by the receptionist that she should go back to where she came from to have her baby would have only the remedies and enforcement mechanisms available under Title VI for the denial of translation services and harassment because of her country of origin *or* those available under Title IX for the harassment because she was pregnant. Under the Proposed Rule, one person who faces intersectional discrimination would have different remedies and enforcement mechanisms for the same incident and under the same law. That is an absurd outcome that is not supported by the text or intent of Section 1557.[88]

The Proposed Rule would delete the provisions in the 2016 Final Rule that recognized a private right of action in federal court. 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.[89] The existence of such a right is clear from the statutory language in Section 1557, which explicitly references and incorporates the "enforcement mechanisms" of the four civil rights laws listed—all of which contain a private right of action. This understanding is also consistent with Congress's intent that civil rights laws be broadly interpreted to effectuate the remedial purposes of those laws.

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. This is contrary to the statute and court precedent.[90]

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[88] *See Rumble v. Fairview Health Servs.*, No. 14-cv-2037 (SRN/FLN), 2015 WL 1197415, at *11. (D. Minn. Mar. 16, 2015) (holding that Section 1557 must be interpreted to "create a new, health-specific, antidiscrimination cause of action that is subject to a singular standard, regardless of a plaintiff's protected class status" because "[r]eading Section 1557 otherwise would lead to an illogical result, as different enforcement mechanisms and standards would apply to a Section 1557 plaintiff depending on whether the plaintiff's claim is based on her race, sex, age, or disability.").

[89] *Rumble v. Fairview Health Servs.*, 2015 WL 1197415 at *11 (D. Minn. Mar. 16, 2015). *See, also, Callum v. CVS Health Corp.*, 137 F.Supp.3d 817, 845 (D.S.C. 2015); *Esparza v. Univ. Med. Ctr. Mgmt. Corp.*, No. CV 17-4803, 2017 WL 4791185, at *4 (E.D. La. Oct. 24, 2017); *Griffin v. Gen. Elec. Co.*, No. 1:15-CV-4439-AT, 2017 WL 8785572, at *3 (N.D. Ga. Dec. 6, 2017), aff'd, 752 F. App'x 947 (11th Cir. 2019); *Audia v. Briar Place, Ltd.*, No. 17 CV 6618, 2018 WL 1920082, at *3 (N.D. Ill. Apr. 24, 2018); *Ass'n of New Jersey v. Horizon Healthcare Servs., Inc.*, No. CV 16-08400(FLW), 2017 WL 2560350, at *4 (D.N.J. June 13, 2017); *York v. Wellmark, Inc.*, 2017 WL 11261026, at *16 (S.D.Iowa Sep. 06, 2017); *Briscoe v. Health Care Serv. Corp.*, 281 F.Supp.3d 725, 737 (N.D. Ill. 2017).

[90] Courts have held that damages are available under Title VI, Title IX, and Section 504. *See, e.g., Alexander v. Sandoval*, 532 U.S. 275 (2001) (damages remedy available under Title VI for claims of intentional discrimination); *Franklin v. Gwinnett County Public Schools*, 503 U.S. 60 (1992) (damages remedy available under Title IX); *Consol. Rail Corp. v. Darrone*, 465 U.S. 624 (1984) (backpay available under Section 504).

V. By opening the door to discrimination, the Proposed Rule will harm individuals' health and increase health disparities.

The combined effect of the Proposed Rule will be to embolden discrimination and make it harder for people who face discrimination to exercise their rights. The impact will be devastating, affecting access to health care for millions across this country and increasing already troubling health disparities.

Certain groups of individuals have historically faced discrimination in health care. For example, despite the historic achievements of the ACA, women – particularly women of color – are far more likely to suffer verbal abuse, stigma, and discrimination by a health care provider.[91] Thirty-three percent of indigenous women reported mistreatment, followed by twenty-five percent of Latina women and twenty-three percent of Black women.[92] Moreover, when women are able to see a provider, women's pain is routinely undertreated and often dismissed.[93] 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.[94]

Women of color receive improper diagnoses more frequently, are provided less effective treatments, and are sometimes denied care altogether.[95] In one report, Black women disclosed that their doctors failed to inform them of the full range of reproductive health options regarding labor or delivery and "pushed certain procedures based not on the patient's best interest but rather based on stereotypes about Black women's sexuality and reproduction."[96] The cumulative effect of this discrimination is already seen most acutely in black maternal mortality and morbidity rates.

Discrimination, which this Proposed Rule will embolden, reduces access to care and diminishes trust in the health care system. For example, fear of continued racial discrimination in medical facilities deters Black people from utilizing available services.[97] Due to discrimination, Black

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[91] *See* Saraswathi Vedam et al., *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, REPROD. HEALTH, vol. 16, art. 77 (2019).
[92] *See* Saraswathi Vedam et al., *supra* note 91.
[93] *See* CHRONIC PAIN: PSYCHOSOCIAL FACTORS IN REHABILITATION (Eldon Tunks et al., eds., 2d ed. 1990).
[94] *See* Laura Kiesel, *Women and Pain: Disparities in Experience and Treatment*, HARVARD HEALTH BLOG (Oct. 9, 2017, 10:30 AM), https://www.health.harvard.edu/blog/women-and-pain-disparities-in-experience-and-treatment-2017100912562
[95] *See* Lu Chen & Christopher I. Li, *Racial Disparities in Breast Cancer Diagnosis and Treatment by Hormone Receptor and HER2 Status*, CANCER EPIDEMIOL BIOMARKERS PREV, vol. 24(11), 1666 (October 13 2015).
[96] *See* Lisa Rosenthal & Marci Lobel, *Stereotypes of Black American Women Related to Sexuality and Motherhood*. PSYCHOL. WOMEN Q., vol. 40(3), 414 (Feb. 17, 2016); *See also* SISTERSONG, NAT'L LATINA INST. FOR REPROD. HEALTH, & CTR, FOR REPROD. RTS., *Reproductive Injustice: Racial and Gender Discrimination in U.S. Healthcare*, 1, 15-24 (2014), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf.
[97] *See* Erin Pullen et al., *African American Women's Preventative Care Usage: The Role of Social Support and Racial Experiences and Attitudes*. SOCIOL. HEALTH ILLN., vol. 36(7), 1037 (Apr. 21, 2014).

people reported lower levels of trust in both their physician and in the health care system, as compared to white people. Moreover, Black women were more likely avoid preventive services due to low levels of trust in their primary care provider.[98]

As the Department itself has explained, discrimination has harmful negative health outcomes, especially among racial/ethnic minorities, women, LGBT individuals, older adults, and people with disabilities.[99] These negative health impacts include depression, suicidal ideation, self-harm, reduced utilization of health care services, worse self-reported health, low birth weight, high blood pressure, and poor health status.[100] And, as the Department has also acknowledged, individuals who live at the intersection of multiple identities experience discrimination differently, which may affect health outcomes.[101] Yet despite the clear evidence of the harm of discrimination among individuals who have historically faced and currently still face discrimination, the Proposed Rule would open the door wide for more discrimination.

VI. The justifications put forth in the Proposed Rule are wholly inadequate.

In addition to justifying the Proposed Rule because of a single district court decision, which is improper for the reasons already stated, the Department puts forth additional insufficient and improper reasoning that cannot justify its actions.

a. The Department improperly suggests Supreme Court precedent justifies rolling back civil rights protections.

The Proposed Rule improperly refers to the Supreme Court's decision in *National Federation of Independent Business v. Sebelius* (*NFIB*) to support the Department's roll back of Section 1557 protections. *NFIB* held that the Affordable Care Act's Medicaid expansion program was an unconstitutionally coercive use of Spending Clause authority. But that finding was narrowly applied to the Medicaid expansion program and does not affect federal agencies' ability to implement Title IX or Section 1557 or to restrict federal funding if covered entities fail to comply with those laws.[102] Further, if a recipient violates Section 1557, it does not stand to lose all of its federal funding but only the funding that supports the specific discriminatory program. The *NFIB* decision does not change the interpretation of Section 1557 or any other anti-discrimination statute passed under Congress' authority to enforce Section 5 of the Equal Protection Clause or under Congress' spending clause authority.

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[98] *See* Pullen et al., *supra* note 97.

[99] *See* Social Determinants of Health Literature Summaries, *Discrimination*, HEALTHY PEOPLE 2020 (last viewed on Aug. 10, 2019), https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/discrimination.

[100] See Social Determinants of Health, *supra* note 99.

[101] *See* Social Determinants of Health, *supra* note 99.

[102] *See* Emily Martin, *Title IX and the New Spending Clause*, AM. CONST. SOC'Y FOR LAW AND POL'Y (Dec. 2012) (analyzing the *NFIB* decision and concluding that its holding does not impact Title IX).

Importantly, Federal civil rights laws are intended to create a floor of civil rights protections to which all individuals—regardless of the state they reside in—are entitled.[103] In upholding civil rights laws, the Supreme Court has explicitly acknowledged that protecting civil rights is a crucial role assigned to the federal government.[104]

b. The Regulatory Impact Analysis is insufficient and fails to justify the Proposed Rule.

The Proposed Rule provides a Regulatory Impact Analysis (RIA) that is wholly insufficient to justify the extensive scope of the proposed changes. Agencies are required to account for direct and indirect health costs to the fullest extent practicable, including "outcomes that cannot be quantified but may have important implications for decision-making."[105] The RIA, however, entirely fails to identify and to quantify costs to protected individuals or to society as a whole. This failure, along with the Proposed Rule's failure to provide a reasoned explanation for the abrupt reversal of policy, renders the rule arbitrary and capricious.

i. The Proposed Rule failed to consider the costs of discrimination to individuals, the health care system, and the government.

The Department does not account for any of the costs imposed on the general public or our public health systems, even as it acknowledges that the Proposed Rule may increase discrimination and make it less likely that people will exercise their rights. In fact, the Department states that eliminating the notice requirement will mean that an "unknown number of persons are likely not aware of their right to file complaints." Similarly, the Department acknowledges that the elimination of the notice and tagline requirements "may impose costs, such as decreasing access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services." The Department perfunctorily labels the impact as "negligible" while providing no evidentiary basis.

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[103] *See, e.g., Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241 (1964) (the Supreme Court unanimously holding that it was well within the federal government's power to enforce civil rights law against a motel refusing to accommodate Black guests);); *Katzenbach v. McClung*, 379 U.S. 294 (1964) (the Supreme Court rejecting the argument that Congress exceeded its authority to regulate interstate commerce by passing the Civil Rights Act and enforcing the Act against a restaurant that refused to seat Black patrons).

[104] *See, e.g., Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241 (1964); *Katzenbach v. McClung*, 379 U.S. 294 (1964).

[105] U.S. Dep't of Health and Human Servs., *Guidelines for Regulatory Impact* Analysis, 1, 47 (2016), https://aspe.hhs.gov/system/files/pdf/242926/HHS_RIAGuidance.pdf. "[R]easonable regulation ordinarily requires paying attention to the advantages and the disadvantages of agency decisions." *Michigan v. EPA*, 135 S. Ct. 2699, 2707 (2015). A cost-benefit analysis should account for direct and indirect costs associated with a rulemaking. *Id.* "As a general rule, the costs of an agency's action are a relevant factor that the agency must consider before deciding whether to act," and "consideration of costs is an essential component of reasoned decisionmaking under the [APA]." *Mingo Logan Coal Co. v. EPA*, 829 F.3d 710, 732–33 (D.C. Cir. 2016).

The costs, though, are anything but negligible. Ultimately, the discrimination invited by the Proposed Rule will lead to exorbitant costs to the economy. Racial health disparities are associated with substantial annual economic losses nationally, including an estimated $35 billion in excess health care expenditures, $10 billion in illness-related lost productivity, and nearly $200 billion in premature deaths.[106] The Joint Center for Economic and Political Studies estimates that between 2003 and 2006, over thirty percent of direct medical care expenditures for racial and ethnic minorities were excess costs stemming from health inequalities,[107] and eliminating health disparities for minorities would reduce direct medical care expenditures by nearly $230 billion.[108] Alternatively, exacerbating health disparities – as the Proposed Rule would do – would necessarily drive up the overall cost of health care expenditures.

ii. The RIA did not properly consider alternatives to eliminating the language access and notice requirements

The RIA specifically tries to justify the Proposed Rule by citing to the cost savings of eliminating the language access and notice requirements. The Department's estimate of the burden to covered entities for compliance with the nondiscrimination notice and tagline requirements is based on voluntary actions and interpretations by covered entities. OCR based the elimination of the notice and taglines on these estimates but did not consider whether alternatives, such as further clarification about the requirements, was warranted in the form of FAQs or other guidance. That is, OCR failed to consider alternatives to a complete repeal of notices and taglines that could have appropriately balanced the need to inform individuals of their rights while recognizing there may be a difference in the intentions behind the 2016 Final Rule and how covered entities have interpreted it.

Similarly, the majority of the costs are associated with the provision of a single type of document -- the Explanation of Benefits (EOB). OCR did not consider alternatives as to how it would consider enforcement and interpretation of the "significant document" standard with respect to the provision of multiple EOBs sent during a coverage year.

VII. The Department cannot suspend Subregulatory Guidance, including the Preamble to the 2016 Final Rule.

HHS is bound by the Administrative Procedures Act to provide justification for proposed changes to implementation of law and cannot change current regulations without going through the notice and comment period, considering those comments, and then providing justification for its changes in a new final regulation. However, the Proposed Rule states the Department will suspend all subregulatory guidance regarding the Section 1557 protections including the preamble to the 2016 Final Rule. Suspending this guidance while the current

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[106] *See* John Z. Ayanian, MD, *The Costs of Racial Disparities in Health Care*, HARVARD BUS. REV. (Oct. 1, 2015), https://hbr.org/2015/10/the-costs-of-racial-disparities-in-health-care.

[107] *See* Ayanian, *supra* note 106.

[108] *See* William Riley, Ph.D, *Health Disparities are Costly for (U.S.) All*, NAT'L INST. OF HEALTH (Apr. 1, 2016), https://obssr.od.nih.gov/health-disparities-are-costly-for-u-s-all-think-about-it-in-april-and-beyond/.

regulations remain in effect violates the procedural requirements of the Administrative Procedure Act and signals to covered entities that the Department does not intend to fully enforce Section 1557, as required by law.

The Department cites to the Attorney General's memoranda of November 16, 2017 and January 25, 2018 that provide that that Department of Justice litigators cannot use noncompliance with guidance documents as the basis for proving violations of law in civil enforcement actions. The memoranda, however, do not require the withdrawal of the subregulatory guidance. The information in the subregulatory guidance, especially the preamble to the 2016 Final Rule, allows covered entities to understand the parameters of the regulations and how to comply and can be used by the courts to understand the Department's intent in promulgating the current regulations.

VIII. The Department improperly weakens regulations unrelated to implementation of Section 1557.

The Department improperly proposes to rescind portions of ten separate, unrelated regulations adopted by the Centers for Medicare and Medicaid Services (CMS) between 2006 and 2016 to eliminate protections against discrimination on the basis of gender identity and sexual orientation. In addition, the Department proposes to amend regulations implementing Title IX. These rules do not interpret Section 1557 and were adopted under other unrelated statutory authorities. The Department offers no legal, policy, or cost-benefit analysis regarding these rules, the impacts they have had during the years they have been in place, or the costs and benefits of rescinding them. In fact, each of these provisions is legally sound and a reasonable measure to protect patients and effectively implement statutory programs. The Center specifically comments on the Department's attempt to weaken Title IX; however, it also supports the comments by the National Center for Transgender Equality that address the rescission of the CMS regulations.

a. The Department should not weaken civil rights protections under its Title IX regulations.

In its proposed rule, the Department inappropriately proposes to amend regulations interpreting a wholly different statute from Section 1557 of the ACA. As an initial matter, the Center objects to this procedural bootstrapping of rulemaking on laws outside of the scope of Section 1557. However, given that the Department indicates it will move forward with this inappropriate rulemaking process, the Center responds to the substance of the proposal below.

The Center opposes any attempt to weaken the Department's Title IX regulations, including removing the regulation that explicitly concerns rules of appearance and attempting to incorporate religious exemptions that have no relevance in the education context. It is also particularly troubling that the Department would attempt to undermine civil rights protections in schools through an NPRM that is focused on HHS's Section 1557 regulations concerning nondiscrimination in health care. By attempting to amend its Title IX regulations within broader

changes to Section 1557's rules, the Department seeks to insulate the proposed changes from the thorough public review that they would otherwise receive, rendering the proposed changes procedurally infirm.

i. The Proposed Rule's attempt to remove prohibitions against discrimination dased on one's appearance is dangerous and threatening to public health.

The Proposed Rule seeks to remove Title IX regulatory language prohibiting discrimination "against any person in the application of any rules of appearance" in education programs and activities.[109] Contrary to HHS's assertions, the "rules of appearance" regulation appropriately reflects Title IX's prohibitions. Punishing individuals for not conforming to style standards traditionally associated with their sex or for dressing in ways that others may find objectionable—for example, men who have long hair or women who wear pants—is a prime example of treating individuals differently based on sex-stereotyping, which is prohibited under Title IX.[110] For the same reason, dress codes discriminate against transgender and gender-nonconforming individuals when they require people to adhere to dress policies that conflict with their gender identity or expression.[111] The Department claims that removing the "rules of appearance" regulation would eliminate "confusion" about Title IX's protections because no other agency has such an explicit prohibition on discrimination based on appearance or dress codes in its Title IX rules. However, this prohibition is implicit in the Title IX final common rule that was adopted by 20 federal agencies[112], which includes Department of State, NASA, Department of Justice and National Science Foundation, and it is implicit in the Department of Education's Title IX regulations. Both the Department of Education's Title IX regulations *and* the Title IX final common rule prohibit schools from "subject[ing] any person to separate or different rules of behavior, sanctions, or other treatment" on the basis of sex, thus reaching dress codes that impose separate rules of behavior on students based on sex, and different treatment based on sex for purported violations of dress codes.[113] Courts have also recognized

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[109] *Proposed Rule*, 84 Fed. Reg. at 27,871 (citing 45 C.F.R. § 86.31(b)(5)).

[110] *See Whitaker v. Kenosha Unified Sch. Dist.*, 858 F.3d 1034 (7th Cir. 2017) (finding that sex stereotyping can violate Title IX).

[111] *See Price Waterhouse v. Hopkins*, 490 U.S. 228, 235, 255 (1989) (finding that employer's advice for female employee to "dress more femininely, wear make-up, have her hair styled, and wear jewelry" was sufficient evidence of sex stereotyping in violation of Title VII); *Lewis v. Heartland Inns of Am., L.L.C.*, 591 F.3d 1033, 1040 (8th Cir. 2010) ("an employer who discriminates against women because, for instance, they do not wear dresses or makeup, is engaging in sex discrimination"); *Smith v. City of Salem, Ohio*, 378 F.3d 566, 574 (6th Cir. 2004) (employers who discriminate against men because they do wear dresses and makeup, or otherwise act femininely, are [] engaging in sex discrimination"); *Rosa v. Park W. Bank & Tr. Co.*, 214 F.3d 213 (1st Cir. 2000) (finding sex discrimination where bank instructed customer dressed in "traditionally feminine attire" to go home and change into "more traditionally male clothing" that matched the customer's identification card in order to receive loan application form).

[112] Nondiscrimination on the Basis of Sex in Education Programs or Activities Receiving Federal Financial Assistance, 65 Fed. Reg. 52,857, 52,858 (Aug. 30, 2000).

[113] 34 C.F.R. § 106.31(b)(4); 65 Fed. Reg. at 52,870 (Aug. 30, 2000); *see Hayden v. Greensburg Community Sch. Corp.*, 743 F.3d 569 (7th Cir. 2014) (hair length policy that applied only to members of the boys basketball team

dress and style codes that impose different restrictions and requirements on student depending on their sex can constitute discrimination in violation of the Equal Protection Clause of the U.S. Constitution.[114] For these reasons, implying that Title IX does not prohibit sex-based discrimination in dress or appearance codes will actually create new confusion about the protections that Title IX provides and invite further litigation against health care providers.

Indeed, explicitly prohibiting discrimination in "rules of appearance" is all the more important in HHS-funded education programs and activities, which will often operate in the health care context and may include provision of patient care. Individuals seeking medical care have the right to equal treatment, regardless of whether their appearance conforms to traditional sex stereotypes. In the school health care context, allowing medical and health providers at a school to deny care to a student or an employee of the institution for something as frivolous as their appearance can result in life or death consequences—directly and immediately threatening the patients' individual health. While it is an injustice to deny any civil right, such as educational opportunities, because of a person's nonconformity to sex stereotypes, HHS's attempt to give medical professionals license to deny students and school employees life-saving treatment based on their appearance is particularly repugnant. And the impact of removing this regulation would have a particularly harmful impact on LGBTQ individuals of color, who already face disproportionate rates of discrimination in health care[115] and would embolden providers to discriminate based on how a patient presents themselves. As with many other sections of this Proposed Rule, the decision to remove the "rules of appearance" regulation is clearly intended to further revoke protections against discrimination on the basis of gender identity.

ii. The Department proposes to improperly and impermissibly include a litany of religious and abortion exemptions to Title IX.

The Department attempts to incorporate a laundry list of dangerous federal refusal laws and other abortion restrictions into the Title IX regulations, proposing that Title IX must be "construed consistently with" this litany of laws. As an initial matter, Title IX's statute already includes provisions regarding abortion and religious entity compliance with the law; therefore, the Department's proposal is improper given that the law already specifically speaks to these issues. Second, the Department includes several provisions in the laundry list that have no relevance to the Title IX context, and yet the Department fails to explain how any of these laws should "be construed consistently with" Title IX. Take, for example, the Department's

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violated Title IX and the Equal Protection Clause); *but see Peltier et al. v. Charter Day Sch.*, No. 17-cv-30-H, 2019 WL 2352130 (Mar. 28, 2019) (finding that Title IX did not pertain to dress codes because the "rules of appearance" regulation had been removed from other agencies' regulations).

[114] *See, e.g., Glenn v. Brumby*, 663 F.3d 1312, 1320-21 (11th Cir. 2011) (affirming summary judgment for transgender woman who was fired because she appeared at work "wearing women's clothing"); *Peltier et al. v. Charter Day Sch.*, No. 17-cv-30-H, 2019 WL 2352130 (E.D.N.C. Mar. 28, 2019) (dress code policy requiring girls to wear skirts, skorts, or jumpers violated the Equal Protection Clause); *Sturgis v. Copiah Cty. Sch. Dist.*, No. 3:10-CV-455, 2011 WL 4351355, at *1-4 (S.D. Miss. Sept. 15, 2011) (denying motion to dismiss where school district required female students to wear drapes and male students to wear tuxedos for their senior yearbook portraits).

[115] *See, e.g.,* Mirza & Rooney, *supra* note 69; LAMBDA LEGAL, WHEN HEALTH CARE ISN'T CARING (2010), https://www.lambdalegal.org/publications/when-health-care-isnt-caring.

suggestion that the Title IX regulations must be read alongside the Helms Amendment. The Helms Amendment is a restriction on abortion funding that applies to U.S. foreign assistance. The Department does not explain how Title IX should be read alongside it, but its inclusion suggests that there are implications that an entity must consider. Thus, the Department unnecessarily creates confusion by suggesting, without explaining, that all of these laws impact Title IX. In fact, the inclusion of provisions such as the Helms amendments better reflects the Department's systemic efforts to attack abortion access and expand religious exemptions whenever it has the opportunity to, even if it lacks any basis to do so, rather than any serious proposal for delineating the rights and obligations of entities subject to Title IX.

The Center strongly objects to the Department's careless, baseless, and ideological incorporation of abortion and religious exemptions to the Title IX regulations.

Conclusion

The Proposed Rule is an unlawful, improper, and unjustifiable attempt to undo current protections against discrimination in health care. It opens the door to allow discrimination in health care, which will have devastating consequences for individuals in this country. For all the reasons stated above, the Department should withdraw the Proposed Rule and fully enforce Section 1557 and the 2016 Final Rule.

Sincerely,

Fatima Goss Graves

Fatima Goss Graves
President and CEO, National Women's Law Center

National Hispanic Leadership Agenda

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:

On behalf of The National Hispanic Leadership Agenda (NHLA), a coalition of 45 leading national Latino nonpartisan civil rights and advocacy organizations, we submit this comment in response to 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") to express our concerns with the proposed rule entitled "Nondiscrimination in Health and Health Education Programs or Activities," published in the Federal Register on July 14, 2019.

NHLA was established in 1991 as a nonpartisan association of major Hispanic national organizations and distinguished Hispanic leaders from all over the nation. NHLA's mission calls for unity among Latinos around the country to provide the Hispanic community with greater visibility and a clearer, stronger influence in our country's affairs. NHLA brings together Hispanic leaders to establish policy priorities that address, and raise public awareness of, the major issues affecting the Latino community and the nation as a whole. NHLA is composed of 45 of the leading national and regional Hispanic civil rights and public policy organizations and other elected officials, and prominent Hispanic Americans. NHLA coalition members represent the diversity of the Latino community – Mexican Americans, Puerto Ricans, Cubans, and other Hispanic Americans. NHLA supports the positive changes the Affordable Care Act ("ACA") has brought to Hispanics living in the United States and maintaining access to quality and affordable health care.

NHLA strongly opposes the proposed elimination or rollback of critical protections guaranteed by Section 1557 of the Affordable Care Act ("Section 1557") and the 2016 Nondiscrimination in Health Programs or Activities final rule ("2016 final rule"). We demand that this NPRM be rescinded in its entirety.

Communities of color, including immigrant women and lesbian, gay, bisexual, transgender, and queer ("LGBTQ") Latinos, have historically experienced many systemic barriers such as high costs, lack of access to clinics in rural areas, and insufficient culturally and linguistically competent health care. As Latinos face increasing hostility and life threatening circumstances in this country and attacks on our civil rights, it is more important than ever to ensure that our communities have protections and access to the health care they need. These proposed changes to the implementing regulations of

Section 1557 are an attack on our civil rights, and if implemented, would only create more barriers to accessing care for the communities we serve.

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.

The 2016 final rule implementing Section 1557 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 LGBTQ individuals, 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. LGBTQ Latinos find themselves at the intersections of many identities including race, gender, sexual orientation, class, citizenship status, and many more. 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, an immigrant woman seeking reproductive health care could face harassment because she is a woman and has LEP. Similarly, a provider could discriminate against an Afro-Latina woman because of both her race and gender.

Section 1557 is the law of the land, but 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 robust public comment, including a request for information and one notice of proposed rulemaking. HHS considered more than 24,875 public comments submitted for the 2016 final rule.[1] 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

[1] 81 Fed. Reg. 31376.

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 Latinos living in the United States.

In order to reflect the ACA's clear intent and its overriding purpose of eliminating discrimination in health care, the proposed rule should not be finalized.

I. 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."[2] 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)."[3]

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

This rollback could mean that certain insurance plans, like STDLIs, would not be subject to the language access requirements of the Section 1557 regulations. LEP Latinos faces

[2] 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/.
[3] 42 U.S.C. § 18116(a)

several challenges to care, and if implemented, this would only exacerbate this inequity and associated health disparities. Finding a provider who provides culturally and linguistically appropriate care is already challenging for many in the Latino community. When these barriers are coupled with an insurance plan that would not meet the language access requirements of Section 1557, this only adds additional hurdles to accessing the care a person needs.

The proposed rule would also allow STDLIs 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 like cervical cancer. Latinas suffer from cervical cancer at a higher rate than their white counterparts[4] and critical coverage of preventive care helps to reduce rates of the highly preventable disease. Additionally, a 2018 study found that not a single short-term plan covered maternity care.[5] Short-term plans also discriminate based on gender identity by excluding coverage for transition-related services for gender affirming care, such as surgery and can charge higher premiums for women.

Women have long been the subject of discrimination in health care[6] and this is only worse for women of color. This includes discrimination in emergency rooms where men are more likely to treated quickly[7] and wait times for Hispanics are 13 percent longer than those for whites.[8] Despite the historic achievements of the ACA, women are still more likely to forego care because of cost.[9] In the last 12 months, nearly a quarter of Latinos have gone without health care services due to cost, as opposed to 13 percent of their white counterparts.[10] These barriers mean women, and specifically women of color, are more likely not to receive routine and preventive care than men. With the proposed changes to narrow the scope of who must comply with Section 1557, Latinas may face additional discrimination and continue to lack care.

II. 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

[4] U.S. Cancer Statistics Working Grp, *U.S. Cancer Statistics Data Visualizations Tool: Rate of New Cancers, Cervix, United States, 2016,* Ctrs. for Disease Control & Prevention (Jun. 2019), https://www.cdc.gov/cancer/cervical/statistics/race.htm.
[5] 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/.
[6] Prior to the ACA, women were charged more for health care on the basis of sex and were continually denied health insurance coverage for services that only ciswomen, transgender, and gender non-conforming patients need. *See Turning to Fairness*, Nat'l Women's L. Ctr. 1, 3-4 (2012), https://nwlc.org/wp-content/uploads/2015/08/nwlc_2012_turningtofairness_report.pdf (noting that while the ACA changed the health care landscape for women in significant ways, women still face additional hurdles).
[7] "Waiting Time at the Emergency Department from a Gender Equity Perspective." (thesis, University of Gothenburg, Sweden, 2014). https://gupea.ub.gu.se/bitstream/2077/39196/1/gupea_2077_39196_1.pdf
[8] Silberner, Josefina. "Study: Longer Wait Times for Emergency Rooms." NPR. January 15, 2008.
[9] *See* Shartzer, et al., Health Reform Monitoring Survey, Urban Inst. Health Policy Ctr. (Jan. 2015), http://hrms.urban.org/briefs/Health-Care-Costs-Are-a-Barrier-to-Care-for-Many-Women.html.
[10] "Health and Health Care for Hispanics in the United States." Kaiser Family Foundation. May 19, 2019. https://www.kff.org/infographic/health-and-health-care-for-hispanics-in-the-united-states/

critical 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**

LGBTQ Latinos face a number of health inequities due to discriminatory practices by providers, insurers, and other systemic barriers. LGBTQ Latinos already experience high rates of poverty and discrimination in employment that contribute to poor health outcomes.[11]

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.

A 2016 study conducted by the Williams Institute found that 21 percent of transgender identified adults also identify as Latino or Hispanic.[12] Within this community, transgender and gender non-conforming Latinos are already subject to a number of intersecting barriers to quality health care and increased health disparities.

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.

The 2015 U.S. Transgender Survey showed that over a fourth of transgender individuals did not see a doctor when they needed to because of fear of being mistreated as a transgender person, and 37 percent, more than a third, did not see a doctor when needed because they could not afford it.[13] 32 percent, about one-third, of transgender individuals who saw a health care provider in the past year reported having at least one negative experience related to being transgender.[14] The reported negative experiences included being refused treatment, being verbally harassed, being physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care.[15] 29 percent of transgender individuals were refused to be seen by a health care provider on

[11] National Center for Transgender Equality, National Gay and Lesbian Taskforce and LULAC. (2012, September 11). Injustice at every turn: a look at Latino/a respondents in the National Transgender Discrimination Survey, 1-2. Retrieved at http://www.transequality.org/Resources/Injustice_Latino_englishversion.pdf (28 % of Latina/o transgender individuals live in poverty and 26 % of Latina/o transgender persons were terminated from their jobs because of bias and 47 % were not hired due to bias.)

[12] Flores, Andrew et al. "Race And Ethnicity Of Adults Who Identify As Transgender In The United States." Williams Institute. October 2016. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Race-and-Ethnicity-of-Transgender-Identified-Adults-in-the-US.pdf

[13] James, S. E. & Salcedo, B. (2017). 2015 U.S. Transgender Survey: Report on the Experiences of Latino/a Respondents. Washington, DC and Los Angeles, CA: National Center for Transgender Equality and TransLatin@ Coalition.

[14] James, S. E. & Salcedo, B. (2017). 2015 U.S. Transgender Survey: Report on the Experiences of Latino/a Respondents. Washington, DC and Los Angeles, CA: National Center for Transgender Equality and TransLatin@ Coalition.

[15] James, S. E. & Salcedo, B. (2017). 2015 U.S. Transgender Survey: Report on the Experiences of Latino/a Respondents. Washington, DC and Los Angeles, CA: National Center for Transgender Equality and TransLatin@ Coalition.

the basis of their perceived or actual gender identity and 29 percent experienced unwanted physical contact from a health care provider.[16]

There is also data showing how Latino transgender individuals are refused care or are mistreated by providers. According to a national survey of transgender people conducted by the National Gay and Lesbian Task Force and National Center for Transgender Equality, one in three Latino and Hispanic respondents reported unequal treatment by a doctor or hospital.[17] Undocumented transgender respondents were found to be particularly vulnerable to physical attack in doctors' offices, hospitals, and emergency rooms.[18] Additionally, transgender persons have been denied care even for medically necessary treatment, and this discrimination has sometimes resulted in death.[19] The fear of being treated differently or discriminated against has lasting consequences for individuals. For example, 36 percent of Latino transgender persons postponed care when they were sick or injured because they feared discrimination.[20]

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 categorically excluding coverage of gender-affirming care from their plans or denying individuals coverage of procedures used for gender affirmation. Prior to the 2016 final rule, many insurers did not cover gender-affirming care. However, as a result of Section 1557 and the 2016 final rule, many insurers removed categorical coverage exclusions that harmed transgender people and began to cover gender-affirming services,[21] increasing access to care. The proposed rule could give insurers the false impression that they could refuse to cover gender-affirming care.

The World Professional Association for Transgender Health guidelines provide that gender-affirming interventions, when sought by transgender individuals, are medically necessary and part of the standard of care.[22] The American College of Obstetricians and Gynecologists warns that failure to provide gender-affirming treatment can lead to serious

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[16] 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-peopleaccessing-health-care/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-fordiscrimination&email_referrer=&email_subject=rx-for-discrimination.

[17] Grant JM et al. National Gay and Lesbian Taskforce; National Center for Transgender Equality. Injustice at every turn: A report of the National Transgender Discrimination Survey, 73-74, 2011, available at http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf.

[18] Grant JM et al. National Gay and Lesbian Taskforce; National Center for Transgender Equality. Injustice at every turn: A report of the National Transgender Discrimination Survey, 73-74, 2011, available at http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf.

[19] Ravishankar M. The story about Robert Eads. The Journal Of Global Health. January 18, 2013. http://www.ghjournal.org/jgh-online/the-story-about-robert-eads/.

[20] Harrison-Quintana, J, Peréz. D. and Grant, J. (2012). Injustice at Every Turn: A Look at Latino/a Respondents in the National Transgender Discrimination Survey, 3. National Center for Transgender Equality; National Gay and Lesbian Taskforce; League of United Latin American Citizens. Retrieved at http://www.thetaskforce.org/downloads/reports/reports/ntds_latino_english_2.pdf

[21] OUT2Enroll, *Summary of Findings: 2019 Marketplace Plan Compliance with Section 1557*, https://out2enroll.org/out2enroll/wp-content/uploads/2018/11/Report-on-Trans-Exclusions-in-2019-Marketplace-Plans.pdf (last visited Jul. 17, 2019).

[22] Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, World Prof. Association for Transgender Health (2011), https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20%202011%20WPATH%20(2)(1).pdf.

health consequences for transgender individuals.[23] This proposed rule could lead to more transgender individuals, including Latinos, to be denied gender-affirming care and the coverage they need to access this care.

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.

If this illegal rule is implemented, a health care provider might deny a transgender Latino man coverage of cervical cancer treatment because of his gender identity. The National Transgender Discrimination Survey found that only 8 percent of transmasculine respondents (assigned female at birth) had a hysterectomy to remove their uterus and, in most cases, the cervix.[24] This demonstrates that the vast majority of transmasculine individuals require cervical cancer screening, but only 27 percent reported that they had a Pap test in the past year.[25] This is especially damaging because queer Latinos are more likely to disproportionately experience cervical cancer because of racial, ethnic, sexual orientation, and gender identity health disparities.[26]

If implemented, under the proposed changes, health care providers could charge higher copayments only for services related to gender-affirming care. Gender-affirming care is already difficult or impossible to access due to cost.[27] The proposed rollback of Section 1557 could significantly harm transgender Latinos in the multitude of ways that individuals access health care services, as listed above.

b. Sex discrimination based on sex stereotyping

The 2016 final rule reiterated that sex stereotpying is a prohibited form of discrimination under the 1989 Supreme Court decision, *Price Waterhouse v. Hopkins.*[28] The proposed

[23] Committee Opinion 512: Health Care for Transgender Individuals, Am. Coll. Obstetricians & Gynecologists (Dec. 2011), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-HealthCare-for-Underserved-Women/Health-Care-for-Transgender-Individuals.
[24] James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality. Pages 101-102. Retrieved from http:// www.transequality.org/sites/default/ files/docs/usts/USTS%20Full%20Report%20-%20FINAL%20 1.6.17.pdf
[25] Rebekah Rollston, The Fenway Inst., Promoting Cervical Cancer Screening Among Female-to-Male Transmasculine Patients(2019), https://fenwayhealth.org/wp-content/uploads/TFIP-28_TransMenCervicalCancerScreeningBrief_web.pdf.
[26] National Latina Institute for Reproductive Health. Cervical Cancer & Latinxs: The Fight for Prevention and Health Equity. January 2018, available at http://www.latinainstitute.org/sites/default/files/NLIRH_CervicalCancer_FactSheet18_Eng_R1.pdf.
[27] 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.
[28] 490 U.S. 228 (1989).

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.

Discrimination based on sex stereotypes can affect anyone who does not conform to traditional, societal expectations of their sex. The proposed rule illegally purports to allow a health care provider to refuse to provide maternity or contraceptive care to an unmarried woman.

LGBTQ Latinos are deeply and personally affected by reproductive health and justice issues like abortion restrictions, access to contraception, and comprehensive sex education and it is critical that the members of the Latino community continue to have access to all of the health care services they need, when they need it. Approximately 21 percent of Latinos and Latinas identify as LGBT[29] and 29 percent of Latino and Latina same-sex couples are raising children.[30] The estimated 146,100 Latino and Latina individuals in same-sex partnerships tend to live in areas where there are higher proportions of Latinos and Latinas.[31] This means that a third of Latino and Latina same-sex couples live in New Mexico, California, and Texas.[32] These individuals and their families could be harmed by the proposed changes if the rule is permitted to go into effect.

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 Latinos, causing them to pay more for health care and to risk receiving improper diagnoses and less effective treatments. The effects of sex discrimination for Latinos 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

[29] Gary J. Gates and Angeliki Kastanis. "LGBT Latino/a Individuals and Latino/a Same-Sex Couples." October 2013. Available at https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-latino-oct-2013/
[30] Gary J. Gates and Angeliki Kastanis. "LGBT Latino/a Individuals and Latino/a Same-Sex Couples." October 2013. Available at https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-latino-oct-2013/
[31] Gary J. Gates and Angeliki Kastanis. "LGBT Latino/a Individuals and Latino/a Same-Sex Couples." October 2013. Available at https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-latino-oct-2013/
[32] Gary J. Gates and Angeliki Kastanis. "LGBT Latino/a Individuals and Latino/a Same-Sex Couples." October 2013. Available at https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-latino-oct-2013/

protection under Section 1557 is clear, without explicit implementing regulations and enforcement, illegal discrimination is likely to flourish.

The proposed rule could result in patients illegally being denied critical care including miscarriage management. This could particularly harm transgender, nonbinary, and gender nonconforming people who already face unique barriers to accessing abortion, pregnancy care, and miscarriage care. For example, a transgender man had a stillbirth after nurses misdiagnosed him as obese rather than pregnant.[33] The proposed rule could make these occurrences more likely.

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 immigrant women and women of color, including Latinos, who already face harassment and discrimination by providers during pregnancy, contributing to the unacceptably high rates of health-related pregnancy complications and death for women of color.

Obstacles including cultural and linguistic differences, and well as restrictions based on age, economic status, immigration status, and geographic location already prohibit many Latinos from obtaining safe abortion services and from exercising their reproductive freedom. Additional denial of care relating to abortion services is wholly unnecessary and would further limit access to abortion services.

Despite the current protections afforded by the ACA, Latinos encounter additional barriers such as cost, lack of transportation and lack of geographically available clinics, insufficient culturally and linguistically competent health systems and providers, and discriminatory immigration policies that make it difficult for individuals and communities to access the full range of reproductive healthcare when they need it. Due to this, discrimination, and other barriers, Latinos experience disproportionately high rates of unintended pregnancy, sexually transmitted infections including HIV, diabetes, [34] asthma,[35] and other health issues. While pregnancy and birth rates among youth have been declining for decades, Latina youth continue to experience higher incidences of pregnancy and birth than their white peers. In 2014, Latinas between the ages of 15 to 19 had experienced birth at least twice the rate of their White peers of the same age.[36] There are many factors that contribute to this disparity including barriers to affordable

[33] Marilynn Marchione, Associated Press, *Nurse Mistakes Pregnant Transgender Man as Obese. Then, the Man Births a Stillborn Baby*, USA Today (May 16, 2019, 12:49 PM), https://www.usatoday.com/story/news/health/2019/05/16/pregnant-transgender-man-births-stillborn-baby-hospital-missed-labor-signs/3692201002/.

[34] Office on Women's Health. (2010, May 18). Minority Women's Health: Latinas and Diabetes. U.S. Department of Health and Human Services. Retrieved 10 May 2017, from https://www.womenshealth.gov/minority-health/latinas/diabetes.html

[35] U.S. Department of Health and Human Services Office of Minority Health. "Asthma and Hispanic Americans." March 13, 2017. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=60

[36] The National Campaign to Prevent Teen and Unplanned Pregnancy. (2015, July). Teen Childbearing in the United States, 2014 Birth Data.. Retrieved at http://thenationalcampaign.org/sites/default/files/resource-primary-download/fast-facts-teen-childbearingin-the-us-2014-birth-data_2.pdf

contraception, lack of sexual health information and services, including culturally competent, comprehensive sex education, and lack of financial resources. Latinas are diagnosed with cervical cancer, a disease that is almost entirely preventable, at nearly twice the rate of non-Latina White women.[37] In fact, according to the latest statistics from the Centers for Disease Control and Prevention, Latinas have the highest cervical cancer incidence rates amongst all racial and ethnic groups.[38] Furthermore, Latinas already face challenges in consistently accessing contraception that is affordable and available, preventing them from planning their futures and their families.

Moreover, immigration status plays a role in the health care that individuals can access. Immigrant Latinas also experience these inequities because they lack employment opportunities that provide insurance coverage, face extreme poverty, and lack culturally and linguistically appropriate health care providers and services. 30 percent of Latinos under the age of 18 live in poverty, making it already quite difficult to obtain needed health care services.[39] These compounded barriers and challenges in health care could only be exacerbated if this proposed rule is to go into effect.

d. Religious Exemption

We oppose the inclusion of Title IX exemptions since they do not apply to health care situations and settings. As HHS concluded in the 2016 Final Rule:

> "[S]tudents or parents selecting religious educational institutions typically do so as a matter of choice; a student can attend public school (if K–12) or choose a different college. In the healthcare context, by contrast, individuals may have limited or no choice of providers, particularly in rural areas or where hospitals have merged with or are run by religious institutions. Moreover, the choice of providers may be even further circumscribed in emergency circumstances. Second, a blanket religious exemption could result in a denial or delay in the provision of health care to individuals and in discouraging individuals from seeking necessary care, with serious and, in some cases, life threatening results. Thus, it is appropriate to adopt a more nuanced approach in the health care context, rather than the blanket religious exemption applied for educational institutions under Title IX."[40]

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

[37] U.S. Department of Health and Human Services. (2012, April 10). The Afordable Care Act and Latinos. Retrieved at https://aspe.hhs.gov/report/afordable-care-act-and-latinos

[38] Centers for Disease Control and Prevention. (Last updated 2015, August 20). Cervical Cancer Rates by Race and Ethnicity. Incidence Rates by Rates/Ethnicity. Retrieved at: http://www.cdc.gov/cancer/cervical/statistics/race.htm

[39] Krogstad, J. M. (2014, September 19). Hispanics only group to see its poverty rate decline and incomes rise. Pew Research Center. Retrieved at http://www.pewresearch.org/fact-tank/2014/09/19/hispanics-only-group-to-see-its-poverty-rate-decline-and-in82comes-rise/.

[40] 81 Fed. Reg. 31380.

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 health care providers, including insurance companies, hospitals, 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.[41] The proposed rule could encourage these entities to engage in illegal discrimination.

This could permit a religiously affiliated pharmacy to illegally refuse to prescribe contraception to someone because they are not married or refuse to provide infertility treatment to a same-sex or transgender couple. This could permit a pharmacist to illegally refuse to provide the medication for someone who is miscarrying or a hospital to refuse care to a woman who has had an abortion.

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. A recent study by the National Latina Institute for Reproductive Health with PerryUndem found that 4 in 10 Latina and Latino voters under age 45 (41 percent) have gone without the birth control method they wanted in the past two years because of access issues.[42] This proposed rule would only exacerbate the barriers to care that are preventing individuals from accessing the care they need.

Religious exemptions disproportionately harm LGBTQ people, especially those who are transgender, nonbinary, gender nonconforming. LGBTQ people are often refused health care services because of their sexual orientation and/or gender identity.[43] 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,[44] and 12

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[41] *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.

[42] Nat'l Latina Inst. for Reprod. Health & PerryUndem, *Latina/o Voters' Views and Experiences Around Reproductive Health: Results from a National Survey of Latina/o Voters* (Oct. 4, 2018), https://latinainstitute.org/sites/default/files/NLIRH%20Survey%20Report_F_0.pdf.

[43] 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/.

[44] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM),

percent were refused gender-affirming health care.[45] The proposed rule purports to allow further illegal refusals of care for LGBTQ people.

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.[46] 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 Latinxs to access the health services they need.

Latinos seeking access to abortion or other reproductive health 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. "As of 2014, 90 percent of U.S. counties lacked an abortion clinic. . . . Many states have only one clinic."[47] The proposed rule would make it harder for people needing reproductive care to access the health services they need. People living in the United States often must travel between 10-79 miles to reach their nearest abortion clinic, with 20 percent having to travel 42-54 miles or more.[48] "[T]hose living in rural areas typically have to travel greater distances who live in urban areas."[49] In Texas, the distance pregnant individuals have to travel to access abortion has dramatically increased as the number of providers has decreased. The number of women of reproductive age in Texas living more than 50 miles from a clinic increased from 816,000 in May 2013 to 1,680,000 in April 2014.[50] Also, the number of women living more than 200 miles from a clinic increased from 10,000 in May 2013 to 290,000 in April 2014.[51] Latino individuals seeking health care services are often misunderstood or

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https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[45] 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/.

[46] 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/.

[47] 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.

[48] 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.

[49] 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.

[50] Texas Policy Evaluation Project. (2014, July 1). Access to abortion care in the wake of HB2. Retrieved 1 November 2016, from http://liberalarts.utexas.edu/txpep/_files/pdf/ AbortionAccessafterHB2.pdf

[51] Texas Policy Evaluation Project. (2014, July 1). Access to abortion care in the wake of HB2. Retrieved 1 November 2016, from http://liberalarts.utexas.edu/txpep/_files/pdf/ AbortionAccessafterHB2.pdf

mistreated simply because of their English language proficiency, gender identity, or other factors.

Over the past several decades, religious exemptions 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.[52] 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.[53] A recent study found that continuing an unwanted pregnancy and giving birth is associated with more serious health problems than abortion.[54]

Religious exemptions have a particularly negative impact on people of color. Women, people of color, and those living at the intersections of these identities are disproportionately served by Catholic hospitals.[55] 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."[56] The proposed rule would make it harder for Latinos and Latinas, especially those that are LGBTQ and/or needing reproductive care, to access the health services they need.

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. 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 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 Latinas and Latinos 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

[52] 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).
[53] 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).
[54] 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).
[55] *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.
[56] *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.

through their doors. Half of the 4 million patients who receive care by Title X health care providers identify as people of color and 32 percent identify as Hispanic.[57] Additionally, one in 10 recipients has limited English proficiency and are able to receive the care they need, in the language in which they need it.[58] 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 provides 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 their U.S.-born peers (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 roll back the protections for those individuals is both contrary to the plain language and spirit of the law.

III. 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, including LGBTQ Latinxs and Latinos.

Prior to the passage of the ACA, being transgender was treated as being a pre-existing condition. As a result, transgender people could not get insurance coverage or affordable insurance. Under the proposed rule, states and Marketplaces could discriminate against LGBTQ people in eligibility determinations, enrollment periods, and more. Similarly, agents and brokers who assist with enrollment in marketplace plans could discriminate against LGBTQ people.

If this rule is implemented, insurance issuers could employ discriminatory marketing practices and benefit design that would harm LGBTQ individuals, including LGBTQ Latinos. For example, issuers could inquire about an applicant's sexual orientation or gender identity and use that information for underwriting or determining insurability.[59] Issuers could also charge higher premiums for LGBTQ people, or could cancel or deny coverage for LGBTQ people.[60] As a result, LGBTQ people would face additional barriers to getting the health care they need.

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[57] Office of Population Affairs. Family Planning Annual Report: 2016 National Summary. August 2017. https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf

[58] Office of Population Affairs. Family Planning Annual Report: 2016 National Summary. August 2017. https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf

[59] 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/.

[60] 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/.

Under the proposed rule, Medicaid managed care entities and state Medicaid programs could be emboldened to discriminate against LGBTQ beneficiaries in enrollment. Medicaid covers a disproportionate share of women from vulnerable populations such as those who are in poor health, living with low-incomes, single parents, LGBTQ, have disabilities, and women of color.[61] Nearly one-third (31 percent) of Black women of reproductive age and 27 percent of Latinas of reproductive age are enrolled in the Medicaid program.[62] LGBTQ people are more likely to live in poverty than the overall U.S. population.[63] As a result, LGBTQ people are more likely that non-LGBTQ people to use Medicaid.[64] 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.[65] Additionally, elderly Latinos tend to have complex needs, with multiple-diseases, and are on Medicare and Medicaid (dual eligible), or to be in need of language and culturally competent services. As of 2016, over two thirds (68.1 percent) of all Medicaid beneficiaries were enrolled in a comprehensive Managed Care Organization.[66] The proposed rule would impermissibly open the door to discrimination against the many LGBTQ people, including Latinos, enrolled in Medicaid programs across the country.

V. 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.[67]

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[61] Kaiser Family Foundation. "Medicaid's Role for Women." June 22, 2017. https://www. kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/ (last accessed April 19, 2018).

[62] Sonfield, A. (2017). Why Protecting Medicaid Means Protecting Sexual and Reproductive Health. Guttmacher Policy Review, 20, 39-40. Retrieved 16 March 2017, from https://www.guttmacher.org/sites/default/files/article_files/gpr2003917.pdf.

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

[64] 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.u/wp-content/uploads/LGBT-Medicaid.pdf (last visited May 02, 2019)).

[65] 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/.

[66]Center for Medicaid and Medicare Services with Mathmatica Policy Research . "Medicaid Managed Care Enrollment and Program Characteristics, 2016." Spring 2018. https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2016-medicaid-managed-care-enrollment-report.pdf

[67] 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).

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.

Discrimination on the basis of national origin, which encompasses discrimination on the basis of limited English proficiency (LEP),[68] creates unequal access to health, particularly for LEP Latinas. LEP is often compounded with the "cumulative effects of race and ethnicity, citizenship status, low education, and poverty," resulting in more barriers to access.[69] In 2015, 64 percent of LEP individuals in living the United States spoke Spanish and more than half were female.[70] There are over 25 million individuals with LEP currently living in the United States.[71] Language assistance services are especially critical for individuals with LEP who are unfamiliar with our complex healthcare system.

Individuals with LEP may fear that speaking a foreign language could make them the target of increased scrutiny about their immigration status. Additionally, due to a person's country of origin, they may also fear immigration-related consequences at the doctor's office. Immigrants often lack access to transportation and may have to travel great distances to get the care they need. In rural areas, there may be no other sources of health care, and when individuals encounter denial of care, they may have nowhere else to go. This limits their options for accessing care and need to know they can safely access the services available to them.

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 health 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.

Without adequate language assistance services, LEP individuals face difficulty enrolling in and accessing health programs and activities. Unfamiliarity with the health care system arises from unfamiliarity with its cultural norms, vocabulary, and procedures. Data and stories demonstrate that individuals with LEP often forgo primary care altogether, as a result of not understanding how to fill out enrollment applications in English or inaccurately translated non-English languages, not understanding the benefits and costs of

[68] Lau v. Nichols, 414 U.S. 563 (1974).
[69] Kaiser Family Foundation, Overview of Health Coverage for Individuals with Limited English Proficiency, at 3.
[70] Monica Whatley and Jeanne Batalova. "Limited English Proficient Population of the United States." Migration Policy Institute. July 25, 2013. https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states-0#6
[71]Monica Whatley and Jeanne Batalova. "Limited English Proficient Population of the United States." Migration Policy Institute. July 25, 2013. https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states-0#6; U.S. Census Bureau, *American Community Survey, Selected Social Characteristics in the United States: 2011 American Community Survey 1-Year Estimates* (25,303,308 speak English less than "very well"). http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_1YR_DP02&prodType=table

services in a health plan, or not having the appropriate cultural and language brokers to communicate with English-speaking physicians and pharmacists. One study found that Latina breast cancer survivors needed simple information in Spanish about breast cancer, treatment, management of side effects, and community resources because they often felt confusion regarding terminology, expressed myths about cancer, and did not know how to pay for treatment, especially if they were undocumented.[72] Additionally, in a study conducted from 2009 to 2012, 64 percent of LEP Latina mothers of infants and toddlers were found to have clinically significant symptoms of depression.[73] Two of the contributing factors may have been economic hardship and the stress of immigration status.[74]

LGBTQ people face significant obstacles in accessing health care and these barriers are exacerbated when a person is both LGBTQ and LEP, especially if the person is also an immigrant. Many LGBTQ immigrants have limited educational opportunities in their home countries due in part to persecution they may have faced. Further, many immigrants with limited English language skills find themselves facing barriers to employment,[75] which in turn produces additional barriers to accessing health care.

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.

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 and low-cost way 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.

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[72] Anna Nápoles, University of Cal. S.F., Improving Inequities in Diagnosis, Treatment, and Survival among Latinas, Komen SF Bay Area Many Faces-One Voice Conference (June 17, 2013).
[73] Linda Beeber, T. Schwartz, & L. Smith, *The "Wings" Depressive Symptom Intervention for Latina Mothers* (2012), https://grantome.com/grant/NIH/R34-MH086553-02S1.
[74] Linda Beeber, T. Schwartz, & L. Smith, *The "Wings" Depressive Symptom Intervention for Latina Mothers* (2012), https://grantome.com/grant/NIH/R34-MH086553-02S1.
[75] Sharita Gruberg, et al., *Serving LGBTQ Immigrants and Building Welcoming Communities*, Ctr. for Am. Progress (Jan. 24, 2018, 9:03 AM), https://www.americanprogress.org/issues/lgbt/reports/2018/01/24/445308/serving-lgbtq-immigrants-building- welcoming-communities.

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 OCR's obligation to consider these plans. 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 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.

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

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.[76] 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."[77] The proposed rule improperly attempts to eliminate these prohibitions.

The proposed rule would make it harder for LGBTQ people and people of color, including Latinos and LGBTQ Latinos, living with disabilities and chronic conditions to afford coverage and care. The final rule's prohibition on discriminatory plan benefit designs helped people living with HIV get the medications they need. In 2016, Hispanics/Latinos accounted for 26 percent (10,292) of the 40,324 new HIV diagnoses in the United States and more Hispanics and Latinos have HIV compared to some other races and ethnicities[78] and one fifth of those living with HIV are Latino.[79] HIV

[76] 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/.
[77] 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/.
[78] Center for Disease Control and Prevention. "HIV and Hispanics/Latinos." November 1, 2018. https://www.cdc.gov/hiv/group/racialethnic/hispaniclatinos/index.html
[79] Center for Disease Control and Prevention. "CDC Factsheet: HIV and Latinos." https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-hiv-latinos-508.pdf

disproportionately affects gay, bisexual, and queer men of color and transgender women of color.[80] For example, more than 25 percent of Black and Brown transgender women are living with HIV,[81] and 60 percent (10,070) of Black or African American individuals who received an HIV diagnosis in 2017 were gay or bisexual men.[82] Additionally, more than 100,000 Latinos with stage 3 HIV (AIDS) have died since the start of the epidemic.[83] Latino men accounted for 90 percent of new HIV infections among Latinos in 2016, and 88 percent of these were among Latino gay and bisexual men[84] Many LGBTQ Latinos experience negative health outcomes because of barriers to care and discrimination, resulting in higher rates of HIV/AIDS.[85]

Also, due to systemic barriers to health care, people of color experience higher rates of chronic conditions. For example, Latinas are 17 times more likely to die from diabetes than non-Hispanic white women.[86] The proposed rule would disproportionately harm LGBTQ individuals and people of color, including those who have these intersecting identities, who live with disabilities and chronic conditions. It is critical that those with significant health needs are able to access the care and coverage they need without discrimination.

VII. 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.[87] 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.

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[80] Intersecting Injustice: A National Call to Action 63-64 (Lourdes Ashely Hunter, Ashe McGovern & Carla Sutherland eds., 2018), http://socialjusticesexuality.com/intersecting_injustice/.
[81] Intersecting Injustice: A National Call to Action 64 (Lourdes Ashely Hunter, Ashe McGovern & Carla Sutherland eds., 2018), http://socialjusticesexuality.com/intersecting_injustice/.
[82] *HIV and African Americans*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html (last updated March 19, 2019).
[83] Center for Disease Control and Prevention. "CDC Factsheet: HIV and Latinos." https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-hiv-latinos-508.pdf
[84] Center for Disease Control and Prevention. "CDC Factsheet: HIV and Latinos." https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-hiv-latinos-508.pdf
[85] The Henry J. Kaiser Family Foundation. (2014, April 15). Latinos and HIV/AIDS, 1-3. Retrieved at http://kf.org/hivaids/fact-sheet/latinos-and-hivaids/
[86] Office on Women's Health. (2010, May 18). Minority Women's Health: Latinas and Diabetes. U.S. Department of Health and Human Services. Retrieved 10 May 2017, from https://www.womenshealth.gov/minority-health/latinas/diabetes.html
[87] 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/.

Section 1557 is still the law of the land and the proposed rule's inconsistency with the statute itself would cause confusion for both health care entities and patients. This would ultimately increase 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 critical for Latinos and Latinas, including those who are LGBTQ, immigrants, and those living at the intersections of these identities. 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.

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.

Many people who experience discrimination cannot access the court system due to cost.[88] When people can afford to bring judicial actions, they generally receive little in the form of compensatory relief.[89] This could make it even more expensive for people to enforce their rights, including Latinos and Latinas, 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

[88] *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.

[89] 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.

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.

The proposed rule is unrealistic and overburdensome. 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."[90] Thus, the law aimed to make it easier for people to file complaints of intersectional discrimination in one place. The proposed rule will only make it harder for people to file complaints. For example, an afro-Latina woman who experienced compounded discrimination based on both her race and her sex would have to file two separate claims of discrimination. This would have harmful consequences for communities who have historically been discriminated against in health care settings.

VIII. Conclusion

This proposed rule could impose wide ranging harm on Latinos and Latinas. The proposed rule is just the latest attack from the Trump-Pence Administration on people seeking reproductive health care, including abortion, LGBTQ individuals, individuals with LEP, including immigrants, those living with disabilities, and people of color. Moreover, this rule would embolden compounding levels of discrimination against those who live at the intersection of these identities. The proposed rule is dangerous and contravenes the plain language of Section 1557, specifically, and the ACA broadly.

For the reasons detailed above, HHS and CMS should not finalize the proposed rule and redirect their efforts to advancing health care access and equity for all.

Thank you for the opportunity to submit comments on the proposed rule. Please contact NHLA through Jessica González-Rojas at Jessica@Latinainstitute.org or Elena Rios, MD, MSPH, FACP at nhma@nhmamd.org with any questions. Thank you for your time and consideration.

Sincerely,

National Latina Institute for Reproductive Health

[90] 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.

July 31st, 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:

New Mexico Asian Family Center (NMAFC) thanks the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) for the opportunity to comment on 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"). NMAFC is the only organization in the state of New Mexico providing culturally tailored programs and services to the Pan-Asian community in order to uplift families that can advocate and support themselves. As an organization, we have led policy change initiatives within the city of Albuquerque as well as statewide to ensure that language access is prioritized within governmental systems as required by federal law. Through conducting a health impact assessment within immigrant and refugee communities, we have compiled community driven data that demonstrates that language access is a social determinant of health that determines the overall health and well-being of limited English proficient families (link to HIA report: http://nmafc.org/publications/global-505-health-impact-assessment/)

Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, and disability. As an organization that is committed to upholding the civil rights of all persons, we strongly oppose the NPRM provisions which seek to eliminate and limit protections for individuals who are limited English proficient, LGBTQ+ persons, persons with disabilities and chronic conditions, and persons needing reproductive health services. Section 1557 addresses not only protections for each protected class covered, but the intersection of those protections. As such, an attack on the civil rights of one group in the NPRM is an attack on the civil rights of all.

Our comments focus on the NPRM's language access provisions to ensure that persons with limited English proficiency (LEP) have the meaningful access required not only by Section 1557 but also by Title VI of the Civil Rights Act of 1964 (Title VI) and its implementing regulations. As such, we oppose eliminating the language access protections as proposed in the NPRM. In addition, we oppose any other efforts to otherwise eliminate or roll back protections and provisions contained in the 2016 Nondiscrimination in Health Programs and Activities Final Rule (2016 Final Rule) as they apply to other protected classes, including LGBTQ+ persons, women and persons with disabilities. Overall, we urge HHS to withdraw and not finalize this rule.

According to the 2015 American Community Survey, the Asian population for Bernalillo County is 23,887, with an overall increase of 7.4% of the total Asian population from 2010-2015. Albuquerque's Asian population is largely immigrant with 64% being foreign born and 27% being limited English proficient, increasing barriers this community faces when accessing U.S.

systems. The proposed rule would deeply impact the communities that we serve on a daily basis. Of the 238 individuals supported through our organization last year on direct services (case management, counseling, legal) for issues including domestic violence and sexual assault, many of whom need support in accessing and establishing healthcare, 85% were limited English proficient and received services in an Asian language.

Language access in health care services and activities particularly impacts Asian Americans (AAs), Native Hawiians (NH) and Pacific Islanders (PI), given the population's demographics. AAs and NHPIs represent the fastest growing communities in the United States and similarly represent incredible diversity. AAs and NHPIs trace their heritage to nearly 100 different ethnic groups and speak more than 250 different languages. Sixty six percent of AAs speak a language other than English at home and twenty nine percent are LEP, meaning that English is not their primary language and they have a limited ability to read, write, speak or understand English. Twenty-eight percent of NHPIs speak a language other than English at home. Sixty-three percent of Burmese, 45 percent of Nepalese and 44 percent of Bangladeshis are LEP, as are 16 percent of Micronesians. AAs and NHPIs make up twenty-two percent of LEP individuals in the country.

Language barriers to health care are further compounded by immigration and citizenship status, educational attainment and poverty. Sixty percent of Asian Americans are foreign-born, representing every immigration status. Medically underserved AA and NHPI communities—including communities where AAs and NHPIs lack access to health care, have high rates of poverty, and have high numbers of LEP populations—are growing across the country. As of the 2000 Census, there were 282 counties or 13.1% of counties classified as medically underserved or severely underserved AA and NHPI communities.

I. Proposed Subpart A General Provisions

We oppose the proposed changes in § 92.1 - 92.3 that would narrow the scope of application of Section 1557. Section 1557 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. Thus, Section 1557 applies to *all* health programs or activities administered by the Department (as well as other federal Departments) *plus* those established under Title I. Further, similar to Title VI, Section 1557 applies to *all* parts of the covered entity, not only the portion receiving federal financial assistance. 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 changes run counter to the statutory text and intent of Section 1557 and would limit severely limit its application. We therefore oppose them.

Proposed § 92.5 Enforcement

We oppose the proposed changes to § 92.301 as newly designated § 92.5. OCR incorrectly limits the remedies available under Section 1557, in part by referencing the regulations implementing the cited statutes. One of the goals of Section 1557 was to build and expand on prior civil rights laws such that individuals seeking to enforce their rights would have access to the full range of available civil rights remedies and not be limited to only the remedies provided to a particular protected group under prior civil rights laws. This is why Section 1557 expressly provides individuals access to any and all of the "rights, remedies, procedures, or legal standards available" under the cited civil rights statutes, regardless of the type of discrimination.

II. Proposed Subpart B Specific Applications to Health Programs or Activities

Proposed § 92.101 Meaningful Access for Individuals with Limited English Proficiency

a. Obligations

The proposed § 92.101 inappropriately switches the emphasis from "each individual with limited English proficiency" as provided in the 2016 Final Rule to the covered entity's program or activities. In Section 1557, Congress declared "an individual shall not" be subject to discrimination. Section 1557 regulations cannot offer less protection than the statute that authorizes such regulations. Therefore, the correct emphasis in the 1557 regulations must be on each individual and not programs. As such, this NPRM would weaken meaningful access, runs counter to Congressional intent and the thorough administrative record supporting the 2016 Final Rule, and we oppose it.

b. Specific applications

We appreciate the Department's historical emphasis on ensuring meaningful access for LEP individuals as required by Title IV and regulations and consistent with over four decades of U.S. Supreme Court precedent and enforcement by HHS and the U.S. Dept. of Justice (DOJ). As language access advocates, we have strongly supported Title VI and 2003 HHS LEP Guidance and have provided significant input on how to interpret the 4-factor test to ensure its application results in meaningful access for LEP persons required by Title VI and its regulations. We oppose, however, the codification of the 4-factor test in the Section 1557 regulation for the following two reasons. First, it is already the interpretation of OCR that the 2-factor test in the 2016 Final Rule is consistent with Title VI, the only statute in Section 1557 that prohibits national origin discrimination against LEP individuals. The protections in Section 1557 and its regulations cannot be anything less than those already guaranteed by Title VI. This interpretation negates the claims made by OCR in the current NPRM that it seeks to align Section 1557 with Title VI, as they are already in alignment.

Second, in providing the 2-factor test based upon, informed by and consistent with Title VI, OCR was providing a method of articulating how it would engage in its enforcement review in the health activities and programs context, a specific application of Title VI and newly created by Section 1557. The 2-factor test incorporates the principles in the HHS LEP Guidance and allows OCR to better explain how the factors will be considered in the specific 1557 health activities and programs context giving substantial weight to the nature and importance of the particular communication at issue.

III. Opposition to Current 1557 Provisions Proposed for Repeal or Reconsideration

Overall, we strongly disagree that the nondiscrimination notice, taglines and language access plan language in the 2016 Final Rule were not justified by need, were overly burdensome and created inconsistent requirements. In focusing most significantly on the costs and burdens to covered entities and devoting minimal discussion and analysis to the costs to LEP individuals, OCR is not acting consistent with the balancing principles identified by it in the 2003 HHS LEP Guidance which states "First we must ensure that federally assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English."

a. Proposed Repeal of Nondiscrimination Notice

We oppose the repeal of the requirement that covered entities provide a notice of nondiscrimination that informs the public of their legal rights.The notice requirement is

consistent with the long history of civil rights regulations requiring the posting of notice of rights, including Title VI, Section 504, Title IX and the Age Act, which all require that recipients of federal financial assistance notify recipients that they do not discriminate.

OCR has provided no explanation for how individuals will know of their rights and how elimination of notices will not deny LEP individuals, LGBTQ+ persons, women and persons with disabilities meaningful access. Without the notice, members of the public will have limited means of knowing that language services and auxiliary aids and services are available, how to request them, what to do if they face discrimination, that they have the right to file a complaint, and how to file such a complaint. NMAFC as a small nonprofit organization provides language access to our communities and expects governmental entities such as OCR who have much larger operating budgets and resources to comply with federal law in providing meaningful access to LEP communities.

OCR incorrectly asserts that the nondiscrimination notice is redundant of existing civil rights notices under other statutes. Rather, the notice recognizes the fact that individuals may face multiple forms of discrimination and in fact eliminates duplication by consolidating the underlying statutes' notice requirements into one.

b. Proposed Repeal of In-Language Taglines

We strongly oppose the repeal of the requirement for covered entities to provide in-language taglines informing recipients of the availability of language assistance on significant documents because, combined with the elimination of the nondiscrimination notice, the repeal threatens the civil rights of LEP persons. The inclusion of taglines is well-supported by long-standing federal and state regulations, guidance and practice. The use of taglines is a cost-effective approach to ensuring that covered entities are not overly burdened while maintaining access for LEP individuals.

In the absence of fully translated documents, taglines are necessary "to ensure that individuals are aware of their protections under the law, and are grounded in OCR's experience that failures of communication based on the absence of auxiliary aids and services and language assistance services raise particularly significant compliance concerns under Section 1557, as well as Section 504 and Title VI." As such, we oppose the proposal to eliminate them.

c. Proposed Repeal of Video Interpretation Standards

We oppose the removal of technical and training requirements for the use of video remote interpreting services for spoken language interpretation. The type of interpreting during a medical visit should depend on the encounter as telephonic communication may be appropriate for scheduling, but not for interpreting information for trauma, mental health, or death. Non verbal cues in the health care setting or prescription writing cannot be observed via telephone. Further, even with the higher cost in equipment and training, Video Remote Interpreting has saved costs from in person interpreting as there are no minimums, travel time, or cancellation risks, though we believe in-person interpreting is still best for the patient. Keeping the current standard allows providers to determine which technology is appropriate and when an entity uses video, that it is high quality and without lagging.

d. Language Access Plans

We oppose removing all references to language access plans because under the 2016 Final Rule, They are voluntary, not required by the 2016 rule and only a factor to be considered. Language access plans are not required by Title VI or its regulations, but have long been

recognized as a way for a covered entity to ensure it is compliant with Title VI. OCR has required language access plans from covered entities as a key component of Title VI enforcement actions involving LEP individuals since before Executive Order 13166 was issued in 2000. Executive Order 13166 also required HHS create and implement a language access plan for its federally conducted programs and activities. That Executive Order also required HHS to issue Title VI LEP Guidance which provided multiple factors an entity could take when developing a language access plan. As such, repealing the voluntary language removes a tool that HHS has used for enforcement and that covered entities can use to support their compliance efforts. Covered entities may, as a result, fail to fully plan on how to best meet the needs of LEP patients and customers.

IV. The Regulatory Impact Analysis is Flawed and Ignores Costs to LEP Individuals

a. The Regulatory Impact Analysis (RIA) is Insufficient and Fails to Justify the Proposals
The NPRM provides a RIA that is wholly insufficient to justify the extensive scope of the proposed changes to language access and entirely fails to identify and to quantify costs to protected individuals. OCR's estimate of the burden to covered entities for compliance with the nondiscrimination notice and tagline requirements is based on voluntary actions and interpretations by covered entities. OCR based the elimination of the notice and taglines on these estimates, but did not consider whether alternatives, such as further clarification about the requirements, was warranted in the form of FAQs or other guidance. That is, OCR failed to consider alternatives to a complete repeal of notices and taglines that could have appropriately balanced the need to inform individuals of their rights while recognizing there may be a difference in the intentions behind the 2016 Final Rule and how covered entities have interpreted it.

Similarly, the majority of the costs are associated with the provision of a single type of document -- the Explanation of Benefits (EOB). OCR did not consider alternatives as to how it would consider enforcement and interpretation of the "significant document" standard with respect to the provision of multiple EOBs sent during a coverage year.

OCR states it has received little evidence that more beneficiaries are seeking language assistance and uses this claim as a justification to remove the notice and taglines. This claim, which relies on reports from health plans, is insufficient to justify their repeal. The regulation has been in effect for three years in which OCR, by its own admission, has had limited resources to conduct public outreach. Second, the protections guaranteed by Section 1557 are both continuing and many are new, warranting a public effort to conduct outreach. Third, the notices and taglines were selected as a compromise position, to avoid requiring covered entities to translate large numbers of documents. Fourth, LEP persons are uniquely at risk of facing barriers to knowing and asserting their rights. Lack of uptake of services raises questions about the extent to which the public knows its rights and what covered entities are doing to communicate those rights, as opposed to justifying elimination of notices and taglines.

Language Access Requirements in the 2016 Final Rule Are Justified by Need
OCR has provided no tangible analysis of the costs and burdens of repealing the notice and tagline requirement. Instead, OCR provides only acknowledgment that repeal "may impose costs, such as decreasing access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services." OCR perfunctorily labels the impact as "negligible" while providing no evidentiary basis.

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 1557, especially regarding the notices which include information about the broader nondiscrimination requirements of Section 1557. OCR's only acknowledgement of this impact is one statement about the "unknown number of persons are likely not aware of their right to file complaints."

Discrimination on the basis of national origin, which encompasses discrimination on the basis of language, creates unequal access to health care. Language access in health care is just as critical now as when the Civil Rights Act was originally passed in 1964. Over twenty-five million individuals in the United States are LEP. An estimated 19 million LEP adults are insured. Language assistance is necessary for LEP persons to access federally funded programs and activities in the healthcare system. Without meaningful access, the estimated 25 million individuals who are LEP would be excluded from programs and services they are legally entitled to, including the 181,430 total individuals living within the state of New Mexico.

HHS seeks comment on continuing unaddressed civil rights barriers, which are significant when it comes to language access. For example, over the past Open Enrollment periods for the Marketplace, language has presented a significant barrier for AAs and NHPIs attempting to enroll in coverage. Once enrolled, many LEP consumers continued to have difficulties understanding their benefits and coverage. For example, AA and NHPI community-based organizations reported cases in which individuals did not know their rights and did not realize they were sent legal notices because notices were not provided in their language. Without enforcement of language assistance services, legal notices and taglines to inform persons of their rights, discrete communities, such as those AAs and NHPIs, with large numbers of LEP individuals will be systematically excluded from opportunities to achieve better health and have their civil rights violated. It is this rationale and strong data record that guided the intent behind including the Section 1557 nondiscrimination provision in the ACA and corresponding incorporation of existing civil rights protections.

Thank you for the opportunity to comment on the nondiscrimination NPRM.

Sincerely,

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New Mexico Asian Family Center
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NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

August 6, 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: Center for Medicare & Medicaid Services' Notice of Proposed Rulemaking (Docket No.: HHS-OCR-2019-0007; RIN 0945-AA11)

To Whom it May Concern:

The New York State Department of Health (NYSDOH) submits the following comments in response to the notice in the Federal Register soliciting comments on the Proposed Rule regarding "Nondiscrimination in Health and Health Education Programs or Activities" (84 Fed. Reg. 27846). NYSDOH supervises the administration of a wide range of programs that provide services and support to low-income families and individuals. The mission of NYSDOH is to protect, improve and promote the health, productivity and well-being of all New Yorkers.

Thank you for the opportunity to comment.

Sincerely,

Howard Zucker M.D.

Howard A. Zucker, M.D., J.D.
Commissioner

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

New York State Department of Health

Comments in Response to the Center for Medicare & Medicaid Services' Notice of Proposed Rulemaking

The New York State Department of Health (NYSDOH) strongly opposes the rule proposed by the Centers for Medicare & Medicaid Services, titled "Nondiscrimination in Health and Health Education Programs or Activities" (hereinafter, "Proposed Rule"). Among other things, this rule would roll back crucial protections for vulnerable populations nationwide, such that individual healthcare providers or healthcare plans will no longer be prohibited under federal law from denying treatment or healthcare coverage to individuals who are transgender or gender non-conforming, or persons who have received or are seeking an abortion.

I. Opposition to the Proposed Rule's Discrimination Provisions

A. New York State Nondiscrimination Laws and Policies

In New York State, it is unlawful to deny equal access to healthcare because of gender identity or expression; indicate that transgender persons are unwelcome or objectionable; refuse to use a transgender person's legal name; refuse to refer to a transgender person by that person's requested pronouns; deny the use of restrooms or other facilities consistent with a person's gender identity; or refuse to treat a transgender person because that person has complained about discrimination.

In 2016, New York State Division of Human Rights (NYSDHR) adopted regulations on gender identity which clarified that discrimination on the basis of gender identity is a form of sex discrimination. These regulations provide that the term "sex," when used in the Human Rights Law, includes gender identity and the status of being transgender, and that harassment on the basis of a person's gender identity or the status of being transgender constitutes sexual harassment (9 NYCRR 466.13[c]).

In 2019, with the passage of the Gender Expression Non-Discrimination Act (GENDA), "gender identity or expression" was added as an explicit protected class under the Human Rights Law (Laws 2019, ch 8, §§ 2,3). The term "gender identity or expression" means "a person's actual or perceived gender-related identity, appearance, behavior, expression, or other gender-related characteristic regardless of the sex assigned to that person at birth, including, but not limited to, the status of being transgender" (N.Y. Exec. Law § 292[35]). Discrimination based on gender identity or expression is prohibited in all places of public accommodation, including hospitals and other healthcare providers (*id.* § 296).[1] These legal amendments only serve to

[1] *See also* NYSDHR, "New Yorkers are Protected from Gender Identity Discrimination by Hospitals," https://dhr.ny.gov/sites/default/files/pdf/postings/DHR_Gender_Identity_Handout.pdf.

amplify what has been the longstanding understanding in New York State: that sex stereotyping and discrimination based on gender identity are forms of sex discrimination.

At that time, NYSDOH also amended the Hospital Patients' Bill of Rights to expressly require all hospitals in New York State to update their statements of patient rights to prohibit discrimination against transgender patients (10 NYCRR 405.7). These regulations required hospitals to affirmatively inform patients of their rights related to gender identity.

Further, New York State's Reproductive Health Act, which codified into state law the reproductive health protections articulated in *Roe v. Wade*, has made New York State a national leader in this area by allowing New Yorkers to make confidential, personal healthcare decisions with their healthcare provider. The Reproductive Health Act is one piece of New York State's commitment to ensuring that individuals are not treated differently based on their reproductive health choices.

Consistent with New York State law, all programs within the Department of Health provide eligible services to individuals regardless of sexual orientation and gender identity or reproductive health choices. NY State of Health (NYSOH)—New York State's Official Health Plan Marketplace—helps New Yorkers enroll in healthcare programs like Medicaid, Child Health Plus, the Essential Plan, and Qualified Health Plans (QHP) and explains what financial assistance is available to help applicants purchase health insurance. These services have always been, and will continue to be, provided regardless of an applicant's sex or gender identity, including identification as an LGBTQ individual. Additionally, the Comprehensive Family Planning and Reproductive Health Care Services Program within the Department's Division of Family Health provides comprehensive, confidential reproductive health services for approximately 300,000 low-income, uninsured and underinsured New Yorkers of reproductive age, including adolescents, through a statewide network of 48 grant-funded healthcare facilities that operate 172 service sites.

B. The Proposed Rule's Effect on Healthcare Discrimination in New York State and Nationwide

NYSDOH understands that the Proposed Rule does not prohibit states from providing greater protections for individuals, and New York State will continue to mandate stronger protections given the importance of equal access to healthcare. Nevertheless, NYSDOH remains concerned about New Yorkers' welfare if this Proposed Rule goes into effect given the regularity and ease of interstate travel. New Yorkers traveling out of state who find themselves in need of medical care should not fear discriminatory conduct merely because they visit a hospital outside of New York State, nor should they be forced to forego necessary medical care rather than risk harassment at an out-of-state healthcare facility. If the federal government is to set the floor for nondiscriminatory conduct, by which all covered healthcare entities must abide, that floor must be higher than the standard set forth in the Proposed Rule. Otherwise, federal law will aggravate existing disparities to healthcare access and harm individual health. As a matter of principle, NYSDOH firmly believes that disparities in access to healthcare must be reduced, not enhanced.

Further, notwithstanding New York State's expansive legal protections, NYSDOH anticipates that the Proposed Rule will negatively impact the healthcare industry nationwide by creating confusion among healthcare employees and recipients alike as to their rights and obligations. In New York State, covered healthcare entities may believe the federal rules prevail rather than New York State's stronger nondiscrimination provisions. NYSDOH will therefore be forced to expend additional resources to monitor reports of LGBTQ individuals being turned away from care based on their identity. Nationwide, the Proposed Rule permits even single healthcare entities to implement varying policies on nondiscrimination across its services depending on whether its healthcare activities are funded by HHS. As a result, vulnerable individuals may receive varying care (or no care at all) merely depending on where they live or which healthcare facility they choose to visit. These healthcare disparities cannot stand.

Finally, by removing "termination of pregnancy" from the definition of sex discrimination, the Proposed Rule could have far-reaching impacts on reproductive health. The Proposed Rule seeks to undo the goals of the New York State Reproductive Health Act by impeding an individual's ability to make personal healthcare decisions without fear of discrimination or retaliation. Such fears could prevent individuals from seeking safe, quality healthcare and promote poor outcomes for infants and their families. Individuals seeking emergency care after a termination could be denied services or referred to a facility at great distance due to healthcare providers' moral or religious objections to the individual's reproductive health choice.

II. Opposition to the Proposed Rule's Limited English Proficiency and Tagline Provisions

As part of its commitment to protecting vulnerable populations, New York State strives to ensure language access. Nearly 1 in 4 New Yorkers (over 4.7 million) have comprehensive health coverage though the NYSOH Marketplace across all 62 counties of the State. Twenty-two percent of these Marketplace enrollees indicated a preferred written language other than English. Providing information and assistance to consumers in their preferred language has been critical to reaching populations with historically higher uninsurance rates. Accordingly, the NYSOH Customer Service Center answered nearly 300,000 calls in one of 101 languages over the course of the most recent open enrollment period, and NYSOH navigators assist consumers in 41 different languages.

The Proposed Rule eliminates the requirement that covered entities include the notice of nondiscrimination and taglines in at least the top 15 languages in significant publications and communications. The currently-required notices are so integrated into NYSOH's processes, including system-generated notices and consumer education materials, that eliminating the notice of nondiscrimination and taglines from notices would result in significant cost increases to New York State. Indeed, NYSOH estimates that removing taglines and testing new notices to ensure they are displaying the correct messages will cost New York State $2 million upon implementation of the Proposed Rule. The human toll is just as costly; removing language access would indirectly increase costs by diminishing public knowledge of the means and methods for accessing health insurance, and regressing gains made in reducing uninsured rates among persons with limited English proficiency.

By limiting protections for persons with limited English proficiency, the Proposed Rule stands to interfere with NYSOH's ability to serve the State's most vulnerable populations, and risks reversing the important progress that has been made in reducing uninsurance rates across the State.

III. Conclusion

NYSDOH adamantly opposes adoption of the Proposed Rule. As the agency whose mission it is to protect, improve and promote the health, productivity and well-being of all New Yorkers, NYSDOH has serious concerns with the Proposed Rule. The prospect of denying vital health services to individuals based on gender identity, sexual orientation, or reproductive choices is dangerous and has the potential to harm the physical health and well-being of these individuals.

VOLS
VOLUNTEERS of LEGAL SERVICE

August 13, 2019

Submitted via www.regulations.gov

Luben Montoya
Section Chief, Civil Rights Division
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Hubert H. Humphrey Building, Room 509F
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RE: Notice of proposed rulemaking
Federal Register No. 2019-11512; HHS Docket No. HHS-OCR-2019-0007-0001
RIN 0945-AA11
Nondiscrimination in Health and Health Education Programs or Activities

Comments of Volunteers of Legal Service

Volunteers of Legal Service ("VOLS") appreciates this opportunity to submit these comments in response to the rules proposed by the U.S. Department of Health and Human Services ("HHS") in the above captioned dockets. This notice of proposed rule making will serve to harm our clients by making healthcare less accessible for both LGBT and limited English proficient patients and will make discrimination they may face in heath care settings harder to remedy. We believe that the clients of two of VOLS' Projects in particular, the Elderly and Immigration Projects, will be detrimentally impacted by these proposed regulatory changes, and we are compelled to submit this public comment in opposition to the proposed rule.

This proposed rule making would eliminate the definitions section of the current rule making unclear who is a "covered entity" and eliminating "on the basis of sex" as covered discrimination under the regulation; it would eliminate specific nondiscrimination protections based on sex, gender identity, and association; it would

repeal many of the law's language access requirements; it would remove notice requirements that call for covered entities to post information about Section 1557 and nondiscrimination at its locations and on its website; it would no longer require covered entities to have a compliance coordinator and written grievance procedure to handle complaints about alleged violations of Section; and it would also curtail various enforcement-related provisions of the law.

The net result of these changes will be worsening health outcomes for many seniors because fewer LGBT seniors will be comfortable accessing much needed medical care; limited English proficient seniors will not be provided with adequate language access when seeking medical care; and when patients face discrimination they will not have suitable means to address their complaints.

The Mission of Volunteers of Legal Service

The mission of VOLS is to provide pro bono civil legal services to benefit low-income people in New York City. Since 1984, VOLS has identified areas of legal need, created projects to meet these needs, and recruited and trained volunteer lawyers to provide the needed legal services. By providing pro bono legal services to people in need in our city, we strive to fulfill the highest aspirations of the legal profession. VOLS projects serve several vulnerable New York City populations, including, as relevant here, low-income immigrants and elderly individuals. We conduct active outreach to the New York City legal community to encourage pro bono work by lawyers. We strive to provide pro bono legal assistance when and where it will be most accessible to our clients, in settings familiar to them, instead of requiring people in desperate need to come to us.

We do this by working closely with hospitals, schools, senior centers, and other community organizations, and by integrating pro bono legal assistance into the array of services these organizations already provide.

The VOLS Elderly Project staff and other pro bono volunteers provide free legal advice, information, document drafting, and other services to low-income New York City residents aged 60 and over, and to the social workers and advocates who assist them. These services include direct counseling on critical issues involving housing, government benefits, and consumer debt, and the drafting and execution of wills, powers of attorney, and other essential life-planning documents. The Elderly Project emphasizes outreach to underserved populations with the goal of helping vulnerable seniors stay in their homes. A key aspect of our success is our ability to combine social work resources already available to seniors with pro bono legal services. We work closely with senior centers, share information and communicate regularly by email with over 600 social workers and other advocates in the elder services community, and have a roster of dozens of volunteer lawyers who provide free legal services to our clients.

VOLS' Immigration Project staff works directly with people who have needed to regulate their immigration status to gain greater security and financial stability for themselves and their families. The people we serve are at various stages along their immigration journey, and include United States citizens and lawful permanent residents hoping to remain or reunify with parents, children, siblings and other family members. We collaborate with New York City schools, community based organizations and health care centers to identify individuals who need legal assistance to address a variety of immigration law challenges, which often threaten to limit career options, access to

comprehensive health services, and long-term prospects for economic opportunity.

The Proposed Rule Will Harm Older LGBT People

The proposed rule seeks to remove protections against discrimination on the basis of sexual orientation and gender identity from regulations enacted under Section 1557 of the Affordable Care Act. However, research demonstrates that many older LGBT Americans fail to disclose their sexual orientation and gender identity to healthcare professionals for fear of discrimination, being judged, and receiving compromised medical treatment. For instance, 36% of LGBT older Americans report that their primary healthcare providers are unaware of their sexual orientation.[1] Nearly one in four LGBT older people are reluctant to discuss certain issues for fear that their healthcare providers will judge them.[2] 20% of LGBT older people and 44% of transgender older people worry that their relationships with healthcare providers, such as hospital or nursing home staff, would be adversely affected if their sexual orientations or gender identities were known.[3] Further, two-thirds of transgender older people feel that there will be limited access to healthcare as they grow older and more than half feel that they will be denied medical treatment as they age.[4] According to the 2015 U.S. Transgender Survey, nearly one quarter of transgender people avoided going to a doctor when sick or injured out of fear of discrimination in the past year and one third of transgender people who saw a health care provider in the past year were harassed,

[1] Robert Espinosa, *Out & Visible: The Experiences and Attitudes of Lesbian, Gay, Bisexual and Transgender Older Adults, Ages 45-75*, SAGE, 14 (2014), https://www.sageusa.org/wp-content/uploads/2018/05/sageusa-out-visible-lgbt-market-research-full-report.pdf.
[2] *Id.*
[3] *Id.*
[4] *Id.*

denied care, or even assaulted.[5]

These concerns underscore the need to maintain the current non-discrimination provision. This lack of disclosure, driven by fear of discrimination in the healthcare context runs counter to the open relationship that doctors and patients should have and may tend to undermine the quality of care that older LGBT individuals receive. Healthcare providers should be asking questions about sexual orientation and gender identity at intake, rather than requiring LGBT people to affirmatively raise the issue, or at minimum creating an open environment in which LGBT individuals feel free to raise any issue. Further, healthcare professionals should be trained to protect LGBT patients from discrimination. The existing regulation reinforces such openness and discourages discriminatory conduct.

VOLS' elderly LGBT clients regularly experience discrimination in the healthcare context. For example, the VOLS Elderly Project was recently engaged by a transgender woman, who sought to legally change her name to her chosen, female name from the male name given to her at birth. In the interview process, the client indicated that she wanted to avoid uncomfortable situations where the use of her birth name "outed" her as transgender. An example she gave was medical staff in doctors' offices calling out her birth name rather than her chosen name, leading others in the waiting room to stare and snicker at her. While this is by no means an extreme example of discrimination, as transgender individuals face a disproportionate risk of violence and harassment, it illustrates the indignities that transgender people suffer every day. Medical offices should train their staff to be sensitive to LGBT patients, so seeking medical assistance is

[5] http://www.ustranssurvey.org/reports

not a traumatic experience for LGBT individuals.

Protecting against discrimination on the basis of sexual orientation and gender identity in the healthcare context is especially important as a societal matter. LGBT older people are statistically more financially insecure than similarly situated non-LGBT people.[6] If patients fear mistreatment or embarrassment in the context of preventative care, they will stop seeking it out and instead rely on far more expensive emergency and chronic care.

HHS relies heavily on *Franciscan Alliance, Inc. v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016), to support its contention that the existing Section 1557 Regulation prohibiting discrimination on the basis of gender identity is arbitrary and capricious. In *Franciscan Alliance*, the Northern District of Texas issued a nationwide preliminary injunction barring the enforcement of the Section 1557 regulation as it applies to "gender identity" and "termination of pregnancy." By selectively citing *Franciscan Alliance*, the administration ignores a growing body of case law from other federal district courts holding that discrimination on the basis of gender identity is clearly covered by the statutory language of Section 1557 itself, including the United States District Courts for the Western District of Wisconsin, the District of Minnesota, and the Southern District of California.[7] These cases call *Franciscan Alliance* into question and demonstrate that, at the very least, there is significant disagreement about the scope of the statute. To adequately discharge its obligations under the Administrative Procedure

[6] *Id.* at 15 (reporting that 47% of LGBT older people are very or extremely concerned that they will not be able to live the lives they want in retirement due to lack of money, as compared to 28% of non-LGBT older people).
[7] *Flak v. Wis. Dept. of Health Servs.*, 328 F. Supp. 3d 931, 951 (W.D. Wis. 2018); *Tovar v. Essential Health*, 342 F. Supp. 3d 947, 953 (D. Minn. 2018); *Prescott v. Rady Children's Hospital-San Diego*, 265 F. Supp. 3d 1090, 1105 (S.D. Cal. 2017).

Act, HHS should consider the holdings of these peer federal district courts that Section 1557 protects individuals from discrimination on the basis of gender identity and whether the proposed rule is itself arbitrary and capricious to the extent that it seeks to exclude gender identity from the protections provided by the statute.

The Proposed Rule Will Harm Immigrants and Other Individuals with Limited English Proficiency

HHS also seeks to roll back provisions that the existing 1557 Regulation established to protect individuals with limited English proficiency, meaning those who speak little to no English. If HHS adopts the proposed rule, covered healthcare entities will no longer be required to provide notices of non-discrimination and language assistance in non-English languages, and these entities will no longer be incentivized to develop language access plans, meaning that the populations we assist will be more likely to be unaware of their legal rights and to experience barriers to sufficient healthcare.[8]

There are approximately 860,000 immigrants over the age of sixty residing in New York City – a staggering 57% of the city's population in that age group.[9] About half of New York City residents over sixty use a language other than English as their primary language.[10] Finally, there are more than 400,000 New York City residents over the age of sixty who speak English less than very well and may not be able to adequately

[8] *Proposed Changes to the Health Care Rights Law and Language Access*, ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM, 1 (June 2019), https://www.apiahf.org/wp-content/uploads/2019/06/June2019_ProposedChangesToHealthCareRightsLawAndLanguageAccess_Factsheet.pdf.
[9] *Profile of Older New Yorkers*, NEW YORK CITY DEPARTMENT FOR THE AGING, 35 (2019), https://www1.nyc.gov/assets/dfta/downloads/pdf/reports/ProfileOfOlderNewYorkers2019.pdf.
[10] *Id.* at 30.

communicate in English in a healthcare setting.[11] This substantial population of New Yorkers will face additional hurdles in obtaining medical assistance if the proposed rule is adopted.

The current regulations are a common sense approach to preventing national origin discrimination in health care settings and requires covered entities to take reasonable steps to provide meaningful access to each individual with limited English proficiency who is eligible to be served or likely to be encountered within the entities' health programs and activities. It applies to any health program or activity, any part of which receives funding from the Department of Health and Human Services (HHS), such as hospitals that accept Medicare or doctors who receive Medicaid payments.

Currently covered entities are required to post a notice of individuals' rights providing information about communication assistance for individuals with limited English proficiency, among other information; post taglines in the top 15 languages spoken by individuals with limited English proficiency in that state that indicate the availability of language assistance; covered entities are prohibited from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services; and are encouraged to develop and implement a language access plan to ensure they are prepared to take reasonable steps to provide meaningful access to each individual that may require assistance.

The proposed regulations will severely curtail these requirements and make it much more difficult for limited English proficient seniors to access medical care. The risks for older adults who are unable to access health care due to language or other

[11] *Id.* at 46-48.

barriers are great because most people's health care needs increase and become more complicated as they age. Health care information is complex and can only be communicated effectively in an individual's primary language. The added costs that the current regulations add to health care providers are clearly outweighed by the benefit provided to limited English proficient patients.

Conclusion

Thank you for considering these comments as HHS reviews the proposed rule. Because it harms the clients and the communities we serve, we strongly urge HHS to withdraw this notice of proposed rulemaking in its entirety.

Respectfully submitted,

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August 13, 2019

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

Dear Secretary Azar:

The Women's Law Project (WLP) submits these comments in response to the Department of Health and Human Services' (HHS) and the Center for Medicare and Medicaid Services (CMS) Notice of Proposed Rulemaking to express our opposition to the proposed rule entitled "Nondiscrimination in Health Programs or Activities," published in the Federal Register on July 14, 2019.

The Women's Law Project is a public interest law center with offices in Philadelphia and Pittsburgh, Pennsylvania. Founded in 1974, WLP is dedicated to creating a more just and equitable society by advancing the rights and status of all women, girls, and LGBTQ people through high impact litigation, advocacy, and education. WLP believes that all people should be able to access health care for themselves and their families without fear of discrimination. We strongly oppose the proposed rule because it would remove protections against discrimination within the health care system which would have a disastrous impact on the health and well-being of the communities we serve.

Specifically, the proposed rule would especially harm people who already experience significant barriers to accessing health care, including LGBTQ people, people who need reproductive health care, people living with disabilities and/or chronic conditions, and people whose primary language is not English. The proposed changes would create additional barriers to accessing adequate health care, disproportionately impacting those living at the intersections of marginalized identities.

The Proposed Rule Drastically Narrows the Scope of Section 1557.

Section 1557 of the ACA is a landmark civil rights law that prohibits discrimination based on race, color, national origin, sex, age, and disability in health care. In 2016, the Obama administration

issued a final rule on the scope and application of Section 1557 (herein referred to as "the 2016 final rule"). The 2016 final rule clarified that the law covers any health care program or activity that receives federal financial assistance, including health insurance companies, hospitals, clinics, and employers that receive federal funds. It also applies to entities that receive federal funds through credits, subsidies, contracts of insurance, or under any program or activity that is administered by an executive agency.[1]

The rule proposed on June 14, 2019 would reduce the number of covered health plans under Section 1557 in two significant ways. First, if the 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."[2] Second, under the proposed changes, Section 1557's protections would cover only the portion of a health care program or activity that received federal financial assistance. By limiting the scope of Section 1557, the proposed rule would create a patchwork of discriminatory practices in health plans and exacerbate already existing disparities in health care systems.

The Proposed Rule Narrows the Definition of Sex Discrimination Under Section 1557.

Section 1557 is crucial to ending gender-based discrimination in health care. The 2016 final rule made clear that sex discrimination prohibited under Section 1557 includes discrimination based on gender identity, sex stereotypes, sexual orientation, and pregnancy, including termination of pregnancy, childbirth or related conditions. The proposed regulation seeks to roll back these protections, which would have grave effects on the health and well-being of women, especially women of color who experience compounded forms of discrimination based on race, gender, and immigration status.

Sex discrimination can occur at every step of obtaining health care and result in harmful health outcomes, like receiving improper diagnoses at higher rates, experiencing poorer health outcomes, and delaying treatment.[3] Black women, women of color, LGBTQ people, and immigrants are more likely to experience discrimination in medical care due to implicit and explicit racial and gender bias.[4] In the context of reproductive health care, Black women and women of color experience discrimination when their legitimate health concerns and symptoms are disregarded and untreated.[5] For example, Black women are three to four times more likely to die from pregnancy-related complications than white women, and Native American women are over four times more

[1] 42 U.S.C. § 18116(a).
[2] 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/.
[3] Brad N. Greenwood, et al., *Patient-Physician Gender Concordance and Increased Mortality Among Female Heart Attack Patients*, National Academy of Sciences of the United States of America (Aug. 21, 2018), https://rewire.news/article/2018/10/04/new-paper-examines-how-gender-bias-in-health-care-can-be-deadly/.
[4] *See Discrimination in America: Experiences and Views of American Women*, NPR & Harvard T.H. Chan Sch. of Pub. Health (Dec. 2017), https://cdn1.sph.harvard.edu/wp-content/uploads/sites/21/2017/12/NPR-RWJF-HSPH-Discrimination-Women-Final-Report.pdf.
[5] Linda Villarosa, *Why American's Black Mothers and Babies Are in a Life-or-Death Crisis*, N.Y. Times (Apr. 11, 2018), https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html.

likely to die during pregnancy or immediately after childbirth than white women.[6] In Pennsylvania, Black women account for eleven percent of women but account for thirty-one percent of all pregnancy related maternal deaths.[7]

The proposed rule attempts to incorporate Title IX's religious exemption to Section 1557, which would allow providers' personal beliefs as a basis for refusal or denial of the broad range of reproductive health care services, including birth control, abortion, and gender affirming care. Similarly, the proposed rule seeks to add Title IX's "Danforth Amendment," which exempts abortion care and coverage from the ban on sex discrimination in education. Should the proposed changes go into effect, the foreseeable harm is that people needing abortion care or other services that violate a health care provider's personal, moral objections or religious beliefs could be denied or delayed from obtaining life-saving, time-sensitive medical care.[8] This is a serious concern here in Pennsylvania where 30,011 abortions were performed in 2017.[9]

Not only is the proposed rule in conflict with the text and purpose of Section 1557, it also would continue to perpetuate the harmful trend of putting people's health and well-being at risk by blocking access to needed health care due to discrimination based on race, sexual orientation, and gender identity.

The Proposed Rule Would Amend Unrelated Regulations to Exclude Sexual Orientation and Gender Identity Protections.

Section 1557 provided unprecedented federal protections for LGBTQ people by prohibiting discrimination in health care on the basis of sex, which, under the current rule, is defined to include both sexual orientation and gender identity.[10] The proposed rule seeks to eliminate these protections by permitting gender identity and sexual orientation discrimination in a range of health care programs, including private insurance and education programs. The proposed rule would also roll back the Section 1557 protections against transgender people from being treated as having a pre-existing condition which would decrease their access to affordable health care. This would enable states and marketplaces (including agents and brokers) to deny LGBTQ people eligibility for certain health care plans and enrollment periods because of their gender identity and sexual orientation.

The proposed rule would also disproportionately impact LGBTQ people, especially transgender, non-binary, and gender nonconforming people, who already face unique barriers to accessing

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[6] Center for Disease Control and Prevention, *Pregnancy Mortality Surveillance System* (Aug. 10, 2019), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm.

[7] *The Pennsylvania Health Care Landscape*, Kaiser Family Foundation (updated Apr. 2016), http://files.kff.org/attachment/fact-sheet-the-pennsylvania-health-care-landscape-april-2016.

[8] 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/.

[9] Pennsylvania Department of Health, 2017 Abortion Statistics (Dec. 2018), *available at* https://www.health.pa.gov/topics/HealthStatistics/VitalStatistics/Documents/Pennsylvania_Annual_Abortion_Report_2017.pdf.

[10] *Id.*

health care like, high uninsurance rates, discrimination, and harassment. According to the 2015 U.S. Transgender Survey, in Pennsylvania, twenty-two percent of transgender people did not see a doctor when they needed to for fear of being mistreated as a transgender person.[11] Thirty percent of transgender people in Pennsylvania who did see a health care provider had at least one negative experience because of their gender identity, including being refused treatment, verbal harassment, and physical and sexual assault.[12]

Moreover, a 2011 survey found that one-quarter of the more than 6,400 transgender and gender-nonconforming respondents reported experiencing discrimination.[13] The discrimination included being denied needed medical treatment, being harassed in health care settings, or postponing needed medical care due to fear of mistreatment from providers.[14] Currently, there are more than 3 million LGBTQ people age fifty-five and older in the United States.[15] In Pennsylvania, 4.1 percent of the population identifies as LGBTQ.[16] While some states offer state level protections against discrimination based on sexual orientation and gender identity, Pennsylvania is not one of them.[17] Therefore, Section 1557 provides LGBTQ people living in states without state protections against discrimination a level of protection they might not have otherwise.

Should the proposed rule take effect, LGBTQ people fearing discrimination would be discouraged from sharing information that is essential to their health care needs and critical to treating serious conditions, which would result in negative health outcomes among communities worldwide.[18]

The Proposed Rule Would Eliminate Language Access Protections.

Over twenty-one percent of the U.S. population speak a language other than English at home, and twenty-five million of them speak English less than "very well" and thus are considered Limited English Proficiency ("LEP").[19] The 2016 rule increased access to information, services, and care

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[11] 2015 U.S. Transgender Survey: Pennsylvania State Report (May 2017), *available at* http://www.transequality.org/sites/default/files/docs/usts/USTSPAStateReport%281017%29.pdf.
[12] *Id.*
[13] Kellan Baker, *Sexual Orientation and Gender Identity Protections in Health Care*, Center for American Progress (Apr. 30, 2015, 9:57 AM), https://www.americanprogress.org/issues/lgbt/reports/2015/04/30/-112169/open-doors-for-all/.
[14] *Id*.
[15] 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.
[16] Movement Advancement Project, *Pennsylvania's Equality Profile*, http://www.lgbtmap.org/equality_maps-/profile_state/PA, (last visited Aug. 8, 2019).
[17] *Id*.
[18] 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/.
[19] 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*,

for people with limited English proficiency. The proposed rule seeks to relax language access protections for people with LEP. Specifically, the proposed changes would eliminate requirements for taglines on significant medical documents, standards for remote interpreting standards, and recommendations that entities develop language access plans.

Should the proposed rule go into effect, the harm it would yield would disproportionately fall upon low-income, immigrants with LEP and people of color. In 2015, Hispanic women of reproductive age were far more likely to be uninsured compared to white and Black women.[20] In Pennsylvania, the majority of the state's immigrant population are women and children, comprised of 402,706 women and 62,817 children in 2015.[21] More specifically, LEP individuals make up 3.84 percent (492,286) of the Pennsylvania's population.[22] The lack of doctors who are multilingual and trained to provide culturally-informed care can result in grave health outcomes among LEP and immigrant communities. Indeed, one study found that Latina breast cancer survivors needed simple information in Spanish about breast cancer, treatment, management of side effects, and community resources because they often felt confusion regarding terminology, expressed myths about cancer, and did not know how to pay for treatment, especially if they were undocumented.[23] In Pennsylvania, Latinas across the state reported that the lack of Spanish-speaking doctors contributed to their feeling distrust and unease at almost every stage of receiving health care, and some Latinas forgo seeing a provider altogether.[24] Therefore, the proposed changes would worsen existing logistical barriers that prevent LEP individuals from accessing health care for themselves and their families.[25]

Individuals with LEP need medical information and services to be accessible in the language they understand, including written materials and taglines so they can make informed decisions that are best for themselves and their families.

The Proposed Rule Eliminates Protections Against Discrimination in Insurance Plans.

Before the ACA, people with serious and/or chronic health conditions were often denied health insurance coverage or subject to higher premiums, leaving many people without the health care

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https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_S1601&prodType=table (last visited Jul. 17, 2019).

[20] Uninsured Rate Among Women of Reproductive Age Has Fallen More Than One-Third Under the Affordable Care Act, Guttmacher, https://www.guttmacher.org/article/2016/11/uninsured-rate-among-women-reproductive-age-has-fallen-more-one-third-under.

[21] *Fact Sheet: Immigrants in Pennsylvania*, American Immigration Council (Oct. 4, 2017), https://www.americanimmigrationcouncil.org/research/immigrants-in-pennsylvania.

[22] U.S. Census Bureau, *QuickFacts: Pennsylvania; United States*, http://www.healthyfranklincounty.org/population-limited-english-proficiency, (last visited Jul. 1, 2018).

[23] Anna Nápoles, University of Cal. S.F., Improving Inequities in Diagnosis, Treatment, and Survival among Latinas, Komen SF Bay Area Many Faces-One Voice Conference (June 17, 2013).

[24] *A Report on Pennsylvania's Community Conversations on Women's Health*, Pennsylvania Campaign for Women's Health, 20-26 (Jan. 2018), http://pa4womenshealth.org/wp-content/uploads/2018/01/PA4WomensHealth_Community-Conversations_Final-Report.pdf.

[25] *Percent of Person 5 Years and Over Who Speak a Language Other Than English at Home and Speak English Less Than Very Well*, Limited English Proficiency Federal Interagency, (Aug. 08, 2019, 2:04 PM), https://www.lep-.gov/-aps/.

they needed. Section 1557 of the ACA provided federal protections for LGBTQ people by prohibiting discrimination on the basis of sex, broadening access to insurance by expanding Medicaid coverage for lower income individuals, removing spending caps on insurance coverage, and adding protections against discrimination based on a health status, including HIV.[26] The proposed rule would eliminate these protections.

The proposed rule will disproportionately impact LGBTQ people and people of color who live with disabilities and/or chronic conditions. Due to systemic barriers to health care and toxic stress caused by discrimination, people of color and LGBTQ people are at a higher risk of developing chronic conditions and have a higher prevalence of disabilities. LGBTQ people have a greater risk of HIV/AIDS, frequent tobacco and other substance use, and higher risk of certain cancers, such as breast cancer. [27] These disparities are magnified for LGBTQ people who live at the intersection of other marginalized groups, like race, ethnicity, class, and immigration status.

The Proposed Rule Undermines Notice, Remedies, and Enforcement Requirements.

The proposed rule also seeks to weaken 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.[28] As a result, the proposed rule would limit claims of intersectional discrimination that go against the text and intent of Section 1557. Ultimately, the proposed rule would make it harder for those who are discriminated against to access meaningful health care and to enforce their rights.

Conclusion

This proposed rule would be detrimental to those most impacted by discrimination in health care which include women of color, LGBTQ individuals, people with LEP, immigrants, and people living with disabilities. The proposed rule disregards the original purpose and plain language of Section 1557, specifically, and the ACA broadly.

On all levels, the proposed changes undermine WLP's values and mission to protect and advance the health and safety of women, girls, LGBTQ people and their families. The Department of Health and Human Services and the Center for Medicare and Medicaid should immediately withdraw its proposed rule.

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[26] 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/.

[27] Jen Kates, Et al., *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.*, Kaiser Family Foundation (May 2020), http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US.

[28] 84 *Fed. Reg.* at 27882.

Respectfully submitted,

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2015 Proposed Rule

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November 9, 2015

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Electronic Submission via http://www.regulations.gov

RE: Nondiscrimination in Health Programs and Activities, Proposed Rule
RIN 0945-AA02

The National Center for Lesbian Rights (NCLR) is a non-profit, public interest law firm that litigates precedent-setting cases at the trial and appellate court levels, advocates for equitable public policies affecting the lesbian, gay, bisexual, and transgender (LGBT) community, provides free legal assistance to LGBT people and their legal advocates, and conducts community education on LGBT issues. NCLR has been advancing the civil and human rights of LGBT people and their families across the United States through litigation, legislation, policy, and public education since it was founded in 1977. NCLR serves more than 5,000 LGBT people and their families throughout the United States each year, including LGBT parents, seniors, immigrants, athletes, and youth. NCLR's legal, policy, and legislative victories set important precedents that improve the lives of all LGBT people and their families across the country. We also seek to empower individuals and communities to assert their own legal rights and to increase public support for LGBT equality through community and public education.

The Movement Advancement Project is a national think tank that that provides rigorous research, insight and analysis that help speed equality for lesbian, gay, bisexual and transgender (LGBT) people.

The Department of Health and Human Services ("HHS" or the "Department"), through its Office for Civil Rights ("OCR"), has issued a proposed rule on Section 1557 of the Affordable Care Act (the "ACA" or the "Act") that will prohibit discrimination in certain health programs and activities on the basis of race, color, national origin, sex, age, or disability. We commend the Department for issuing proposed regulations that take critical steps toward realizing the promise of Section 1557 in ending sex discrimination in health care.

As the only national legal advocacy organization with an explicit mission to further the interests of lesbians, this rule's focus on eradicating sex-based discrimination in health care is of particular salience to NCLR. Lesbians as a group experience high rates of gender-based discrimination in the provision of health care, and lesbians of color face the additional burden of racism. The promise of this rule is therefore great, as it will provide powerful tools against

all of the myriad forms of oppression faced by too many in our society. We offer below our comments, drawn from our nearly four decades of advancing the interests of lesbians and the entire LGBT community, in the health care arena and beyond.

As a leading national organization devoted to ensuring that laws, regulations, and policies affecting LGBT people are based on sound research and evidence, MAP is pleased to join these comments to ensure that the proposed regulations fully and fairly address the negative impact of discrimination against LGBT people in our nation's health care systems.

The LGBT Community and the Health Care System

Lesbian and Bisexual Women Face Discriminatory Barriers to Health Care

Lesbian and bisexual women face pervasive barriers to equal health care. In its groundbreaking 1999 report on lesbian health, the Institute of Medicine noted that "until this time, avoidance and silence dominated both professional and societal attitudes toward lesbian health needs."[1] The report identified several barriers to health care access for lesbians in the U.S., including structural barriers (e.g. managed care), lack of legal recognition of relationship partners, financial and insurance barriers, and personal and cultural barriers, including the attitudes of health care providers and the lack of cultural competency among providers.[2] "In addition to facing many of the same stressors as heterosexual women, women who self-identify as lesbian may also experience stressors not commonly faced by heterosexual women (e.g. stigmatization both in and outside the health care setting)."[3]

These concerns remain salient today. Lesbians and bisexual women encounter barriers to health care that include concerns about confidentiality and disclosure, discriminatory attitudes and treatment, limited access to health care and health insurance, and often a limited understanding as to what their health risks may be.[4] Studies have found that lesbians and bisexual women have higher rates of breast cancer than heterosexual women.[5] They also get less routine health care than other women, including colon, breast, and cervical cancer screening tests.[6] Some of the reasons for this include the fear of discrimination for being

[1] COMM. ON LESBIAN HEALTH RESEARCH PRIORITIES, LESBIAN HEALTH – CURRENT ASSESSMENT AND DIRECTIONS FOR THE FUTURE vii (Andrea L. Solarz ed. 1999).
[2] *Id*. at 10-11.
[3] *Id*. at 21.
[4] COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, HEALTH CARE FOR LESBIANS AND BISEXUAL WOMEN, COMMITTEE OPINION NO. 525 1 (2012), *available at* http://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co525.pdf?dmc=1&ts=20151029T1608314581.
[5] OFFICE ON WOMEN'S HEALTH, DEP'T OF HEALTH AND HUMAN SERVS., LESBIAN AND BISEXUAL HEALTH 1 (2009), *available at* http://www.womenshealth.gov/publications/our-publications/fact-sheet/lesbian-bisexual-health.pdf.
[6] Blosnich *et al.*, *Health inequalities among sexual minority adults: Evidence from ten U.S. states*, 46(4) AM. J. PREVENTIVE MED. 337 (2010), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4102129/.

lesbian or bisexual, and negative experiences with healthcare providers.[7] Lesbian and bisexual women report poorer overall physical health than heterosexual women.[8]

While lesbians and bisexual women are as likely as heterosexual women to develop cervical cancer, they are up to ten times less likely to undergo regular screening for the disease.[9] Lesbians are less likely to access preventive care compared to other women, and both lesbians and bisexual women are less likely to be insured compared to other women. Lower rates of regular screening put lesbians at greater risk of late diagnosis, when the disease is less treatable.[10] Lesbian and bisexual women over the age of 50 have a higher risk of cardiovascular disease and prevalence of myocardial infarction than heterosexual women of the same age.[11]

The LGBT Community Faces Discriminatory Barriers to Health Care

LGBT people and people living with HIV experience pervasive discrimination in the provision of health care. According to an in-depth survey conducted by Lambda Legal concerning health care discrimination against LGBT people and people living with HIV, more than half of all respondents reported that they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health care status; or health care professionals being physically rough or abusive.[12] Many members of the LGBT community have a "high degree of anticipation and belief that they w[ill] face discriminatory care" which ultimately causes many people to not seek the essential care that they need.[13] For many transgender and gender-nonconforming people the fear of potential negative treatment from health care professionals

[7] AM. CANCER SOC'Y, CANCER FACTS FOR LESBIAN AND BISEXUAL WOMEN 1 (Sept. 2015), *available at* http://www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-044844.pdf.
[8] David J. Lick, Laura E. Durso & Kerri L. Johnson, Minority Stress and Physical Health Among Sexual Minorities, 8 PERSP. ON PSYCHOL. SCI. 521 (2013), *available at* http://williamsinstitute.law.ucla.edu/research/health-and-hiv-aids/minority-stress-and-physical-health-among-sexual-minorities/.
[9] THE FENWAY INST., POLICY FOCUS: PROMOTING CERVICAL CANCER SCREENING AMONG LESBIANS AND BISEXUAL WOMEN 1 (2013), *available at* http://www.lgbthealtheducation.org/wp-content/uploads/Cahill_PolicyFocus_cervicalcancer_web.pdf.
[10] *Id.* at 2.
[11] Fredriksen-Goldsen KI, et al, *Health Disparities Among Lesbian, Gay, and Bisexual Older Adults: Results From a Population-Based Study*, 103 AM. J. OF PUB. HEALTH 1802 (2013).
[12] LAMBDA LEGAL, WHEN HEALTH CARE ISN'T CARING, LAMBDA LEGAL'S SURVEY ON DISCRIMINATION AGAINST LGBT PEOPLE AND PEOPLE LIVING WITH HIV, 5 (2010), available at http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf (explaining that "almost 56 percent of lesbian, gay or bisexual (LGB) respondents had at least one of these experiences; 70 percent of transgender and gender-nonconforming respondents had one or more of these experiences; and nearly 63 percent of respondents living with HIV experienced one or more of these types of discrimination in health care. In almost every category, transgender and gender-nonconforming respondents reported higher levels of discrimination by health care providers.").
[13] *Id.* at 6.

is even more exacerbated. Undocumented transgender persons were found to be vulnerable to physical attacks in doctors' offices, hospitals, and emergency rooms.[14] There are also geographic considerations that may further exacerbate discrimination against LGBT individuals.[15] These realities have created a major barrier to health care services for LGBT people.

LGBT people of color and people with lower socioeconomic status experience even higher levels of discriminatory and substandard care.[16] Data from one report[17] show, among other things:

- Only 64 percent of LGB Latino adults had health insurance coverage compared to 77 percent of all LGB adults and 82 percent of the heterosexual adult population.
- Thirty percent of LGB African-American adults were likely to delay or not get needed medication compared to 19 percent of African-American heterosexual adults.
- Twenty-six percent of LGB Latino adults did not have a regular source for basic health care.
- Only 35 percent of LGB African-American women had a mammogram in the past two years, compared to 57 percent of all LGB women and 62 percent of all heterosexual women.

Another subgroup within the LGBT community that often receives little attention are bisexuals. Bisexual people are more likely to lack access to health insurance, and report lower levels of private health insurance; they are also less likely to have accessed needed medical care in the past year due to cost.[18] Bisexual women are more likely to develop cardiovascular

[14] GRANT JM. ET AL., INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 74 (2011), *available at* http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf.

[15] NAT'L WOMEN'S LAW CTR., FACT SHEET: HEALTH CARE REFUSALS HARM PATIENTS: THE THREAT TO REPRODUCTIVE HEALTH CARE 2 (2014), *available at* http://www.nwlc.org/sites/default/files/pdfs/refusals_harm_patients_repro_factsheet_5-30-14.pdf.

[16] WHEN HEALTH CARE ISN'T CARING, *supra* note 12, at 11 ("In addition to the overall rates of substandard care, respondents (defined in this survey as having a household income under $20,000) in nearly every category experienced higher rates of discrimination and substandard care. For example, while transgender respondents as a whole reported a care-refusal rate of almost 27 percent, low-income transgender respondents reported a rate of almost 33 percent. Almost 11 percent of low-income LGB respondents and LGB respondents of color were refused care compared to almost 8 percent of LGB people overall."); see also Institute of Medicine, The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding (2011), available at http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx.

[17] Center for American Progress, "Health Disparities in LGBT Communities of Color: By the Numbers" (2010), available at https://www.americanprogress.org/issues/lgbt/news/2010/01/15/7132/health-disparities-in-lgbt-communities-of-color

[18] Brian W. Ward et al., "Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013," *National Health Statistics Report*, July 15, 2014, http://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf.

disease.[19] Older bisexuals are also less likely to be out to their doctors than older gay and lesbian adults. Overall, both bisexual and transgender older adults are critically underserved populations at heightened risk of physical and mental health disparities.[20]

The evidence is clear that being LGBT has a significant negative effect on access to health care, underscoring the importance of this proposed rule. Below we provide comments on specific provisions in the NPRM.

SUBPART A – GENERAL PROVISIONS

All Federal Agencies Should Be Covered by the Rule [§ 92.2(a) – Application]

The ACA expressly authorizes HHS to issue regulations for the implementation of Section 1557's nondiscrimination protections for all health programs and activities that receive federal financial assistance.[21] Consistent with that broad authority, HHS should apply this rule to all federally-administered and federally-funded health programs and activities. We strongly urge HHS to exercise this authority in light of its expertise in health care and its leading role in implementing Section 1557 since the ACA's passage, to ensure that Section 1557's protections are implemented fully and fairly.

If HHS chooses not to exercise its authority to apply the final rule across all federal agencies, we urge HHS to work with the Department of Justice and other federal agencies to ensure that Section 1557's protections are fully implemented by all federally funded health programs and activities and to prioritize those agencies with significant involvement in health care, such as the Department of Veterans Affairs[22] and the Office of Personnel Management.[23]

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[19] Clark CJ, et al. Disparities in long-term cardiovascular disease risk by sexual identity: The National Longitudinal Study of Adolescent to Adult Health. Prev Med. 2015;76:26-30.

[20] Karen I. Fredriksen-Goldsen et al., "The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults," 2011, http://caringandaging.org/wordpress/wp-content/uploads/2011/05/Full-Report-FINAL-11-16-11.pdf.

[21] 42 U.S.C. §§ 18116(c) (2012).

[22] See U.S. DEP'T OF VETERAN AFFAIRS, http://www.va.gov/health (last visited Nov. 5, 2015) ("The Veterans Health Administration is America's largest integrated health care system with over 1,700 site of care, serving 8.76 million Veterans each year.").

[23] KIRSTIN B. BLOM ET AL., CONG. RESEARCH SERV., R42741, LAWS AFFECTING THE FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM 1 (2015), *available at* https://www.fas.org/sgp/crs/misc/R42741.pdf (FEHB is the "is the largest employer-sponsored health insurance program in the country, covering about 8.2 million enrollees each year.").

No Religious Exemptions Should Be Added to the Rule's Prohibition Against Sex Discrimination [§ 92.2(b) – Application]

The preamble to the proposed rule solicits comment as to whether exceptions such as those set out in Title IX's protection from sex discrimination in education programs and activities should be added to Section 1557's broad protection against sex discrimination.[24] HHS further asks if the rule "appropriately protects religious beliefs" or if the regulations should create additional exemptions from the protection against sex discrimination.[25] Any additional exemptions from these vital non-discrimination protections should be rejected.

As noted in the proposed rule, many protections for health care providers regarding religious beliefs already exist, and these protections were not displaced by ACA Section 1557. These existing exemptions already allow LGBT people and women seeking reproductive health care to be denied necessary services due to the religious beliefs of others. Given the negative health consequences of these current exemptions, particularly for women and LGBT persons who are low income and living in rural areas, additional exemptions should be rejected, as they would only exacerbate these harms and hinder the ability of ACA Section 1557 to ensure health equity and nondiscrimination in health care services and coverage.

The proposed rule defines a health program or activity as "the provision or administration of health-related services or health-related insurance coverage and the provision of assistance in obtaining health-related services or health-related insurance coverage."[26] As the proposed rule notes, there is a large number of entities that will be subject to its provisions, including those established under Title I of the ACA, health programs or activities conducted by HHS, and entities receiving federal financial assistance through their participation in Medicare or Medicaid.[27] Specifically, Section 1557 prohibits the following entities from discriminating against consumers on the basis of sex: hospitals, health clinics, group health plans, health insurance issuers, physician practices, community health centers, rural health centers, nursing facilities, and other similar entities.[28] Notably, *nearly all,* if not all, physicians will be covered by this proposed rule because almost all licensed physicians accept federal financial assistance.[29] Due to the breadth of the rule's coverage, an expansion of religious exemptions would have far-reaching impact and lead to further discrimination against women and LGBT people in health care settings.

[24] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54173 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).
[25] Id.
[26] Id. at 54174.
[27] Covered entities are those that "operate a health program or activity, any part of which receives Federal financial assistance; [a]n entity established under Title I of the ACA that administers a health program or activity; and [t]he Department [of Health and Human Services]." *Id.*
[28] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54194.
[29] *Id.* at 54195.

Only One Exemption Applies to the Prohibition Against Sex Discrimination Under ACA Section 1557 and Any Additional Exemptions, including Religious Exemptions, Should Not Apply.

The final rule should not include any specific exemptions for health providers, health plans or other covered entities with respect to the requirements in the proposed rule related to sex discrimination. In particular, it should not include any specific religious exemptions to the prohibition against sex discrimination.

The requirements of ACA section 1557 explicitly provide,

> [E]xcept as otherwise provided for in [Title I of the Patient Protection and Affordable Care Act (ACA),] an individual shall not, on the grounds prohibited under… Title IX of the Education Amendments of 1972… 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 of the ACA.][30]

In the 2013 Request for Information (RFI) that preceded this rule, "OCR specifically inquired as to what exceptions, if any, should apply in the context of sex discrimination in health programs and activities" and "nearly all commenters who provided a response indicated that Section 1557 includes only one exception—that the statute applies except as otherwise provided in Title I of the ACA."[31] Most commenters also argued that "nothing in the language or legislative history of Section 1557 allows for any other limitations or exceptions regarding its application, highlighting that exemptions to general rules like Section 1557's antidiscrimination provision must be read strictly and narrowly."[32] We joined then, and now reiterate, these arguments against an expanded regime of religious exemptions.

Existing Religious Exemptions Already Discriminatorily Harm LGBTQ Persons and Women, Including Low-Income Persons and Persons of Color, Seeking Needed Health Care.

There are already numerous provisions in federal and state law that allow health care providers and entities providing health care coverage to deny services or coverage based on institutional or personal religious beliefs. Unlike other nations whose legal regimes have also sought to balance the conscience rights of providers with the rights of persons to access health care, in the United States there is often insufficient consideration given to the impact of overly broad conscience laws on patients. In other words, the playing field is already tilted heavily in favor of those seeking to deny care. And given the nature of the services to which religious exemptions are most commonly applied, these refusal laws have a discriminatory

[30] 42 U.S.C. § 18116(a) (2012).
[31] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54173.
[32] *Id*., *see* Nussle v. Willette, 224 F.3d 95, 99 (2d Cir. 2000) (quoting Commissioner v. Clark, 489 U.S. 726, 739 (1989), *overruled on other grounds by* Porter v. Nussle, 534 U.S. 516 (2002)). *See also* New York v. Bloomberg, 524 F.3d 384, 402 (2d Cir. 2008). *See also* Detroit Edison Co. v. SEC, 119 F.2d 730, 739 (6th Cir. 1941) ("[e]xceptions in statutes must be strictly construed and limited to objects fairly within their terms, since they are intended to restrain or except that which would otherwise be within the scope of the general language.").

impact on LGBT people and women seeking reproductive health care. HHS explicitly declares that a range of religious exemptions already apply to ACA Section 1557; however, the proposed rule omits any discussion of the severe harm that current religious exemptions cause for women and members of the LGBT community, two key populations that this proposed rule strives to protect. Exacerbating these existing harms would run directly counter to the purpose of section 1557's protections.

Statutory Refusal Laws

At the federal level, there are already numerous statutory protections for health care providers' religious beliefs. These laws include the Church,[33] Weldon,[34] and Coats[35] amendments, which allow providers to refuse to perform or otherwise facilitate abortion services. The Church Amendment also reaches sterilization services.[36]

Most states have similar laws; forty-five allow individual healthcare providers, and forty-three allow institutions, to refuse to provide abortion services.[37] Provider conscience clauses at the state level apply not only to abortion services but also to contraceptive care. Twelve states permit some healthcare providers to refuse to provide contraception and related services (such as counseling).[38] Refusal provisions targeting contraception delay access, increase costs, and may result in unintended pregnancies. 18 states allow providers to refuse to provide sterilization services.[39]

State conscience clauses have now expanded to end of life care, stem cell research, and to any unspecified health services to which a moral or religious objection may be raised, including counseling or providing information regarding the patient's health status.[40] These state laws are also expanding to cover more entities.[41] Provider conscience laws exist in states where there are significant numbers of communities of color, including Texas and Florida,[42] and many of these states have enacted additional, broad constitutional or statutory religious exemptions that impact LGBT persons.[43]

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[33] 42 U.S.C. § 300a-7 et seq.
[34] Consolidated Appropriations Act, 2012, Pub. L. No. 112-74, 125 Stat 786.
[35] 42 U.S.C. § 238(n).
[36] 42 U.S.C. § 300a-7 et seq.
[37] GUTTMACHER INST., REFUSING TO PROVIDE HEALTH SERVICES 2 (2015), *available at* http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf.
[38] *Id.*
[39] *Id.*
[40] Elizabeth B. Deutsch, *Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act's Nondiscrimination Mandate*, 124 Yale L. J. 2470, 2470 (2015).
[41] *Id.*
[42] For instance, Florida allows private, religious, and public institutions and individual providers to refuse abortion care to patients and allows individual providers and pharmacists to refuse contraception. GUTTMACHER INST., *supra* note 37.
[43] MOVEMENT ADVANCEMENT PROJECT, LGBT POLICY SPOTLIGHT: STATE AND FEDERAL RELIGIOUS EXEMPTIONS AND THE LGBT COMMUNITY (2015), *available at* http://www.lgbtmap.org/policy-and-issue-analysis/policy-spotlight-rfra.

While religiously-based objections to contraception and abortion are well known and have posed access barriers for years, less well known is how these types of refusals can also affect the LGBT community, even in instances involving people trying to become pregnant, rather than avoid or terminate a pregnancy. Many religious health care providers are "opposed to infertility treatments altogether or are opposed to providing it to certain groups of people" such as members of the LGBT community.[44] Health care providers have even "sought exemptions from state antidiscrimination laws to avoid providing reproductive services to lesbian parents."[45] For example, in one case, an infertility practice group subjected Guadalupe Benitez to a year of invasive and costly treatments only to deny her the infertility treatment that she needed because she is a lesbian.[46] When doctors at the practice group recognized that Ms. Benitez "needed in vitro fertilization to become pregnant, every doctor in the practice refused, claiming that their religious beliefs prevented them from performing the procedure for a lesbian."[47] Since this was the only clinic covered by her health insurance plan, Ms. Benitez had to pay out-of-pocket for the treatment at another clinic, which subjected her to serious financial harm.

The Expansion of Religiously-Affiliated Health Systems

The problems for patients presented by the expansion of refusal provisions in state law have been exacerbated by the growth in health care systems owned and operated by religious orders. Mergers between Catholic and nonsectarian hospitals have continued as hospital consolidation has intensified. Catholic hospitals and health systems must follow the Ethical and Religious Directives for Catholic Health Care Services ("Directives"), which prohibit a wide range of reproductive health services, such as contraception, sterilization, abortion care, and other needed health care.[48] Nonsectarian hospitals must often agree to comply with these Directives in order to merge with Catholic hospitals.[49] In 2011, ten of the twenty-five largest health systems in the nation were Catholic-sponsored, and since 1990,[50] eighty percent of 130 known affiliations of Catholic hospitals or health systems included affiliations with non-

[44] U.S. CONF. OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH SERVICES 25 (5th ed. 2009), *available at* http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf. (Directive 41 of the Ethical and Religious Directives for Catholic Health Care states: "Homologous artificial fertilization is prohibited when it separates procreation from the marital act in its unitive significance.")

[45] Douglas Nejaime et al., *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 Yale L.J. 2516, 2518 (2015). *See*, e.g., N. Coast Women's Care Med. Grp., Inc. v. San Diego Cnty. Superior Court, 189 P.3d 959 (Ca;. 2008) (on the potential impact of healthcare refusal laws on same-sex couples).

[46] Benitez v. N. Coast Women's Care Med. Grp., Inc., 106 Cal. App. 4th 978 (2003); *see also* LAMBDA LEGAL, BENITEZ V. NORTH COAST MEDICAL GROUP (Jul. 1, 2001), http://www.lambdalegal.org/in-court/cases/benitez-v-north-coast-womens-care-medical-group; NAT'L WOMEN'S LAW CTR., *supra* note 15.

[47] *Benitez*, *supra* note 46.

[48] U.S. CONF. OF CATHOLIC BISHOPS, *supra* note 44.

[49] Deutsch, *supra* note 40, at 2488-89.

[50] LOIS UTTLEY L. ET AL., AMERICAN CIVIL LIBERTIES UNION & MERGERWATCH, MISCARRIAGE OF MEDICINE: THE GROWTH OF CATHOLIC HOSPITALS AND THE THREAT TO REPRODUCTIVE HEALTH CARE 5 (2013) [hereinafter Miscarriage of Medicine Report], *available at* https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.

Catholic organizations.[51] According to the Catholic Health Association of the United States, 1 in 6 patients in the U.S. is cared for in a Catholic hospital.[52]

Having to seek care from a religiously affiliated institution can prove dangerous to an individual's health if the care they require runs afoul of the religious directives followed within that institution. The following narratives provide compelling illustrations.

> Tamesha Means arrived at Mercy Health Partners in Michigan after her water broke and she began having contractions. She was 18-weeks pregnant. The hospital diagnosed her with preterm premature rupture of membranes (PPROM) and sent her home to wait, telling her there was nothing it could do. It did not tell her that, given the stage of her pregnancy and her condition, the fetus she was carrying had almost no chance of survival and that prolonging the pregnancy could put her health and possibly even her life at risk. Nor did the hospital tell her that the safest treatment option was to induce labor and terminate the pregnancy. The following morning, Ms. Means returned to the hospital with painful contractions, bleeding, and an elevated temperature. The hospital monitored her contractions and gave her two Tylenol. After Ms. Means' temperature went down, the hospital again sent her home. Later that night, Ms. Means returned to the hospital in extreme distress. Hospital staff again told her there was nothing they could do. While staff began preparing the paperwork to send her home yet again, Ms. Means began to deliver. The hospital then began tending to her miscarriage. She gave birth to a very premature son, who died within hours. Ms. Means' medical records show acute chorioamnionitis and acute funistis, infections that Ms. Means developed after her water broke. By failing to inform her about her options, the likelihood that her baby would not survive, or the risks of delaying treatment, Mercy Health Partners failed to follow medical standards for PPROM with signs of infection and unnecessarily put Ms. Means' health at grave risk. The ACLU has asked CMS to investigate Mercy Health Partners and filed a lawsuit on behalf of Ms. Means.[53]

> In early 2010, historically secular Sierra Vista Regional Health Center in southeastern Arizona began a trial two-year affiliation with the Catholic Carondelet Health Network, a member of the Ascension Health system.[54] As a

[51] Deutsch, *supra* note 40, at 2488-89.

[52] CATHOLIC HEALTH ASS'N OF THE U.S., CATHOLIC HEALTH CARE IN THE UNITED STATES (2015), *available at* https://www.chausa.org/Store/products/Product?ID=2992.

[53] Miscarriage of Medicine Report, *supra* note 50, at 15; *Letter from Alexa Kolbi-Molinas, Staff Attorney, American Civil Liberties Union, and Brooke Tucker, Staff Attorney, ACLU of Michigan, to Pamela J. Para, Nurse Consultant,* Centers for Medicare & Medicaid Services (Dec. 17, 2013); Complaint, Means v. U.S. Conf. of Catholic Bishops, No. 2:13-cv-14916 (E. D. Mich. Nov. 29, 2013).

[54] Miscarriage of Medicine Report, *supra* note 50, at 14. *See also* Bill Hess, *Carondelet Deal to Bring Changes at Local Hospital*, SIERRA VISTA HERALD, Feb. 2, 2010.

> condition of the affiliation, Sierra Vista, the sole community provider of acute care in a rural three-county region, was required to follow the Directives. In 2010, a woman who was 15-weeks pregnant with twins arrived at the Sierra Vista emergency department after miscarrying one of the twins at home. The remaining fetus had a heartbeat. The doctor who examined her recommended that the pregnancy be terminated, given the low chances of a successful pregnancy and the risks of attempting to continue the pregnancy, including severe hemorrhaging and infection. The physician recalled, "The patient and her husband were, of course, upset by the situation, but decided to proceed with the treatment."[55] The physician and staff then began routine preparations to complete the miscarriage. A hospital administrator intervened and ordered the physician to transfer the patient to avoid violating the Directive against abortion. The patient was sent by ambulance to another hospital 80 miles away where she received the care she needed.[56] "It was a very gut-wrenching thing to put the staff through [and to] put the patient through, obviously," recalled the attending physician.[57] Another obstetrician felt misled by the hospital administration. "We were told that we wouldn't have a problem with dealing with miscarriages…and it turned out not to be true."[58]

Religiously-based refusals of care are also resulting in the denial of medically necessary care to to LGBT people.

> Carl,[59] a transgender man, needed to undergo a hysterectomy and oophorectomy as part of his medically-supervised transition. Working with this healthcare providers, Carl obtained insurance coverage for the procedure. His surgeon, who had privileges at several hospitals in the area, scheduled the procedure at the hospital that was nearest to Carl and the surgeon. That hospital happened to be a religiously-affiliated facility. A few days before the procedure was scheduled to occur, Carl was informed that he could not have the procedure done at the hospital. According to the surgeon, the decision was made by the hospital's Ethics Committee. The reason Carl was given for the decision was that "the hospital does not perform that type of hysterectomy." Due to the short notice of the cancellation, the surgeon was unable to get the procedure moved to another hospital.

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[55] Miscarriage of Medicine Report, *supra* note 50, at 14. *See also* Affidavit of Dr. Robert Holder at 1-2 (Dec. 10, 2010), *available at* http://www.washingtonpost.com/wp-srv/health/documents/abortion/holder-affidavit.pdf (last visited Nov. 5, 2015).

[56] Miscarriage of Medicine Report, *supra* note 50, at 14. *See also* Jonathan Cohn, *Unholy Alliance,* THE NEW REPUBLIC, (Feb. 22, 2012), *available at* http://www.newrepublic.com/article/politics/magazine/100960/catholic-church-hospital-health-care-contraception (last visited Nov. 5, 2015).

[57] Miscarriage of Medicine Report, *supra* note 50, at 14.

[58] *Id.*

[59] This incident was reported to NCLR Legal Help Line attorneys; the name has been changed to protect the caller's privacy.

These incidents demonstrate how additional religious exemptions may further hinder a person's access to care, especially in areas of the country where there are few providers.

Catholic hospitals have also denied emergency contraception to survivors of rape. Due to the Directives, in 2002, only twenty-three percent of Catholic hospital emergency rooms provided emergency contraception to rape survivors, with only three percent providing emergency contraception without any restrictions.[60] These denials violate the medical standards of care that health care consumers deserve and lead to negative health outcomes.

Provider conscience clauses and mergers with Catholic hospitals are now creating an environment in which providers, personnel, and payors can object to reproductive and other health care services, and increasingly, there are fewer alternatives for those seeking care.[61] Due to these trends, additional religious exemptions would only undermine the "fundamental purpose of the ACA to ensure that vital health care services are broadly and nondiscriminatorily available to individuals throughout the country."[62] Existing religious exemptions are already overly broad and impede access to reproductive and other care; the creation of additional exemptions is unnecessary, unwarranted, and would only exacerbate these harms.

Current ACA Regulations, Including Religious Exemptions, Limit Access to Abortion Services.

As the proposed rule points out, there are provisions in the ACA related to abortion services that permit health providers and facilities to deny abortion care in qualified health plans offered in the health insurance marketplaces, and that retain the federal and state proscriptions on discrimination against providers and insurers who deny abortion services described above.[63] Moreover, twenty-five states have banned coverage of abortion care in their marketplaces,[64] creating a system where persons who are pregnant may not be able to access the care they need due to their source of insurance coverage or where they live. The creation of additional religious exemptions is wholly unnecessary and would further limit access to safe and necessary abortion services.

The Religious Freedom Restoration Act and State RFRAs

Congress enacted the Religious Freedom Restoration Act (RFRA) in large part to protect minority religions.[65] The law prohibits the federal government from substantially burdening a person's religious exercise absent a compelling government interest and a showing that the

[60] CATHOLICS FOR A FREE CHOICE, SECOND CHANCE DENIED: EMERGENCY CONTRACEPTION IN CATHOLIC HOSPITAL EMERGENCY ROOMS 9, 10 (Jan. 2002), *available at* http://www.catholicsforchoice.org/topics/healthcare/documents/2002secondchancedenied_001.pdf.
[61] Deutsch, *supra* note 40, at 2483.
[62] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54173 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).
[63] *See, e.g.,* 42 U.S.C. 18023.
[64] GUTTMACHER INST., *supra* note 37.
[65] 42 U.S.C. § 2000bb-2000bb-4 (2012); *see, e.g.* Holt v. Hobbs, 135 S. Ct. 853, 859-860 (2015).

government action is the least restrictive means of furthering that compelling interest. Recent invocations of RFRA have signaled a disturbing shift in its application, from protecting religious exercise to imposing religious beliefs on others. In *Burwell v. Hobby Lobby,*[66] the Supreme Court allowed the owners of a secular corporation to refuse to provide coverage for contraception in their company-sponsored health plan, despite a legal obligation to do so under the ACA, because the company owners personally objected to birth control. Applying RFRA, the Court deemed the contraception requirement to be a substantial burden on the owners' religious beliefs that was not sufficiently tailored (the Court equivocated on whether providing women with this essential preventive health benefit constituted a compelling government interest). Importantly, the Court did note that its holding should not be construed to permit entities to exempt themselves from nondiscrimination laws.[67]

Following the enactment of the federal statute in 1993, and the Supreme Court holding that RFRA could not be applied to the states as originally intended,[68] many states instituted their own religious freedom acts modeled on the federal law.[69] More recently, efforts to enact new, more sweeping versions of RFRA have emerged in some states as a direct backlash to the advancement of LGBT equality.

While these religious freedom statutes do not expressly permit discriminatory actions that would otherwise be unlawful, the misapplication of the federal RFRA in *Hobby Lobby* and the increasing use of religious liberty arguments to oppose reproductive and LGBT health care is cause for substantial concern. In this environment, and given the existence of a wide range of existing legal protections for the conscience rights of health care providers, the creation of an entire new regime of religious exemptions from this essential nondiscrimination rule would be a grave mistake.

Adding new religious exemptions to the first set of federal protections against sex-based discrimination in health care would have the potential to expand the scope of the above-described harms immeasurably to a wide range of essential health care services of critical importance to women and LGBT people. The adoption of new religious exemptions would afford legal cover to the widespread mistreatment experienced by many LGBT people in the

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[66] Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751 (2014).

[67] *Id.* at 2783 ("The principal dissent raises the possibility that discrimination in hiring, for example on the basis of race, might be cloaked as religious practice to escape legal sanction. Our decision today provides no such shield." (internal citations omitted)).

[68] City of Boerne v. Flores, 521 U.S. 507, 532-34 (1997).

[69] Conn. Gen. Stat. Ann. §§ 52-571b (1993); R.I. Gen. Laws §§42-80.1-1 to -4 (1998); Ill. Comp. Stat. Ann. 35/1-99 (1998); Fla. Stat. Ann. §§ 761.01-.05 (1998); Ala. Const. art. I, § 3.01; Ariz. Rev. Stat. Ann §§ 41-1493-1439.02 (1999); S.C. Code Ann.§§ 1-32-10 to -60 (1999); Tex. Civ. Prac. & Rem. Code. Ann §§ 110.001-0.12 (1999); Idaho Code Ann. §§ 73-401 to -404 (2000); N.M. Stat. §§28-22-1 to -5 (2000); Okla. Stat. Ann. Tit. 51, §§ 251-258 (2000); 71 Pa. Const. Stat. Ann §§ 2401-2407 (2002); Mo. Ann. Stat. §§1.302-.307 (2003); Va. Code Ann. §§ 57-1 to -2.02 (2007); Utah Code Ann. §§ 63L-5-101 to -403 (2008); Tenn. Code Ann. § 4-1-407 (2009); La. Rev. Stat §§ 13:5231-5242 (2010); Kan. Stat. Ann. §§ 60-5301–5305 (2013); Ky. Rev. Stat. Ann. H.B. 279, 2013 Reg. Sess. (Ky. 2013); Miss. Code Ann. § 11-61-1 (2014); Arkan. Religious Freedom Restoration Act, (S.B. 975) (2015); Ind. Religious Freedom Restoration Act (S.B. 568) (2015).

health care system today. Allowing providers and insurers to avail themselves of new exemptions from non-discrimination laws would encourage, rather than decrease, these harms.

The Final Rule Should Contain a Provision Affirming the Right of Patients to Informed Consent, Accurate and Complete Medical Information, and the Autonomy to Make Their Own Health Care Decisions.

Well-established standards of informed consent require that patients have accurate and complete information on which to base their health care decisions. In accordance with American Medical Association and American Congress of Obstetricians and Gynecologists guidelines, a clinician must provide adequate disclosure and explanation of the full range of medically appropriate treatment options before the patient and clinician settle on a course of treatment.[70] The final rule should make clear that religiously-affiliated institutions and providers are not shielded from the obligation under existing law to inform a patient that other medical care options exist and to explain the treatment options the institution or provider is unwilling to provide. This is in line with current standards of care and the current federal commitment to informed consent.[71]

Covered Entities Should Notify Beneficiaries, Enrollees, Applicants, and Members of the Public of Any Exemption the Covered Entity Has Received.

We support HHS' requirement that covered entities notify beneficiaries, enrollees, applicants, and members of the public that the covered entity does not discriminate on basis of sex.[72] However, we urge HHS to add an additional requirement related to religious accommodations and exemptions currently in law. As noted above, religious exemptions already in effect result in numerous barriers for women and LGBT persons accessing reproductive health care and other types of care. Currently, the Centers for Medicare and Medicaid Services (CMS) – through its Conditions of Participation – requires hospitals to notify patients upon admission if the hospital will not honor specific aspects of patients' advance directives for end-of-life care because of religious objections. The end-of-life notice requirement could be used as a model to similarly require covered entities to notify beneficiaries, enrollees, applicants, and members of the public of any exemption the covered entity has received and any health care services that will not be provided or covered as a result of the exemptions currently in law.[73]

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[70] AM. MED. ASSOC., OPINION 8.082 WITHHOLDING INFORMATION FROM PATIENTS (Nov. 2006), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8082.page?; COMM. ON ETHICS, AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, INFORMED CONSENT, COMMITTEE OPINION NO. 439 (Aug. 2009), *available at* http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Informed-Consent.

[71] 42 C.F.R. § 482.55 (2011) (setting forth the conditions of hospital participation in Centers for Medicare and Medicaid Services).

[72] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54172, 54178 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

[73] *See* 42 C.F.R. § 489.102.

The Final Rule Should Cover Discrimination Based on Gender Identity and Sexual Orientation [§ 92.4 - Definitions]

Gender Identity

We commend HHS for clearly stating that discrimination based on sex stereotypes or gender identity constitutes discrimination on the basis of sex. As many federal agencies and courts have recognized, discrimination based on gender identity—including gender expression, gender transition, and transgender status—or on sex-based stereotypes is necessarily a form of sex discrimination.[74]

In 2012, for instance, the Equal Employment Opportunity Commission (EEOC) held that "intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination based on sex and such discrimination therefore violates Title VII."[75] The Attorney General affirmed this interpretation in a 2014 memorandum.[76] The Department of Labor has taken the same position in internal guidance and proposed regulations,[77] as has the Office of Personnel Management in its regulations.[78] Similarly, the Departments of Education and Justice have clarified on multiple occasions that, under Title IX, "discrimination based on gender identity, including transgender status, is discrimination based on sex,"[79] as is discrimination based on sex stereotyping.[80] The Department of Housing and Urban Development has similarly concluded that the Fair Housing Act covers claims based on sex stereotypes and gender identity.[81]

To date, the only court to rule on the issue in the context of Section 1557 has reached the same conclusion: the ACA's sex discrimination prohibition "necessarily" encompasses bias

[74] *See, e.g.*, Smith v. City of Salem, 378 F.3d 566, 572-75 (6th Cir. 2004); Rosa v. Park West Bank & Trust Co., 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); Schwenk v. Hartford, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act). *See also* Statement of Interest of the United States at 14, Jamal v. Saks, No. 4:14-cv-02782 (S.D. Tex. Jan. 26, 2015).

[75] Macy v. Holder, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, *12 (Apr. 20, 2012).

[76] ATTORNEY GEN. MEMORANDUM, TREATMENT OF TRANSGENDER EMPLOYMENT DISCRIMINATION CLAIMS UNDER TITLE VII OF THE CIVIL RIGHTS ACT OF 1964 (Dec. 15, 2014), *available at* http://www.justice.gov/file/188671/download.

[77] Dep't of Labor, Discrimination on the Basis of Sex, Proposed Rule, 80 Fed. Reg. 5246 (Jan. 30, 2015); Office of Federal Contract Compliance Programs (OFCCP) Dir. 2015-1, Handling individual and systemic sexual orientation and gender identity discrimination complaints (Apr. 16, 2015); OFCCP Dir. 2014-02, Gender Identity and Sex Discrimination (Aug. 19, 2014).

[78] *See* 5 C.F.R. §§ 300.102-300.103, 335.103, 410.302, 537.105.

[79] Statement of Interest of the United States at 5, G.G. *ex rel.* Grimm v. Gloucester Cty. Sch. Bd., No. 4:15cv54 (E.D. Va. *filed* June 29, 2015); Statement of Interest of the United States at 12, Tooley v. Van Buren Pub. Sch., No. 2:14-cv-13466 (E.D. Mich. *filed* Feb. 24, 215); DEP'T OF EDUC., TITLE IX RESOURCE GUIDE, 1 (Apr. 2015); DEP'T OF EDUC., QUESTIONS AND ANSWERS ON TITLE IX AND SEXUAL VIOLENCE 5 (Apr. 29, 2014).

[80] *See* DEP'T OF EDUC., DEAR COLLEAGUE 7-8 (Oct. 26, 2010).

[81] HUD v. Toone, Charge of Discrimination, FHEO Nos. 06-12-1130-8; 06-121363-8 (Ofc. Hear. & App. Aug. 15, 2013); Memorandum from John Trasviña to FHEO Regional Directors, *Assessing Complaints that Involve Sexual Orientation, Gender Identity, and Gender Expression* (June 2010).

based on gender identity or transgender status. [82] This is obviously the correct application of the law's plain words. By explicitly articulating Section 1557's application to discrimination based on gender identity and sex stereotypes, the proposed rule's definition of sex discrimination will provide needed clarity and address a widespread and urgent problem.

On the Basis of Sex

The proposed rule does not include discrimination on the basis of sexual orientation within the definition of discrimination on the basis of sex, even though "as a matter of policy, [HHS] supports banning discrimination in health programs and activities . . . on the basis of sexual orientation."[83] HHS explains this omission by stating that it is unclear "whether existing Federal nondiscrimination laws prohibit discrimination on the basis of sexual orientation as a part of their prohibitions of sex discrimination," and then asks for comments on the best way of ensuring that the proposed rule includes the "most robust set of protections supported by the courts on an ongoing basis."

The recognition that sexual orientation discrimination is based on sex is compelled by a principled analysis of the law and is essential to ensure equal protection for lesbian, gay and bisexual Americans. As a recent Equal Employment Opportunity Commission (EEOC) decision holds,[84] discrimination on the basis of sexual orientation is sex-based discrimination for at least three reasons. First, any discrimination based on sexual orientation necessarily involves sex-based considerations. Sexual orientation is defined by whether a person is attracted to same-sex or different-sex partners. It is thus impossible to discriminate based on sexual orientation without taking the category of sex into account; in the most direct sense, discrimination on the basis of sexual orientation is sex-based. Second, any discrimination based on sexual orientation is associational discrimination on the basis of sex. For example, just as discrimination against an individual because she is dating or in a relationship with someone of a different race constitutes discrimination on the basis of race, discrimination against an individual because she is dating or in a relationship with another woman is discrimination on the basis of sex.[85] Finally, sexual orientation discrimination is also sex discrimination because it is based on gender stereotypes. The Supreme Court held in *Price Waterhouse v. Hopkins*[86] that discrimination based on gender stereotyping is prohibited by Title VII of the Civil Rights Act of 1964.[87]

[82] Rumble v. Fairview Health Services, No. 14–cv–2037, 2015 WL 1197415, *2 (D. Minn. Mar. 16, 2015).
[83] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54176 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).
[84] Baldwin v. Foxx, E.E.O.C., Appeal No. 0120133080, 2015 WL 4397641 (July 16, 2015).
[85] *See* Isaacs v. Felder Services, 2015 WL 6560655 at *3 (M.D. Ala. Oct. 29, 2015) (quoting *Baldwin*, *supra* note 84, at *7)
[86] 490 U.S. 228 (1989).
[87] 42 U.S.C. § 2000e *et seq*.

> "[T]he [EEOC] and a number of federal courts have concluded [that] discrimination against people who are lesbian, gay, or bisexual on the basis of gender stereotypes often involves far more than assumptions about overt masculine or feminine behavior. … Sexual orientation discrimination and harassment are often, if not always, motivated by a desire to enforce heterosexually defined gender norms. . . . In fact, stereotypes about homosexuality are directly related to . . . stereotypes about the proper roles of men and women. . . . The harasser may discriminate against an openly gay co-worker that he perceives to be gay, whether effeminate or not, because he thinks, 'real' men should date women, and not other men"[88]

Thus any discrimination motivated by the target of discrimination not following the sex-stereotype of heterosexuality is sex discrimination.[89]

Some older federal decisions held that sexual orientation discrimination is not actionable under existing sex discrimination laws; however, those decisions are based on outmoded rationales that cannot be reconciled with the U.S. Supreme Court's contemporary sex discrimination jurisprudence. Many are based simply on a conclusory statement that "Title VII [of the Civil Rights Act of 1964] does not prohibit harassment or discrimination because of sexual orientation."[90] To the limited extent these decisions include any analysis at all, they reason that Title VII cannot be applied to prohibit discrimination based on sexual orientation because Congress did not intend to protect gay, lesbian, and bisexual people when it enacted Title VII.[91] These decisions find that Congress had only the "traditional notions of sex in mind" when it passed Title VII and that those "traditional notions" did not include sexual orientation.[92] Additionally, some of the cases rely on a now-outdated EEOC conclusion from 1976 that "when Congress used the word sex in Title VII it was referring to a person's gender" and not to "sexual practices."[93] However, the Supreme Court rejected this mode of statutory interpretation in *Oncale v. Sundowner Offshore Services, Inc.*, holding that "statutory prohibitions often go beyond the principal evil [they were passed to combat] to cover

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[88] *Baldwin*, *supra* note 84, at *7-8 (quoting *Centola v. Potter*, 183 F. Supp. 2d 403, 410 (D. Mass 2002)).

[89] The EEOC has developed this interpretation in a long series of decisions prior to *Baldwin*. *See*, *e.g.*, Complainant v. Johnson, EEOC Appeal No. 0120110576 (Aug. 20, 2014); Complainant v. Cordray, EEOC Appeal No. 0120141108 (Dec. 18, 2014); Complainant v. Donahoe, EEOC Appeal No. 0120132452 (Nov. 18, 2014); Complainant v. Sec'y, Dep't. of Veterans Affairs, EEOC Appeal No. 0120110145 (Oct. 23, 2014); Couch v. Dep't of Energy, EEOC Appeal No. 0120131136 (Aug. 13, 2013); Brooker v. U.S. Postal Service, EEOC Appeal No. 0120112085 (May 20, 2013); Culp v. Dep't of Homeland Security, EEOC Appeal No. 0720130012 (May 7, 2013); Castello v. U.S. Postal Service, Appeal No. 0120111795 (Dec. 20, 2011); Veretto v. U.S. Postal Service, EEOC Appeal No. 0120110873, 2011 WL 2663401 (July 1, 2011).

[90] *See, e.g.*, Dawson v. Bumble & Bumble, 398 F.3d 211, 217 (2d Cir. 2005) (quoting Simonton v. Runyon, 232 F.3d 33, 35 (2d Cir. 2000); Wrightson v. Pizza Hut of Am., Inc., 99 F.3d 138, 143 (4th Cir. 1996); Williamson v. A.G. Edwards & Sons, Inc., 876 F.2d 69, 70 (8th Cir. 1989).

[91] *See, e.g.*, DeSantis v. Pacific Tel. & Tel. Co., 608 F.2d 327 (9th Cir. 1979), abrogated by Nichols v. Azteca Rest. Enters., Inc., 256 F.3d 864, 875 (9th Cir. 2001).

[92] *Id.* at 329.

[93] *See, e.g.*, *DeSantis*, *supra* note 91, at footnote 3.

reasonably comparable evils, and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed."[94] Interpreting Title VII to exclude coverage of discrimination based on sexual orientation violates this principle by inserting a limitation into the plain language and reasonable application of the text. Just as *Oncale* held that Title VII must be applied to prohibit sexual harassment of men by other men, even though Congress did not have that problem in mind when it enacted Title VII,[95] so Title VII must be applied to prohibit discrimination based on sexual orientation, an intrinsically sex-based issue, regardless of whether Congress expressly intended to do so. The plain language of Title VII does not exclude discrimination on the basis of sexual orientation from discrimination on the basis of sex, and, as explained above, any discrimination based on a person's sexual orientation necessarily takes the category of sex into account. Moreover, in *Baldwin v. Foxx*, the EEOC found that sexual orientation discrimination is in fact sex discrimination, therefore abrogating the basis for the court decisions relying on the old EEOC definition.

Some of these decisions cite the fact that Congress has debated but not yet passed legislation expressly prohibiting sexual orientation discrimination.[96] The Supreme Court has ruled, however, that "[c]ongressional 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."[97] Moreover, it is common for federal legislation to seek to codify emerging judicial trends in the interpretation of existing laws where doing so will provide additional clarity and guidance. Therefore, court decisions that cite to congressional inaction as a reason to exclude sexual orientation discrimination from the purview of sex discrimination should not be relied upon while crafting this rule.

In sum, most of the federal court decisions declining to recognize sexual orientation discrimination as sex discrimination pre-date the Supreme Court's decisions in *Price Waterhouse* and *Oncale*, and none can be reconciled with the holdings in those cases. Since those decisions, a number of federal courts have ruled that Title VII claims by plaintiffs who are subjected to gender-based harassment and gender-stereotyping related to their actual or perceived sexual orientation are actionable.[98] Most recently, both the EEOC and a growing

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[94] 523 U.S. 75, 79 (1998).
[95] *Id.* at 80-81.
[96] *See, e.g.*, Bibby v. Phila. Coca Cola Bottling Co., 260 F.3d 257, 261 (3d Cir. 2001); *Simonton*, *supra* note 90, at 35-36.
[97] Pension Benefit Guar. Corp. v. LTV Corp., 496 U.S. 633, 650 (1990) (citation omitted) (internal quotation marks omitted).
[98] *See Centola*, *supra* note 88; Heller v. Columbia Edgewater Country Club, 195 F. Supp. 2d 1212, 1224 (D. Or. 2002); Terveer v. Billington, 34 F. Supp. 3d 100, 116 (D.D.C. 2014); Boutillier v. Hartford Pub. Sch., 2014 WL 4794527 (D. Conn. 2014); Deneffe v. SkyWest, Inc., 2015 WL 2265373 at *6 (D. Colo. 2015). *See also Doe v. City of Belleville*, 119 F.3d 563, 580-83 (7th Cir. 1997) (opinion later vacated and case settled, but holding continues to be followed by district courts within that circuit); *Higgins v. New Balance Athletic Shoe, Inc.*, 194 F.3d 252, 259-61 (1st Cir. 1999); *Bibby*, *supra* note 96, at 262-63; *Simonton*, *supra* note 90, at 37-38.

number of federal courts have held that sexual orientation discrimination is a prohibited form of sex discrimination under Title VII.[99]

RECOMMENDATION:

1. We recommend that the definition of "on the basis of sex" in § 92.4 be revised as follows:

   On the basis of sex includes, but is not limited to, on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, **sexual orientation,** or gender identity.

Sex Stereotypes

We also urge HHS to clarify that the proposed definition of sex stereotypes in § 92.4 includes the targeting of persons based on sex-based stereotypes related to a person's sexual orientation.

For many years now, both courts and the EEOC have recognized that, following the decision in *Price Waterhouse v. Hopkins*, discrimination against persons who are, or are perceived to be, lesbian, gay or bisexual is often based on sex-based stereotypes about how men and woman are "supposed" to look and behave. As the EEOC describes in the *Baldwin* decision, the Supreme Court's robust application of protections from sex stereotyping discrimination also includes the sex-based expectation and stereotype that men must date and marry only women, and women must date and marry only men.

In *Veretto v. United States Postal Service*, for example, the EEOC determined that the complainant's allegation of sexual orientation discrimination was a sufficient sex discrimination claim because the discrimination was based on the sex stereotype that "marrying a woman is an essential part of being a man" and "motivated by . . . attitudes about stereotypical gender roles in marriage."[100] Similarly, the Ninth Circuit has held that an openly gay employee had a valid sex discrimination claim under Title VII for sexual harassment targeting his sexual orientation.[101] Courts have decided similarly under Title IX.[102]

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[99] *See, e.g.*, *Baldwin*, *supra* note 84; *Terveer*, *supra* note 98, at 116; *Isaacs*, *supra* note 85, at *3 (claims of sexual orientation-based discrimination are cognizable under Title VII); Muhammad v. Caterpillar Inc., 767 F.3d 694 (7th Cir. 2014)(amending a previously issued opinion to omit language stating that discrimination on the basis of sexual orientation is not actionable under Title VII).

[100] *Veretto*, *supra* note 89, at *3.

[101] *Rene v. MGM Grand Hotel, Inc*., 305 F.3d 1061 (9th Cir. 2002).

[102] Estate of Brown v. Ogletree, 2012 WL 591190 at *16-17 (S.D. Tex. Feb. 21, 2012), modified on other grounds by Estate of Brown v. Cypress Fairbanks Indep. Sch. Dist., 2012 WL 1900929 (S.D. Tex. May 23, 2012); Schroeder v. Maumee Bd. of Educ., 296 F. Supp. 2d 869, 871 (N.D. Ohio 2003); Ray v. Antioch Unified Sch. Dist., 107 F.Supp.2d 1165, 1170 (N.D.Cal.2000); *see also* Vickedis v. Pepperdine Univ., 2015 WL 1735191, at *8 (C.D. Cal.

RECOMMENDATION: We recommend the following definition of sex stereotypes in § 92.4:

> *Sex stereotypes* refers to 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 expectations that gender can only be constructed within two distinct and opposite forms (masculinity and femininity), and that gender cannot be constructed outside of this gender construct (individuals who identity as neither, both, or a combination of male and female). They also include gendered expectations related to the appropriate roles of men and women, such as the expectation that women are primary caregivers, or gendered expectations related to the sex or gender identity of an individual's intimate or romantic partners.

Benefit Design

We strongly support the recognition that Section 1557 prohibits discriminatory benefit designs and marketing practices. We urge HHS to define benefit design in order to better clarify that Section 1557's nondiscrimination protections apply to the full scope of health programs and activities. In particular, we note that the sphere of benefit design in which discrimination may occur should be defined to include, but not be limited to, prescription drug formularies; tiering structures; wellness programs; cost sharing, including co-payments and co-insurance; utilization management, including coverage exclusions; quantitative treatment limits; non-quantitative treatment limits including prior authorization and step therapy; provider networks, including access to specialists; and pharmacy access.

SUBPART B – NONDISCRIMINATION PROVISIONS

Discrimination Against Women's Health Care Providers [§ 92.101]

Section 1557 marks the first time that federal law contains a broad-based prohibition of sex discrimination in health programs or activities. Sex discrimination takes many forms and can occur at every step in the health care system—from obtaining insurance coverage to receiving proper diagnosis and treatment. This discrimination seriously harms women and other individuals who experience discrimination on the basis of sex, including sex stereotypes, gender identity, and sexual orientation.

2015) (stating strongly in dicta that "the line between discrimination based on gender stereotyping and discrimination based on sexual orientation is blurry, at best, and thus a claim that Plaintiffs were discriminated against on the basis of their relationship and their sexual orientation may fall within the bounds of Title IX"); Letter of Findings to Tehatchapi Unified Sch. Dist., ED/OCR Case No. 09-11-1031, DOJ Case No. DJ 169-11E-38, at 14. (June 30, 2011).

It is critical that regulations issued to effectuate section 1557 reflect a long-established tradition of strong protections against sex discrimination in federal law. As part of these protections, for example, the final rule should clarify that a covered entity engages in unlawful sex discrimination when it employs criteria that have the effect of disfavoring or disqualifying otherwise eligible providers of women's health care for participation in federal health programs, resulting in reduced access to federally supported health care for women in a region.

SUBPART C – SPECIFIC APPLICATIONS TO HEALTH PROGRAMS AND ACTIVITIES

Meaningful Access for Individuals with Limited English Proficiency [§ 92.201]

We strongly support the rule's specific requirements to ensure meaningful access to care for individuals with limited English proficiency, including many LGBT people. In particular, we support the definition of qualified interpreter, and we suggest including a definition of a qualified translator. Further, we strongly support including specific thresholds for translating written documents to ensure minimum standards exist that would directly aid evaluating compliance and enforcement. We also support requirements regarding taglines but recommend that covered entities include taglines in the top 15 languages in their state/service area rather than the proposal to include only the top 15 languages nationally. In many states, the top 15 languages nationally will not be useful for informing local limited English proficient communities. Finally, we oppose continuing the exclusion of Medicare Part B providers from coverage under Section 1557, as this exclusion is inconsistent with the text and purpose of the law.

Equal Program Access on the Basis of Sex [§92.206]

We recommend that HHS specify in the preamble to the final rule that "health programs or activities" includes medical and end-of-life decision making, to ensure that the wishes of LGBT people with respect to the persons they identify as having decision-making authority are respected without discrimination based on the designated person's sexual orientation or gender identity.

Gender Identity and Sex Stereotypes

The proposed rule rightly recognizes that Section 1557's prohibition of discrimination on the basis of sex includes discrimination based on pregnancy, gender identity, and sex stereotypes. We commend HHS for these clear statements, and specifically the clear affirmation of the key principle recognized across the federal government and by many federal courts:

discrimination based on gender identity, gender expression, gender transition, or transgender status is necessarily a form of sex discrimination. We are pleased to have worked with the administration, and OCR specifically, to further this comprehensive understanding, as noted in footnote 19 of the NPRM. The proposed rule will be a powerful weapon in the ongoing fight to overcome discriminatory barriers to health care for transgender individuals.

Agencies across the federal government have already made it explicit that, under Title VII and other sex discrimination laws, equal opportunity includes equal access to gender-appropriate facilities, consistent with a person's gender identity. The EEOC recently held that an employer's refusal to provide equal access to workplace facilities that are consistent with an employee's gender identity, solely because the employee is transgender, violates Title VII.[103] The Justice Department has also adopted this view in litigation and case resolutions under Title IX[104] and the implementation guidance under the Violence Against Women Act.[105] Numerous other federal agencies have also adopted this view, including the Office of Special Counsel in a 2014 decision;[106] the Department of Labor guidance for the Job Corps programs[107] and other employment and training programs,[108] in proposed sex discrimination rules for federal contractors,[109] and in an employee safety and health guidance released by OSHA;[110] the Department of Education in guidance on single-sex classes and programs under Title IX;[111] and the Department of Housing and Urban Development in guidance for homeless shelters and transitional housing programs.[112] To date, 13 states and the District of Columbia have, by regulations, guidance, case law, or specific statutory language, clarified that state laws prohibiting gender identity discrimination require that transgender individuals have access to sex-segregated facilities consistent with their gender identity.

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[103] Lusardi v. McHugh, E.E.O.C. App. No. 0120133395 (Apr. 1, 2015). *See also* EEOC v. Deluxe Financial Services, Inc., No. 15-cv-02646-ADM-SER (D. Minn. Civ., *filed* June 4, 2015).

[104] Statement of Interest of the United States, *G.G. ex rel. Grimm*, *supra* note 79; Statement of the United States, *Tooley*, *supra* note 79; Resolution Agreement between the Arcadia Unified School District, the U.S. Department of Education, Office for Civil Rights, and the U.S. Department of Justice, Civil Rights Division (OCR No. 09-12-1020) (DOJ No. 169-12C-70) (July 24, 2013); Resolution Agreement between the Downey Unified School District and the U.S. Department of Education, Office for Civil Rights (OCR Case No. 09-12-1095 Oct. 8, 2014).

[105] *See* DEP'T OF JUSTICE, FREQUENTLY ASKED QUESTIONS: NONDISCRIMINATION GRANT CONDITIONS IN THE VIOLENCE AGAINST WOMEN REAUTHORIZATION ACT OF 2013 9 (2013).

[106] Report of Prohibited Personnel Practice, OSC File No. MA-11-3846 (Jane Doe) (Aug. 28, 2014), *available at* https://osc.gov/Resources/2014-08-28_Lusardi_PPP_Report.pdf.

[64] Job Corps Program Instruction Notice No. 14-31, Ensuring Equal Access for Transgender Applicants and Students to the Job Corps Program (May 1, 2015).

[108] Training and Employment Guidance Letter No. 37-14, Training and Employment Guidance Letter on Gender Identity, Gender Expression and Sex Stereotyping (May 29, 2015).

[109] Discrimination on the Basis of Sex, Notice of Proposed Rulemaking, RIN 1250-AA05, 80 Fed. Reg. 5247 (Jan. 30, 2015).

[110] OCCUPATIONAL SAFETY AND HEALTH ADMIN., BEST PRACTICES – A GUIDE TO RESTROOM ACCESS FOR TRANSGENDER WORKERS (2015), *available at* https://www.osha.gov/Publications/OSHA3795.pdf.

[111] DEP'T OF EDUC., QUESTIONS AND ANSWERS ON TITLE IX AND SINGLE-SEX ELEMENTARY AND SECONDARY CLASSES AND EXTRACURRICULAR ACTIVITIES 25 (Dec. 1, 2014).

[112] Dep't of Hous. and Urban Dev., Notice CPD-15-02: Appropriate Placement for Transgender Persons in Single-Sex Emergency Shelters and Other Facilities (Feb. 2015).

We also strongly support the recognition in § 92.206 that health services ordinarily associated with one gender may not be denied or limited based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded in a medical record are different. As the preamble to the proposed rule notes, while individuals generally have the right to be treated according to their gender identity, in the context of health care individuals sometimes need clinical services typically associated with another gender, such as a mammogram, a cervical Pap test, or a prostate exam.[113] Providing such services, where clinically appropriate, recognizes the patient's individual medical needs rather than inaccurately—and in an inherently discriminatory manner—basing the availability of medically necessary health care services solely on gender.

This provision in the rule mandating equal access will have a profound and positive impact on the lives of countless transgender people across the country. As evidence of the need, consider these stories: [114]

> Southern California, March 2014
> Andrea was referred to a urologist by her primary care provider for lingering complications from gender affirming surgery, including a vaginoplasty. When she went to the urologist, she disclosed to the nurse there that she was transgender as part of her clinical history, and told the nurse what surgical procedures she had done. When the doctor came in, the nurse informed him of this, and the doctor registered visible disgust. The doctor then was very brusque towards her and asked her to take off her slacks without giving her anything to cover up with. While she is unclothed from the waist down, the doctor opened the door to the examination room and called in two nurses, and proceeded to talk with them while the door was still open. Two other patients passed by the exam room and saw her while she was unclothed. The doctor then said a nurse was going to examine her. She asked for a female nurse. The doctor said she would have to be examined by "whoever is available." A male nurse came in the room. She asked if he could check whether any female nurses were available. The doctor and nurse ignored this request. During her examination, the doctor said, very loudly, while the door was ajar, "you don't have a vagina," then shortly after, "oh there it is." After the exam, the nurse told her the doctor wanted to do an ultrasound and PSA test, but would not tell

[113] *See, e,g.,* WORLD PROF. ASS'N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER AND GENDER-NONCONFORMING PEOPLE 65-66 (2012), *available at* http://www.wpath.org/uploaded_files/140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf; COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, HEALTH CARE FOR TRANSGENDER INDIVIDUALS, COMMITTEE OPINION NO. 512 (2011), *available at* http://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co512.pdf?dmc=1&ts=20141102T1908581640.

[114] These accounts were provided to NCLR Legal Help Line attorneys; the names have been changed to protect the callers' privacy.

her why. As she was leaving, she heard the doctor make audible sounds of disgust.

Arizona, September 2013
Carla checked herself into a hospital because of a sudden onset of severe headache, vomiting, dizziness, and vision problems. While she was there, she disclosed that she was transgender. The hospital therapist then said that she was suicidal and tried to have her involuntarily confined at a mental health facility. The mental health facility assessed her and found that she was not suicidal and discharged her. Although the symptoms eventually went away, she never got a diagnosis or found out what was physically wrong with her.

Jane was a transgender teenager in Florida who was struggling at school, at home, and personally. She was caught in a vicious cycle of discrimination that delayed her ability to obtain medically necessary care and caused her significant harm. Jane developed a severe eating disorder, which started as means to control the affects of puberty because her doctor would not prescribe puberty-delaying medication, despite the fact that the treatment was consistent with the standard of care. Once the doctor finally agreed to prescribe the medication, he refused to do so until Jane obtained treatment for her eating disorder. Jane wanted that treatment, but none of the available treatment programs would place her on the girls' unit. During this time, Jane experienced a significant deterioration in her mental health and was involuntarily committed on multiple occasions, and each time NCLR and local attorneys had to fight to get the Orlando area hospital to put her on the "girls side" of the unit.

The proposed rule has the potential to remove even more barriers to transgender people receiving care without mistreatment by prohibiting discrimination based on gender identity by health care providers.

Sexual Orientation

As noted above in our comments on the Definitions section, this rule should also prohibit discrimination on the basis of sexual orientation, underscoring the above recommendation to include sexual orientation within the definition of "on the basis of sex." Again, the need is clear: [115]

[115] These accounts were provided to NCLR Legal Help Line attorneys; the names have been changed to protect the callers' privacy.

Northern California, March 2015
Elaine's registered domestic partner,[116] Jenna, was in a serious vehicle accident and had to have surgery and was placed in the ICU. Elaine found out about the accident when the hospital called her to identify Jenna's existing doctor. The hospital refused to provide Elaine with information. When Elaine arrived at the hospital to see Jenna and told the hospital staff that she was Jenna's wife, she was denied access or information. After many hours, Elaine learned that Jenna's mother was with Jenna and again asked that she be permitted to see Jenna as well. When she was again denied and because upset with ICU staff, the ICU staff called hospital security, who called the police. Elaine eventually left when it became apparent that hospital staff would not let her into room with Jenna. Elaine filed a complaint with the hospital after Jenna was discharged, but had no response.

Florida, September 2015
Alice went to a new doctor (she had to find a doctor who was in network for her new insurance) for a yearly physical. When she got there, she filled out the routine paperwork that included a question about her spouse. She included information about her wife. During the examination, the doctor asked her a question about the possibility of getting pregnant and about birth control, and Alice joked that since she was married to a woman, she did not have to worry about unintended pregnancy. At that point, the doctor started to verbally scold and abuse her, saying that she was an "abomination" and that she "hated gay people." Alice asked her to keep her comments to herself and conduct the physical. However, the doctor kept making derogatory comments about gay people. Alice felt so angry and upset that she left without completing the physical.

Northern California, October 2014
James and his late partner Jose were California Registered Domestic Partners, and as such must be treated the same as if they were married under California state law. While Jose was receiving treatment in hospital, Jose's sister visited him and told the hospital to revoke James' visiting privileges. The hospital then refused to let James visit and stopped giving him updates on Jose's condition, despite the fact that he, not Jose's sister, was legally Jose's next of kin. Jose died while in the hospital, and the hospital would not give James information about the handling of Jose's remains. James had to retain an attorney to demand that the funeral home turn over Jose's ashes to him, because hospital had told them not to communicate with him.

[116] California Registered Domestic Partners have the same protections under state law as spouses.

Florida, September 2014
Harold was admitted to a hospital in critical condition after he felt very ill and weak. They placed him in isolation because they thought he might have a contagious disease. After some tests, the hospital told him he had AIDS and that they were going to discharge him because "we don't treat AIDS in this hospital." His sister contacted the hospital and asked that they either treat him or at least provide him with a transfer to another facility that would treat him. The hospital said they would not and that they discharged people "to the street" all the time. Despite him being severely ill, in a weakened state, and unable to walk, the hospital discharged him. His sister had to take two days to drive him to a hospital in her home state, Wisconsin, where he was admitted to an ER there and provided with immediate treatment, and then through the hospital, ongoing outpatient treatment, which resulted in an improvement of his condition and decrease in his viral load. Doctors there told him that at the time he was admitted he was very much at risk of dying.

Proposed § 92.206 requires covered entities to provide "individuals equal access to their health programs or activities without discrimination on the basis of sex . . . ." If discrimination on the basis of sexual orientation is not included in the definition of "on the basis of sex," the proposed rule would not prevent covered entities from denying LGB people equal access to health care programs and activities. As described above, this would discourage LGB patients from revealing their LGB identities, and deny LGB people the proper and necessary medical treatment that they require and deserve.

Moreover, in § 92.206, the proposed rule also states that it is consistent with recent guidance and enforcement actions taken by, among others, the EEOC. As mentioned above, the EEOC decision in *Baldwin v. Foxx* stated three reasons why discrimination on the basis of sexual orientation is discrimination on the basis of sex. The omission of "on the basis of sexual orientation" in the definition of "on the basis of sex" makes the proposed rule inconsistent with EEOC enforcement actions. Throughout the proposed rule, EEOC actions, definitions, and guidance have been given deference. The proposed rule should continue this deference and amend the definition of "on the basis of sex" to include language prohibiting discrimination on the basis of sexual orientation.

Nondiscrimination in Health-Related Insurance and Other Health-Related Coverage [§ 92.207]

Benefit Design

We welcome the recognition that care must be taken to ensure that health insurers cannot circumvent the nondiscrimination protections in the Affordable Care Act by employing discriminatory benefit designs or marketing practices when providing or administering health

insurance or coverage. We have identified several areas in particular where issuers frequently employ practices or benefit designs that specifically discriminate against LGBT individuals, people living with HIV, and other vulnerable groups. These practices include:

- Placing entire classes of critical medications, such as those used to treat HIV, in high cost-sharing tiers in prescription drug formularies;
- Establishing narrow provider networks that exclude certain types of specialists; and
- Employing arbitrary, unreasonable, or otherwise discriminatory utilization management practices, such as transgender-specific exclusions or standards for determining medical necessity that are not based on the most up-to-date and medically sound consensus of experts in the relevant field.

We urge HHS to ensure that the final rule clearly prohibits such facially discriminatory practices, regardless of whether they are motivated by a discriminatory purpose.

Sexual Orientation

Section 92.207(a) of the proposed rule sets forth a general prohibition against discrimination in health insurance based on race, color, national origin, sex, age, or disability. As noted above, we strongly urge the Department to expressly provide that this include discrimination based on sexual orientation. The need is undeniable. Consider the following examples:[117]

> Florida, June 2015
> Paul's employer told him he had to wait until an open enrollment period to add his husband to his health plan because they were already married, even though previously the health plan would not allow him to add his husband.
>
> Colorado, July 2015
> Rani and her wife are trying to conceive a child. Their insurance provider would not cover their fertility treatment because they were using donor sperm.
>
> Maryland, December 2014
> Patricia and her wife are trying to conceive a child. Their insurance provider said that although they do cover IUI, they would only do so if the patient was married and using the spouse's sperm.
>
> New York, August 2014
> Tina and her wife are trying to conceive a child. When they contacted their insurance, they were told that because they are not considered "infertile"

[117] These accounts were provided to NCLR Legal Help Line attorneys; the names have been changed to protect the callers' privacy.

> because they were choosing to be in a same-sex relationship, that the insurer would not cover assisted reproduction treatments.

If the final rule fails to include sexual orientation discrimination under sex discrimination, some of the proposed provisions could prove problematic. In the provision and administration of health-related insurance or other health-related coverage, proposed §92.207 emphasizes and provides details regarding the prohibition of discrimination on the basis of sex, among other things. The proposed rule mentions that §92.207 is independent of, but complements, the non-discrimination provisions at 45 CFR 155.120(c)(1) and (2), and at 45 CFR 156.200(e), all of which prohibit the Exchanges and Qualified Health Plan Providers (as defined in 45 CFR 155.20 and 156.20 respectively) from discriminating on the basis of gender identity and sexual orientation. There are certain entities, such as health providers that do receive federal funding from HHS, but are not exchange listed, that the aforementioned provisions would not apply to, and for which the proposed rule would be the only nondiscrimination provision. This gap in protection against sexual orientation discrimination would create a checkered system where certain entities would be allowed to discriminate against LGB people, whereas others would not. In order to provide consistent and the most robust protections, the proposed rule should include the "on the basis of sexual orientation" in the definition of "on the basis of sex."

Gender Identity

We applaud the explicit enumeration in 92.207(b)(4) that blanket exclusions of coverage for transition-related care are prohibited under this rule, and in 92.207(b)(5) that denials or limitations on coverage for specific health services related to gender transition that result in discrimination against transgender individuals is also proscribed. The ACA has ameliorated several longstanding barriers to coverage for transgender people, such as unaffordable premiums and the insurer practice of limiting coverage by designating a transgender identity as a "pre-existing condition." However, many private plans, as well as many state Medicaid programs, continue to discriminate on the basis of gender identity by using categorical exclusions to deny transgender individuals coverage for the same or substantially similar services that are covered for non-transgender people. For instance, 45 of the 51 proposed 2017 state Essential Health Benefit benchmark plans identified by CMS contain exclusions that explicitly limit the services and benefits available to transgender individuals on the basis of gender identity.

Like anyone, transgender individuals need preventive care to stay healthy and acute care when they become sick. Some may also seek medical treatment to bring their bodies into closer alignment with their gender identity. Expert medical organizations such as the American Medical Association, the American Psychological Association, the American Psychiatric Association, the American Academy of Family Physicians, the Endocrine Society, the American College of Obstetricians and Gynecologists, and the World Professional Association for Transgender Health agree that transition-related care is medically necessary

for transgender people who experience clinically significant distress related to a profound misalignment between their gender identity and their assigned birth sex.[118]

The procedures that may be medically necessary for a transgender individual as part of care related to gender transition are regularly prescribed for other medical indications for non-transgender individuals. The hormone therapy involved in gender transition, for example, is the same as that prescribed for endocrine disorders, such as hypogonadism, or women with menopausal symptoms.[119] The reconstructive surgical procedures that may be used in gender transition are regularly covered by insurance companies for non-transgender individuals for purposes such as treating injuries, or for cancer treatment or prevention.[120]

As an illustration of the critical need for these insurance nondiscrimination provisions, below are several examples of instances in which insurance coverage for needed medical care was denied to transgender persons:[121]

> Northern California, January 2015
> Lisa's son is transgender and his treating doctor recommended puberty blockers to be administered through an implant. Their insurance carrier, Blue Shield, denied coverage, based on language in the plan that excludes coverage for services for "transgender or gender dysphoria conditions."
>
> Pennsylvania, June 2015
> Jason has not been able to find any insurer that will sell him a plan that covers transition-related care. He contacted the state healthcare exchange and was told that there is no way to find a plan that will cover care related to being transgender. He also contacted Aetna, Blue Cross, and United and was told no plans were available to him. Aetna told him that unless it was required by law, they would not issue such a plan.
>
> Washington, March 2015
> Lucy's daughter has been prescribed hormones for gender transition that cost almost $3000 a month. Their insurance plan initially approved coverage for

[118] *See* LAMBDA LEGAL, PROFESSIONAL ORGANIZATION STATEMENTS SUPPORTING TRANSGENDER PEOPLE IN HEALTH CARE (2013), *available at* http://www.lambdalegal.org/sites/default/files/publications/downloads/fs_professional-org-statements-supporting-trans-health_4.pdf. *See also* AM. ACAD. OF PHYSICIAN ASSISTANTS, COMPREHENSIVE HEALTH CARE REFORM (2013), *available at* https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=787 (opposing "arbitrary condition-based exclusions").

[119] Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*. J. CLINICAL ENDOCRINOLOGY & METABOLISM, 3132 (2009).

[120] National Coverage Determination – Transsexual Surgery, Dep't of Health and Human Servs., NCD 140.3, Docket No. A-13-87, Decision No. 2576, 12 (May 30, 2014), *available at* http://www.hhs.gov/dab/decisions/dabdecisions/dab2576.pdf.

[121] These accounts were provided to NCLR Legal Help Line attorneys; the names have been changed to protect the callers' privacy.

these hormones, but later told them this approval was a mistake, and stopped coverage. They were told that although the insurance company did cover these medications when plans were fully insured, because this plan was a self-insured plan that the company was just administering (i.e., employer bore the risk/costs), and their employer had specifically requested that transition related care not be covered, that they would not cover these medications.

Missouri, June 2014
Lydia was seeking hair removal as medically necessary care to treat her gender dysphoria. Missouri's Medicaid provider told her that this was considered a cosmetic surgery, and they would not cover it.

New York, May 2014
Charles is a transgender man seeking a mastectomy as medically necessary care to treat his gender dysphoria. His insurance will cover the mastectomy, but will not cover nipple reconstruction, claiming it is cosmetic, even though the insurance does cover breast reconstruction (including nipple reconstruction) in cases where a non-transgender woman has undergone a mastectomy for other health conditions.

As a result of these types of insurer practices in conjunction with other drivers of uninsurance such as poverty, in 2013 the uninsured rate among low- and middle-income transgender people was a staggering 59 percent.[122] Because they block access to vital health care services, transgender-specific insurance exclusions are also significant contributors to health disparities such as high rates of mental and behavioral health concerns, suicide attempts, experiences of abuse and violence, and HIV infection.[123] We therefore very strongly support the clarification in the proposed rule that such categorical exclusions are facially discriminatory and prohibited under Section 1557.

In fully addressing the issue of transgender-specific exclusions, we appreciate the request for comments "as to whether the approach of § 92.207(b)(1)-(5) is over- or under-inclusive of the types of potentially discriminatory claim denials experienced by transgender individuals in their attempts to access coverage and care, as well as on how nondiscrimination principles apply in this context." As more insurance carriers lift categorical exclusions for care related to gender transition, we are concerned that some carriers will continue to deny medically necessary care to transgender individuals in a discriminatory manner even in the absence of a categorical exclusion.

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[122] KELLAN E. BAKER ET AL., CTR. FOR AM. PROGRESS, MOVING THE NEEDLE: THE IMPACT OF THE AFFORDABLE CARE ACT ON LGBT COMMUNITIES 3-4 (Nov. 2014), *available at* https://cdn.americanprogress.org/wp-content/uploads/2014/11/LGBTandACA-report.pdfhttps://cdn.americanprogress.org/wp-content/uploads/2014/11/LGBTandACA-report.pdf.

[123] *See, e.g.*, INST. OF MED., THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE: BUILDING A FOUNDATION FOR BETTER UNDERSTANDING 65 (2011).

For example, many insurance carriers continue to deny coverage for medically necessary services needed by transgender individuals by claiming that procedures used in gender transition are unique because surgical techniques may be different for transgender versus non-transgender patients. However, these differences do not substantially change the nature of the procedures: they are simply analogous to differences in the manner in which many different surgical procedures are performed. The choice of techniques for surgeries such as joint replacements or hysterectomies, for instance, varies on the basis of considerations such as the patient's weight and age, as well as clinical indications regarding which technique is appropriate for an individual patient's situation (e.g., depending on a variety of factors, a hysterectomy can be performed as an abdominal hysterectomy, vaginal hysterectomy, or laparoscope-assisted vaginal hysterectomy[124]). Some examples of procedures used to treat gender dysphoria that are substantially similar to those needed by non-transgender people to treat other conditions include, but are not limited to:

- Nipple grafts following chest reconstruction are substantially similar to nipple grafts needed by non-transgender women following mastectomy or breast reconstruction;
- Hysterectomy to treat gender dysphoria is substantially similar to hysterectomy for cancer treatment or prevention for non-transgender women;
- Vaginoplasty to treat gender dysphoria is substantially similar to vaginoplasty for non-transgender women with conditions such as Mayer-Rokitansky-Küster-Hauser Syndrome (MRKH);
- Phalloplasty to treat gender dysphoria is substantially similar to phalloplasty following disfiguring genital injuries;
- Orchiectomy to treat gender dysphoria is substantially similar to orchiectomy for cancer treatment for non-transgender men; and
- Facial reconstructive procedures to treat gender dysphoria are substantially similar to facial reconstructive procedures following disfiguring injuries to the face, head, or neck.

We urge HHS to clarify in § 92.207(b)(5) that carriers must provide coverage for a procedure or service used to treat gender dysphoria as long as they cover a substantially similar procedure or service for other conditions.

Relatedly, we are concerned about the ramifications of the statement in § 92.207(d) that nothing in the section is intended to restrict a covered entity from determining whether a service is medically necessary or meets coverage requirements in an individual case. There may be instances in which the process that the covered entity uses to determine whether a service is medically necessary or otherwise eligible for coverage is itself discriminatory. In our experience, plans frequently assess medical necessity for services needed by transgender

[124] Santiago Domingo and Antonio Pellicer, *Overview of Current Trends in Hysterectomy,* 4(6) EXPERT REV. OF OBSTETRICS & GYNECOLOGY 673 (2009).

individuals according to outdated, inaccurate, or even blatantly discriminatory standards for medical necessity, rather than consistent with the prevailing standards of care.

In determining whether a service is medically necessary for a transgender individual, the carrier should evaluate whether the service is medically necessary to treat gender dysphoria. In some circumstances, implementing a nondiscriminatory policy based on medical necessity will require an insurance carrier to provide services for treating gender dysphoria that are sometimes considered cosmetic and therefore not covered when sought for non-medically necessary reasons, but that are generally designated as reconstructive and covered for non-transgender persons with other medical conditions. For example, a procedure such as augmentation mammoplasty, which may be considered cosmetic and excluded from coverage when sought simply as a matter of personal preference, may be medically necessary in the context of gender dysphoria, just as breast reconstruction would be covered for a non-transgender woman who lost her breasts to illness or accident. The essential purpose of transition-related treatment, whether it is genital reconstructive surgery, hormone replacement therapy, or any other gender-affirming procedure or service, is to therapeutically treat gender dysphoria, not to improve a person's appearance. As such, insurance carriers should not be permitted to maintain protocols that categorically exclude particular procedures as always cosmetic and therefore never medically necessary. For procedures that are sometimes excluded when sought merely as a matter of personal preference, but that may be medically necessary to treat gender dysphoria, decisions regarding coverage must be made on an individual basis according to the patient's medical history, physician orders, and the prevailing standards of care.[125]

The multifaceted nature of insurance discrimination against transgender individuals means that the provisions at §§ 92.207(b)(3), (4), and (5) are **all** vital to ensuring that transgender people are able to access the health coverage and care they need. We strongly urge HHS to preserve all three of these provisions in the final rule, with the modifications suggested below. We also strongly urge HHS to amend § 92.207(d) to ensure that carriers cannot use standards for determining medical necessity that are themselves inherently discriminatory.

[125] The Medicare Benefit Policy Manual, for instance, clarifies that its definition of cosmetic procedures includes an exception for surgeries that are therapeutically necessary, despite coincidentally serving some cosmetic purpose. CTRS. FOR MEDICARE AND MEDICAID SERVS., MEDICARE BENEFIT POLICY MANUAL, CHAPTER 16 - GENERAL EXCLUSIONS FROM COVERAGE - 120 - COSMETIC SURGERY (2014), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf (stating, "Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.")

RECOMMENDATIONS:

- Maintain § 92.207(b)(3) without any changes and amend the proposed provisions at §§ 92.207(b)(4)-(5) as follows:

  (4) Categorically or automatically exclude from coverage, or limit coverage for, ~~all~~ health services related to gender transition**, including gender reassignment surgeries and other services or procedures described in the most current version of the recognized professional standard of medical care for transgender individuals**; or

  (5) Otherwise deny or limit coverage, or deny a claim, for specific health services related to gender transition if such denial or limitation results in discrimination against a transgender individual. **A denial or limitation results in discrimination if, inter alia, (a) an individual is denied coverage for services to treat gender dysphoria even though substantially similar services are covered for treatment of other conditions, (b) a medically necessary service for treating gender dysphoria is denied solely because that service is designated as categorically cosmetic or as reconstructive when provided to non-transgender persons to treat other medical conditions (c) an individual is denied access to medically necessary health services that are in accordance with the most current version of the recognized professional standard of medical care for transgender individuals.**

- Amend § 92.207(d) as follows:

  Nothing in this section is intended to determine, or restrict a covered entity from determining, whether a particular service is medically necessary or otherwise meets applicable coverage requirements in any individual case, **provided that the determination of medical necessity or meeting applicable coverage requirements is not itself discriminatory and does not result in discrimination**.

§ 92.209 Nondiscrimination on the Basis of Association

We applaud the inclusion of the explicit prohibition against nondiscrimination on the basis of association. This language is critical for protecting members of many vulnerable groups from discrimination, such as people with disabilities and lesbian, gay, or bisexual individuals in relationships with a same-sex partner.

The proposed rule's language mirrors that of Title I and Title III of the Americans with Disabilities Act (ADA), which have been understood to protect against discrimination based on association or relationship with a disabled person.[126] Section 1557 should, therefore, be

[126] 42 U.S.C. §§ 12112, 12182 (2012).

interpreted to provide at least the same protections for both patients and health care providers and provider entities. In accordance with the ADA, this provision in the proposed rule should extend its protections to providers of health care and other professional services, who are at risk of associational discrimination due to their professional relationships with patients or clients, including those belonging to classes protected under Section 1557.[127] For these purposes, the rule should further state that unlawful discrimination based on association occurs when a provider is subject to adverse treatment because it is known or believed to furnish, refer for, or support services that are medically appropriate for, ordinarily available to, or otherwise associated with a patient population protected by Section 1557. This interpretation would, for instance, prohibit covered entities from using the provision of sex-specific services, such as abortion, as a disqualifying factor in recruiting otherwise eligible and qualified providers for participation in health programs supported by HHS. Providers should not be penalized for offering to competently care for a class of individuals with particular medical needs.

RECOMMENDATION: We recommend amending § 92.209 to include the following additional language consistent with the ADA's prohibition on associational discrimination and the broad, remedial purposes of Section 1557.

> **(a) General.** A covered entity shall not exclude **or deter** 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, age, disability, or sex of an individual with whom the individual or entity is known or believed to have a relationship or association.
>
> **(b) Providers of health care or other related professional services. For the purposes of this section, the term "individual or entity" shall include individuals or entities that provide health care and other related professional services to individuals. Discrimination on the basis of association shall include any action by a covered entity to exclude or deter from participation in, deny the benefits of, or otherwise discriminate against a provider in its health programs or activities based on the services the provider is known or believed to provide, refer for, or support that are medically appropriate for, ordinarily available to, or otherwise associated with individuals of a certain race, color, national origin, age, disability, or sex.**

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[127] 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").

NCLR and MAP applaud the Department's effort to promulgate a groundbreaking rule that will provide essential protections for women and LGBT people in the health care arena. We look forward to working with you to further this important goal.

Sincerely,

National Center for Lesbian Rights
and
Movement Advancement Project

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

November 9, 2015

Director Jocelyn Samuels
Office for Civil Rights
Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue, SW
Washington, D.C. 20201

Submitted Electronically

Attention: 1557 NPRM RIN 0945-AA02

RE: Notice of Proposed Rulemaking Regarding Nondiscrimination in Health Programs and Activities

Dear Director Samuels:

The National Women's Law Center (the Center) appreciates the opportunity to comment on the Department of Health and Human Services' (the Department) and the Office for Civil Rights' (OCR) proposed rule (Proposed Rule) implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA), which for the first time provides broad federal protection against sex discrimination in health care and health insurance—properly understood to include discrimination based on gender identity, sexual orientation, sex stereotypes, and pregnancy—and importantly expands existing protections against health care discrimination based on race, color, national origin, age, and disability. Establishing strong and effective regulations implementing and enforcing Section 1557 of the ACA is key to ending discrimination in health care. Such efforts are necessary to effectuate Congress's strong intent to eliminate discrimination in health care and health insurance as evidenced throughout the legislative history and language of the ACA, including particularly sex discrimination.

Section 1557 marks the first time that federal law contains a broad-based prohibition on sex discrimination in health programs or activities. Sex discrimination takes many forms and can occur at every step in the health care system—from obtaining insurance coverage to receiving proper diagnosis and treatment. This discrimination seriously harms women and threatens their health, causing them to pay more for health care and health insurance and to risk receiving improper diagnoses and less effective treatments.

Since 1972, the Center has worked to achieve gains for women and their families in health and reproductive rights, education, employment, family economic security, and other critical areas. The Center has championed efforts to ensure that women receive the health care they need,

including reproductive health care. To that end, the Center has long worked to end sex discrimination in health care, including its work to ensure passage of Section 1557 and its advocacy for implementation and robust enforcement of Section 1557 consistent with Congress' intent in enacting this provision.

The Center commends the Department for proposing a rule that recognizes the ACA's purpose by establishing many of the principles necessary to end sex discrimination in health care and health insurance. Specifically, the Center strongly supports:

- The proposed definition of "Federal financial assistance," which states that all tax credits created by Title I of the ACA, as well as any funds extended by the Department to pay for health insurance coverage, are considered Federal financial assistance. This will go a long way towards fully eradicating discrimination in health insurance and is required by the language and intent of the ACA;
- Defining "health program or activity" to make clear that Section 1557 reaches *all* the operations of an entity principally engaged in providing or administering health services or health insurance coverage, including employee health benefits, when any part of it receives Federal financial assistance;[1] importantly, as a result, if a health insurance issuer participates in the Marketplaces or receives Medicare Part D payments for any of its plans, then all the plans sold by that issuer will be covered by Section 1557. This approach, which appropriately relies on the Civil Rights Restoration Act, establishes the broad reach of Section 1557's protections;
- The explicit inclusion of "pregnancy, false pregnancy, termination of pregnancy or recovery therefrom, childbirth or related medical conditions, sex stereotyping, or gender identity" in the definition of "on the basis of sex." This definition properly relies on established definitions of sex discrimination included in the implementing regulations for Title IX as well as current guidance from the Equal Employment Opportunity Commission and case law;[2] and
- The Proposed Rule's recognition of a private right of action to challenge discrimination by federally funded health programs and activities or by the Marketplaces. A private right of action is established under Title IX, Title VI, Section 504, and the Age Discrimination Act forming the predicate for enforcement of Section 1557 and is necessary to adequately protect individuals from and provide relief for discrimination by covered entities.

[1] However, as discussed in more detail in Section VI, the Center does not support the proposed rule's exclusion of other forms of employment discrimination.

[2] 34 C.F.R. § 106.40(b)(1) (2015). *See also* Pfeiffer v. Marion Ctr. Area Sch. Dist., 917 F.2d 779, 784 (3d Cir. 1990); Hogan v. Ogden, No. CV-06-5078-EFS, 2008 U.S. Dist. LEXIS 58359, at *26 (E.D. Wash. July 30, 2008); Chipman v. Grant Cty. Sch. Dist., 30 F. Supp. 2d 975, 977-78 (E.D. Ky. 1998); Hall v. Lee Coll., 932 F. Supp. 1027, 1033 n.1 (E.D. Tenn. 1996); Cazares v. Barber, Case No. CIV-90-0128-TUC-ACM, slip op. (D. Ariz. May 31, 1990); Wort v. Vierling, Case No. 82-3169, slip op. (C.D. Ill. Sept. 4, 1984), *aff'd*, 778 F.2d 1233 (7th Cir. 1985); Newport News Shipbuilding & Dry Dock v. EEOC, 462 U.S. 669, 684 (1983) ("The 1978 Act makes clear that it is discriminatory to treat pregnancy-related conditions less favorably than other medical conditions.").

The Center strongly supports the Department's inclusion of these protections in the Proposed Rule and urges the Department to further strengthen the final rule (Final Rule) as set out below. The Center also urges the Department in the strongest terms to move expeditiously in finalizing and implementing the Final Rule, delivering on Section 1557's critically important protections.

I. § 92.2 Applications

a. *The Department Has Government-Wide Enforcement Authority*

As lead agency for enforcement of Section 1557, the Department must work aggressively to ensure that Section 1557 is broadly and promptly implemented across the federal government. Section 1557 expressly delegates rulemaking authority to the Department.[3] This delegation of authority specifically to the Department differs markedly from other similar civil rights statutes addressing Federally funded programs and activities, wherein Congress has directed agencies to separately develop their own implementing rules.[4] The Department thus has the authority to promulgate government-wide regulations implementing Section 1557 for all health programs and activities that receive Federal financial assistance and for all federally-operated health programs and activities.[5]

The Department proposes that the Proposed Rule only reaches health programs and activities funded or administered by the Department (as well as entities established under Title I of the ACA). However, consistent with its broad congressionally-delegated authority, the Department's Section 1557 regulation should apply to *all* federally-administered health programs and activities and all health programs and activities, any part of which receive Federal financial assistance. Such broad application is not only permitted by the text of Section 1557, it is also wholly appropriate as a matter of policy. Given the Department's expertise in health care, in administration of nondiscrimination laws in the context of health programs and activities, and in the implementation of Section 1557 since the ACA's passage, it is clearly the

[3] 42 U.S.C. § 18116(c) (2012).

[4] *See* Title VI, Civil Rights Act 42 U.S.C. § 2000d-1 (2012) ("*Each Federal department and agency* which is empowered to extend Federal financial assistance to any program or activity . . . is authorized and directed to effectuate the provisions of section 2000d of this title . . . ." (emphasis added)); Title IX, Education Amendments 20 U.S.C. § 1682 (2012) ("*Each Federal department and agency* which is empowered to extend Federal financial assistance to any program or activity . . . is authorized and directed to effectuate the provisions of section 1681 of this title . . . ." (emphasis added)); Age Discrimination Act 42 U.S.C. § 6103(a)(4) (2012) ("[A]fter the Secretary publishes final general regulations under paragraph (a)(3), the head of *each Federal department or agency* which extends Federal financial assistance to any program or activity . . . shall transmit to the Secretary and publish in the Federal Register proposed regulations to carry out the provisions of section 6102 of this title . . . ." (emphasis added)); Rehabilitation Act 29 U.S.C. § 794(a) (2012) ("The head of each such [Executive] agency [and United States Postal Service] shall promulgate such regulations as may be necessary to carry out the amendments to this section made by the Rehabilitation, Comprehensive Services, and Developmental Disabilities Act of 1978 . . . .").

[5] Because Congress explicitly delegated rulemaking authority to the Department such rulemaking will be entitled to Chevron deference. Chevron U.S.A., Inc. v. Nat. Res. Def. Council, Inc., 467 U.S. 837, 842-43 (1984) (holding that courts should defer to agency interpretation of enabling statutes as long as the interpretation is reasonable).

agency best suited for creating regulations that ensure that Section 1557's intended protections be put into effect. Consistent regulations across all agencies would also promote the equal and uniform application of the provision's protections to all health programs and activities that receive Federal financial assistance.[6]

If the Department nevertheless chooses not to use its clear rulemaking authority to apply the Final Rule government-wide, then as the agency in which the statute vests primary enforcement power, and thus the lead agency for enforcement of Section 1557, it must collaborate expeditiously with other federal agencies to effect its provisions, in cooperation with the Department of Justice (DOJ) in DOJ's role as coordinating agency for implementation and enforcement of antidiscrimination rules applicable to recipients of Federal financial assistance.[7] The Department and DOJ should seek to ensure that other agencies enter into delegation agreements or memoranda of understanding granting the Department interpretation and enforcement authority over health programs and activities funded and administered by these agencies or, alternatively, move quickly to adopt the standards set out by the Department through their own rulemaking procedures. The Center notes that delegation agreements or formal statements of policy agreement between agencies, such as Memoranda of Agreement, would be far more efficient than many separate rulemakings across agencies and would ensure that Section 1557's protections are efficiently and uniformly implemented for all health programs and activities that receive Federal financial assistance and all federally-operated health programs and activities. In these collaboration efforts, the Department should prioritize those agencies with significant involvement in health care, such as the Department of Veterans Affairs, the Department of Education (given that many educational institutions operate student health care services), the Office of Personnel Management, and the Peace Corps (given its responsibility for providing health care to volunteers). The Final Rule should address the methods by which the Department will ensure implementation of Section 1557 across the federal government.

b. The Department Must Not Craft Exceptions From the Sex Discrimination Prohibition

The Proposed Rule appropriately does not incorporate any exceptions from Section 1557's prohibition on sex discrimination. However, the preamble seeks comment as to whether any exceptions should be added, such as Title IX's exceptions from its prohibition on sex

[6] *Cf.* United States Merit Sys. Prot. Bd. v. Fed. Labor Relations Auth., 913 F.2d 976 (D.C. Cir. 1990) (holding that regulations promulgated by OPM pursuant to the Civil Service Reform Act are "binding on all federal agencies."); 40 C.F.R. § 1500.3 (2015) (stating that regulations issued pursuant to the National Environmental Policy Act by the Council on Environmental Policy are "applicable to and binding on all Federal agencies.").

[7] Exec. Order No. 12,250, 3 C.F.R. § 298 (1980) ("The Attorney General shall coordinate the implementation and enforcement by Executive agencies of various nondiscrimination provisions of . . . [a]ny other provision of Federal statutory law which provides, in whole or in part, that no person in the United States shall, on the ground of race, color, national origin, handicap, religion, or sex, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance.").

discrimination in education programs or activities.[8] The Department further asks if the Proposed Rule "appropriately protects religious beliefs" and if any additional exception should be included to address religion.[9] No such exceptions should be added.

i. Section 1557's Prohibition on Sex Discrimination Is Necessary to End Longstanding Discrimination in Health Care

Prior to Section 1557, there were no broad federal protections against sex discrimination in health care or health insurance. In the absence of such protection, sex discrimination resulted in women paying more for health care, receiving improper diagnoses more frequently, being provided less effective treatments, and sometimes being denied care or health insurance coverage altogether.

Section 1557 was intended to provide robust protection against discrimination on the basis of sex, as the cornerstone of Congress' particular focus on addressing sex discrimination throughout the ACA.[10] Indeed, several important ACA provisions were enacted specifically to correct insurer practices that discriminated against women either on their face or in their effect.[11] As Section 1557 and these provisions make clear, ending health care and health insurance practices that in their intent or in their effect discriminated against women was a primary purpose of the ACA.

[8] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,173 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).
[9] *Id.*
[10] *E.g.*, 156 CONG. REC. H1632-04 (daily ed. March 18, 2010) (statement of Rep. Lee) ("While health care reform is essential for everyone, women are in particularly dire need for major changes to our health care system. Too many women are locked out of the health care system because they face discriminatory insurance practices and cannot afford the necessary care for themselves and for their children."); 156 CONG. REC. H1891-01 (daily ed. March 21, 2010) (statement of Rep. Pelosi) ("It's personal for women. After we pass this bill, being a woman will no longer be a preexisting medical condition."); 155 CONG. REC. S12,026 (daily ed. Oct. 8, 2009) (statements of Sen. Mikulski) ("[H]ealth care is a women's issue, health care reform is a must-do women's issue, and health insurance reform is a must-change women's issue because . . . when it comes to health insurance, we women pay more and get less."); 155 CONG. REC. S10,262-01 (daily ed. Oct. 8, 2009) (statement of Sen. Boxer) ("Women have even more at stake. Why? Because they are discriminated against by insurance companies, and that must stop, and it will stop when we pass insurance reform."); 156 CONG. REC. H1854-02 (daily ed. March 21, 2010) (statement of Rep. Maloney) ("Finally, these reforms will do more for women's health . . . than any other legislation in my career.").
[11] 42 U.S.C. 300gg(a) (2012) (allowing rating based only on family size, tobacco use, geographic area, and age but not based on gender, thereby eliminating a long standing discriminatory practice); 42 U.S.C. 300gg-3 (2012) (prohibiting preexisting condition exclusions which were often used to discriminate against women in part because several of the conditions excluded by insurers primarily affect women and because women are more likely than men to suffer from chronic conditions); 45 C.F.R. § 147.104(e) (2015) (prohibiting discrimination in marketing and benefit design, including on the basis of sex).

ii. The Only Exceptions to Section 1557's Broad Nondiscrimination Mandate Are Specifically and Explicitly Contained in Title I of the ACA Itself

Section 1557 does not by its terms import any exceptions from Title IX or from any other statute. It references Title VI, Title IX, Section 504, and the Age Act solely for the grounds on which they prohibit discrimination (race, color, national origin, sex, disability, and age) and for their enforcement mechanisms.[12] Section 1557's ban against discrimination in health programs or activities includes a single exception – that it applies "[e]xcept as otherwise provided" in Title I of the ACA. The plain language of the statute bars any interpretation that would suggest 1557's prohibition of sex discrimination incorporates the Title IX exceptions or any other exceptions.

Exceptions to general rules like Section 1557's ban on discrimination must be read strictly and narrowly. For example, in considering the same "except as otherwise provided" language in the Americans with Disabilities Act (ADA), the Eleventh Circuit found that language captured only those expressly mentioned in the statute.[13] In that case, the Eleventh Circuit held that the limiting language of "except as otherwise provided" precluded the importation of more restrictive language from the Rehabilitation Act into the ADA. The same principles apply here, as the Rule elsewhere acknowledges. While the Proposed Rule incorporates "exceptions" from Title VI, Section 504, and the Age Act set out at 45 C.F.R. §§ 80.3(d), 84.4(c), 85.21(c), 91.12-.15, 91.17-.18 (2015), these incorporated provisions by and large do not actually set out exceptions from the relevant antidiscrimination mandates.[14] Rather, they clarify that certain programs targeted to meet the particular needs of specific protected groups within the protected class are not properly considered discrimination.[15] This is different in kind from, for example, Title IX's exception completely carving out educational institutions training individuals for military service from its otherwise applicable nondiscrimination mandate.[16] Section 1557's clear text does not permit incorporation of the latter sort of carve-out.

Moreover, as the preamble to the Proposed Rule states, Title IX's exceptions, which are narrowly focused on the educational context, make little sense in the context of health programs and activities.[17] For all these reasons, the Final Rule should not incorporate Title IX exceptions into the prohibition against discrimination on the basis of sex. The only exceptions

[12] The Supreme Court held in a similar context that the incorporation by reference of protections from one civil rights statute into another does not mean that the limitations of the first apply to the second. *See* Consol. Rail Corp. v. Darrone, 465 U.S. 624 (1984) (holding that Section 504's reference to Title VI's remedies, procedures, and rights did not import limitations from Title VI not expressly provided in Section 504).

[13] McNely v. Ocala Star-Banner Corp., 99 F.3d 1068, 1073-74 (11th Cir. 1996).

[14] *See, e.g.*, 45 C.F.R. § 84.4(c) (2015).

[15] *See, e.g., Id.* ("The exclusion of nonhandicapped persons from aids, benefits, or services limited by Federal statute or executive order to handicapped persons . . . is not prohibited by this part.").

[16] *See* 20 U.S.C. § 1681(a)(4) (2012).

[17] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,173. Title IX's exceptions for social fraternities or sororities, scholarship awards in beauty pageants, and Girls State conferences, for example, are irrelevant at best in the context of Section 1557. *See* 20 U.S.C. § 1681(a)(6), (7), (9).

permitted to Section 1557's sex discrimination prohibition are those exceptions expressly stated in Title I of the ACA.

iii. Not Only Does the Plain Language of Section 1557 not Permit a Religious Exemption, Such an Exemption Would Be Contrary to the Express Purpose of Section 1557 and Would Cause Great Harm

Nothing in the text of Section 1557 authorizes the addition of a religious exemption—and certainly no law or policy rationale justifies singling out sex as the sole basis of discrimination for such an exemption.

Moreover, any such exception, from Section 1557's antidiscrimination requirement in general and from the sex discrimination prohibition in particular, would be contrary to the express purpose of Section 1557. Section 1557 was meant to ensure that discrimination does not infect health care or health insurance. This compelling government interest must not be undermined by allowing religion to be used to opt out of its very provisions.

Courts have long rejected arguments that religiously-affiliated organizations can ignore anti-discrimination requirements.[18] Instead, courts have recognized that the government has a compelling interest in ending discrimination and that anti-discrimination statutes are the least restrictive means of doing so. Indeed, the majority opinion in *Burwell v. Hobby Lobby Stores, Inc.,* makes it clear that the decision should not be used as a "shield" to escape legal sanction for discrimination in hiring on the basis of race because such prohibitions further a "compelling interest in providing an equal opportunity to participate in the workforce without regard to race," and are narrowly tailored to meet that "critical goal."[19] The same principles apply here. Section 1557 was narrowly tailored to end longstanding discrimination in health care and the Department must not create a religious exemption, as it would undermine the law's very purpose.

Moreover, adding a religious exemption has the potential to cause great harm. There has been a proliferation both in the health care services to which entities are claiming religious objections and in the scope of entities subject to religious-based directives that prohibit certain kinds of care.

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[18] *See e.g.,* Bob Jones Univ. v. United States, 461 U.S. 574 (1983) (holding that the government's interest in eliminating racial discrimination in education outweighed any burdens on religious beliefs imposed by Treasury Department regulations); Newman v. Piggie Park Enters., Inc., 390 U.S. 400 (1968) (holding that a restaurant owner could not refuse to comply with the Civil Rights Act of 1964 and not serve African-American customers based on his religious beliefs); Dole v. Shenandoah Baptist Church, 899 F.2d 1389, 1392 (4th Cir. 1990) (holding a religious school could not compensate women less than men based on the belief that "the Bible clearly teaches that the husband is the head of the house, head of the wife, head of the family . . . ."); and Hamilton v. Southland Christian Sch., Inc., 680 F.3d 1316 (11th Cir. 2012) (reversing summary judgment for religious school that claimed a religious right to fire teacher for becoming pregnant outside of marriage).

[19] Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751, 2783 (2014).

Religion has been invoked in countless ways to deny individuals access to health insurance and an increasingly broad range of health care services, including birth control,[20] sterilization,[21] certain infertility treatments,[22] abortion,[23] transition-related services for transgender individuals,[24] and end of life care.[25] LGBT individuals have been denied appropriate mental health services and counseling[26]; a newborn was denied care because her parents were lesbians[27]; married female employees were denied health insurance coverage because they were not "head of household"[28]; a woman suffering a miscarriage was denied prescription medication[29]; and an individual was denied his HIV medication,[30] all because of someone else's religious beliefs. Not only can such denials of care directly endanger a patient's health, but they also lead to distrust of the health care system, which can have significant public health consequences.[31]

At the same time that religious beliefs have been asserted to impede access to a growing range of health care services, religious health care entities are expanding. For example, ten of the twenty-five largest hospital systems in the U.S. are Catholic-affiliated, and in 2010 about one-sixth of all patients were admitted to such a hospital.[32] These hospitals have some affiliation with the Catholic religion and elect to follow Catholic health care teachings, which impose

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[20] NAT'L WOMEN'S LAW CTR., HEALTH CARE REFUSALS HARM PATIENTS: THE THREAT TO REPRODUCTIVE HEALTH CARE (May 2014), http://www.nwlc.org/sites/default/files/pdfs/refusals_harm_patients_repro_factsheet_5-30-14.pdf.

[21] *Id.*

[22] *Id.*

[23] *Id.*

[24] NAT'L WOMEN'S LAW CTR., HEALTH CARE REFUSALS HARM PATIENTS: THE THREAT TO LGBT PEOPLE AND INDIVIDUALS LIVING WITH HIV/AIDS (May 2014), http://www.nwlc.org/sites/default/files/pdfs/lgbt_refusals_factsheet_05-09-14.pdf.

[25] Directive 24 denies respect for advance medical directives. U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (5th ed. 2009), http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf.

[26] Ward v. Wilbanks, 09-CV-11237, 2010 WL 3026428 (E.D. Mich. July 26, 2010), *rev'd and remanded sub nom*. Ward v. Polite, 667 F.3d 727 (6th Cir. 2012), *dismissed with prej*. by Ward v. Wilbanks, 09-CV-11237 (E.D. Mich. Dec. 12, 2012) (case settled).

[27] Abby Phillip, *Pediatrician Refuses to Treat Baby with Lesbian Parents and There's Nothing Illegal About It*, WASH. POST, Feb. 19, 2015, https://www.washingtonpost.com/news/morning-mix/wp/2015/02/19/pediatrician-refuses-to-treat-baby-with-lesbian-parents-and-theres-nothing-illegal-about-it/.

[28] EEOC v. Fremont Christian Sch., 781 F.2d 1362 (9th Cir. 1986).

[29] *Denied Care When Losing a Pregnancy: Pharmacies Refuse to Fill Needed Prescriptions*, NAT'L. WOMEN'S LAW CTR. (Apr. 16, 2015), http://www.nwlc.org/our-blog/denied-care-when-losing-pregnancy-pharmacies-refuse-fill-needed-prescriptions.

[30] Complaint, Simoes v. Trinitas Reg'l Med. Ctr., No. UNNL-1868-12 (N.J. Super. Ct. Law Div. May 23, 2012)

[31] NAT'L WOMEN'S LAW CTR., HEALTH CARE REFUSALS HARM PATIENTS: THE THREAT TO LGBT PEOPLE AND INDIVIDUALS LIVING WITH HIV/AIDS, *supra* note 24..

[32] ACLU & MERGER WATCH, MISCARRIAGE OF MEDICINE: THE GROWTH OF CATHOLIC HOSPITALS AND THE THREAT TO REPRODUCTIVE HEALTH CARE 1 (2013), http://static1.1.sqspcdn.com/static/f/816571/24079922/1387381601667/Growth-of-Catholic-Hospitals-2013.pdf?token=VadS%2FDitauEyceumRRtL%2B6pybLc%3D; *Facts and Statistics*, CATHOLIC HEALTH ASS'N. OF THE U.S. (2011), http://www.chausa.org/newsroom/facts-and-statistics.

restrictions on the type of care than can be offered. [33] When religious and secular hospitals merge, the religious restrictions often apply to both the religiously-affiliated and secular hospitals.[34] In addition, religious restrictions often apply to any medical practices using the religiously-affiliated hospital's space. For example, a primary care clinic renting space in a medical office building with a Catholic-affiliated hospital could be prohibited from providing services that conflict with Catholic teaching.[35] And as hospitals increasingly buy medical practices and employ physicians directly, religious restrictions also spread to private practices and other providers with even more tenuous connections to a religious entity.[36] The increase is more pronounced for some health systems. For example, between 2009 and May 2013 Bon Secours, one of the largest Catholic-affiliated health systems and one of the twenty-five largest health systems in the country overall, increased the number of employed physicians by nearly 86%.[37] These practices and physicians are often bound by the same religious restrictions as the hospital.

With an increasing number of hospitals, practices, and providers falling under the umbrella of a religiously-affiliated health system, a religious exemption would make it difficult for some women to access nondiscriminatory health care—and thus to access some health care services at all. This is particularly true in rural areas where women often have limited options.[38] For example, a woman in an area served by a religiously-affiliated health system that includes hospitals and primary care clinics may have access only to local providers who are prohibited from prescribing contraceptives or even providing counseling about contraceptives. This may be the case even when these hospitals or clinics are not formally controlled by a religious entity.

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[33] Most Catholic hospitals are part of the Roman Catholic ministry and must abide by the *Ethical and Religious Directives for Catholic Health Care*, which provide guidance on a range of health services including sterilization, family planning, infertility treatment, abortion, and end-of-life care. U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES *supra* note 25. Some hospital systems, such as Dignity Health, which are not a Roman Catholic ministry, follow Catholic teachings but are not bound by the *Directives*, although individual hospitals within these health systems may still be ministries and, thus, bound by the *Directives.*

[34] ACLU & MERGER WATCH, MISCARRIAGE OF MEDICINE, *supra* note 32, at 16.

[35] *Id.* at 2.

[36] As of 2012, the majority of physicians were employees of health care practices, systems, or hospitals rather than owners. Nearly 58% of family physicians and 50% of internists identified themselves as employees. Scott Baltic, *Monopolizing Medicine*, MODERN MED. (Feb. 24, 2014), http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/hospital-employment/monopolizing-medicine-why-hospital-consolidation-?page=full/.

[37] Beth Kutscher, *Making Physicians Pay Off*, MODERN HEALTHCARE (Feb. 22, 2014), http://www.modernhealthcare.com/article/20140222/MAGAZINE/302229986.

[38] For example, patients living on the Kitsap Peninsula in Washington must either go to a Catholic hospital or affiliated clinic or take a ferry and travel more than an hour to Seattle to reach the next closest acute care facility. ACLU & MERGER WATCH, MISCARRIAGE OF MEDICINE, *supra* note 32, at 16. In addition, as of 2011, eight percent of federally designated "Sole Community Hospitals" serving rural areas were Catholic owned. Nina Martin, *The Growth of Catholic Hospitals, By the Numbers*, PROPUBLICA (Dec. 18, 2013), http://www.propublica.org/article/the-growth-of-catholic-hospitals-by-the-numbers.

The reach of a religious exemption – in terms of potential services and potential health care entities with religious objections reached – could be significant and would leave patients unable to obtain care at a hospital or clinic that is otherwise fully covered by Section 1557's protections.[39] This is contrary to the express goals of the ACA, which seeks to expand access to health care and health insurance. Religious exemptions allow health systems and providers to substitute ideology for medical decision-making, impose barriers to health care access, and threaten patient health. The Department must not add a religious exemption to Section 1557.

II. § 92.3 Relationship to Other Laws

The Center strongly supports the reiteration in the Proposed Rule of Section 1557's clear language that it does not "invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved" under Title VI, Title VII, Title IX, Section 504, or the Age Act.[40] The Department appropriately acknowledges and affirms that "Section 1557 is not intended to apply lesser standards for the protection of individuals from discrimination than the standards" under the statutes referenced by Section 1557.[41]

III. § 92.4 Definitions

a. Employee Health Benefit Program

i. Include All Health Related Benefits

There are multiple types of programs, activities, and benefits that employers offer to employees that constitute health benefit programs. The Final Rule should clearly state that benefits that are considered excepted benefits under the Health Insurance Portability and Accountability Act (HIPAA), as defined in 45 C.F.R. § 148.220 (2015), may still be an employee health benefit program under Section 1557. While the proposed definition expressly and appropriately includes long-term care coverage, other critical forms of health coverage are not expressly included. Employers offer various types of health benefits, including, but not limited to, vision insurance, dental insurance, disease-specific insurance, and fixed indemnity plans. These types of plans provide benefits to employees for health services and are thus clearly health programs that are covered by Section 1557. The Center recommends that the definition of "employee health benefit program" expressly include but not be limited to these types of benefits. Many of these plans do not offer the protections employees and their dependents have through the ACA and other laws, making it especially important that the Department specify that they are reached by Section 1557.

[39] In 2011, 16.7% of all hospital beds in the nation were located in religious hospitals. The majority of these were in Catholic hospitals which have become the largest nonprofit health care provider in the US, with over 600 hospitals. *See Facts and Statistics*, CATHOLIC HEALTH ASS'N. OF THE U.S. (2011), http://www.chausa.org/newsroom/facts-and-statistics; ACLU & MERGER WATCH, MISCARRIAGE OF MEDICINE, *supra* note 32, at 1.
[40] 42 U.S.C. § 18116(b) (2012).
[41] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,173.

In addition, the definition should be clear that for purposes of Section 1557 "employee health benefit program" includes voluntary employer-provided individual or group insurance that is health-related, even if the employee pays the entire cost. As long as the employer is making payroll deductions and forwarding such deductions to the insurer, the employer is taking administrative steps to make the plan available to the employees and such a program constitutes an "employee health benefit program."

ii. Wellness Programs

The Center commends the Department for including employer-provided or -sponsored wellness programs in the definition of "employee health benefit program." However, not all wellness programs are part of an employer's health benefit program. Therefore, the Center recommends that the Final Rule explicitly state that all wellness programs offered by an employer, including but not limited to paying for a benefit to increase wellness, incentive-based participatory or outcome-based programs, or health related inquiries such as health risk assessments or biometric screenings, will be considered part of "employee health benefit program" under Section 1557.

Employers implement wellness programs to improve the health of their workforce and/or to reduce their health care costs. Some wellness programs offer a benefit, such as discounted gym memberships to all employees. Others offer monetary or other incentives to employees who participate. But wellness programs can be vehicles for discrimination. For example, a wellness program that offers a monetary incentive for participation in a physical activity that is not recommended for pregnant women would be discriminatory if it does not provide an alternative way for pregnant women to obtain the incentive. In addition, one half of large firms—those with over 200 employees—and almost a quarter of firms with 25-199 employees ask their employees to fill out a health questionnaire called a Health Risk Assessment as part of a wellness program.[42] Information gathered about women's health through Health Risk Assessments, such as information about pregnancy status, history of hysterectomy, or whether a woman has experienced menopause, could be a basis for adverse employment actions.[43]

[42] GARY CLAXTON ET AL., KAISER FAMILY FOUND. AND HEALTH RESEARCH EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2015 ANNUAL HEALTH SURVEY (2015), http://kff.org/report-section/ehbs-2015-section-twelve-health-risk-assessment-biometrics-screening-and-wellness-programs/.

[43] The Equal Employment Opportunity Commission (EEOC) published guidance in 2014 explicitly instructing employers to avoid inquiries into an employee's pregnancy status: "Because Title VII prohibits discrimination based on pregnancy, employers should not make inquiries into whether an applicant or employee intends to become pregnant." The guidance clarified that "[t]he EEOC will generally regard such an inquiry as evidence of pregnancy discrimination where the employer subsequently makes an unfavorable job decision affecting a pregnant worker." The EEOC has not specifically addressed pregnancy related inquiries as a part of a wellness program, although they raise the same potential for sex discrimination. U.S. EQUAL EMP'T OPPORTUNITY COMM'N, ENFORCEMENT GUIDANCE: PREGNANCY DISCRIMINATION AND RELATED ISSUES (July 14, 2014), http://www.eeoc.gov/laws/guidance/pregnancy_guidance.cfm#know.

Similarly, biometric screenings that test for pregnancy or wellness programs that otherwise require an employee to disclose a pregnancy could be a basis for adverse employment actions.

A wellness program is a health-related activity or program regardless of whether it is offered as a part of health coverage or whether the employer administers the wellness program separately, either directly or through a third-party administrator. The Final Rule should clarify that Section 1557 applies to all employer wellness programs, regardless of structure in relation to employee health benefits coverage, to protect all employees from discriminatory wellness programs.

iii. Other Health Reimbursement Programs

The Center also recommends that the Final Rule add language to the "employee health benefit program" definition that explicitly includes any other program an employer uses to reimburse employee health costs, including programs, such as Health Savings Accounts or Flexible Spending Accounts, that are funded through employee payroll deductions without any employer contribution. If an employer offers such a program and limits reimbursement to only some medical costs, there is a potential for the program to have a discriminatory design. For example, if an employer offers a Health Savings Account that reimburses for office visits and hospital costs for employees and their dependents, but excludes reimbursement for pregnancy and childbirth-related costs for dependent children, such a program would discriminate on the basis of sex. The addition of this language will ensure that Flexible Spending Accounts, Health Savings Accounts, Health Reimbursement Accounts, and any other system an employer uses to pay for health-related costs are considered employee health benefit programs.

RECOMMENDATION:
The Department should clarify in the preamble to the Final Rule that an employee health benefit program includes voluntary health-related programs in which the employee pays the entire cost through a payroll deduction.

In addition, § 92.4 should be rewritten as follows:

Employee health benefit program. The term "employee health benefit program" means (1) health benefits coverage or health insurance provided to employees and/or their dependents established, operated, sponsored or administered by, for, or on behalf of one or more employers, whether provided or administered by entities including but not limited to, a health insurance issuer, group health plan (as defined in the Employee Retirement Income Security Act of 1974 (ERISA, at 29 U.S.C. 1191(a) (2012)), a third party administrator, or an employer; (2) an employer-provided or -sponsored wellness program***, including programs that are not part of health benefits coverage or health insurance****;* (3) an employer-provided health clinic; or (4) long term care coverage or insurance provided or administered by an employer, group health

plan, third party administrator, or health insurance issuer***; (5) dental or vision coverage or insurance provided or administered by an employer, group health plan, third party administrator, or health insurance issuer; (6) coverage or insurance for a specific disease or illness (as defined in 45 C.F.R. § 148.220(b)(3)) provided or administered by an employer, group health plan, third party administrator, or health insurance issuer; (7) fixed indemnity coverage or insurance provided or administered by an employer, group health plan, third party administrator, or health insurance issuer; or (8) any other program an employer uses to reimburse employees or employees' dependents for health-related costs including, but not limited to, flexible spending accounts, health savings accounts and health reimbursement accounts****.

b. Federal Financial Assistance

The Center strongly supports the Proposed Rule's recognition that tax credits created by Title I of the ACA, as well as any "payments, subsidies, or other funds extended by the Department to any entity providing health insurance coverage for payment or on behalf of an individual obtaining health insurance coverage,"[44] are considered Federal financial assistance. The Proposed Rule appropriately recognizes that Section 1557 differs from the civil rights laws to which it refers by expressly identifying "credits, subsidies, [and] contracts of insurance" as forms of Federal financial assistance that trigger its application and further makes clear that such credits and subsidies constitute Federal financial assistance whether they are paid directly by the government to a covered entity, or to an individual for remittance to a covered entity providing health care coverage or services. The Proposed Rule also appropriately acknowledges that Section 1557's inclusion of "contracts of insurance" as Federal financial assistance means that its application is broader than some of the other civil rights laws it references.[45] As noted in the preamble, an insurance company participating in a Health Insurance Marketplace and receiving federally-subsidized payments through premium tax credits is covered by Section 1557.[46]

Unfortunately, the preamble to the Proposed Rule states that the definition of Federal financial assistance does not include Medicare Part B.[47] Although Medicare Part B has not been

[44] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,216.
[45] Unlike Section 1557, Title VI, Title IX, and the Rehabilitation Act either explicitly exclude or have been interpreted in some circumstances to exclude contracts of insurance as a form of Federal financial assistance. Because "contracts of insurance" are not excluded in the statutory text of Section 504, but instead, in its regulations, there are conflicting decisions about whether the regulations properly exclude it. *Compare* Moore v. Sun Bank of N. Fla., 923 F.2d 1423, 1429-32 (11th Cir. 1991) (finding that because Section 504 did not expressly exclude contracts of insurance or guaranty, the regulations containing the exclusion were invalid as inconsistent with congressional intent and that the contract at issue did in fact constitute Federal financial assistance), *with* Gallagher v. Croghan Colonial Bank, 89 F.3d 275 (6th Cir. 1996) (holding that based on the Section 504 regulation's exclusion of contracts of insurance or guaranty as federal financial assistance, a bank's receipt of reimbursement for default loans was not Federal financial assistance and thus the bank was not subject to the Rehabilitation Act).
[46] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,175.
[47] *Id.* at 54, 174.

considered Federal financial assistance for the purposes of Title VI,[48] it should not be similarly excluded for Section 1557. First, The Department currently considers Medicare Part B to be a "contract[] of insurance," which is explicitly excluded from Federal financial assistance under Title VI.[49] In contrast, the statutory language of Section 1557 specifically ***includes*** contracts of insurance. Therefore, this rationale does not apply to Section 1557. Second, the Department has stated that Medicare Part B is paid directly to the beneficiaries.[50] However, Medicare Part B currently provides payments directly to providers, through Medicare Administrative Contractors.[51] Therefore, for the purposes of Section 1557, Federal financial assistance includes Medicare Part B.

RECOMMENDATION:
The Final Rule should reverse the Department's position that Medicare Part B is not a form of Federal financial assistance under Section 1557.

c. Health Program or Activity

The Center strongly supports the Proposed Rule's reliance on the Civil Rights Restoration Act in defining "health program or activity.

Because Section 1557 is structured similarly to Title IX, the Civil Rights Restoration Act's application in the Title IX context is instructive for the interpretation of Section 1557. Like Title IX, Section 1557 is written with a term that modifies the phrase "program or activity" ("education" in Title IX, "health" in Section 1557). Under Title IX and the Civil Rights Restoration Act, if any part of an entity that has education as its primary purpose receives Federal financial assistance, it may not discriminate in any of its activities. If any part of an entity that does not have education as its primary purpose receives Federal financial assistance for any purpose, it may not discriminate in its education programs or activities.[52] Similarly,

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[48] *See, e.g.*, DEPT. OF HEALTH AND HUMAN SERVS., OFFICE OF CIVIL RIGHTS, GUIDANCE TO FEDERAL FINANCIAL ASSISTANCE RECIPIENTS REGARDING TITLE VI PROHIBITION AGAINST NATIONAL ORIGIN DISCRIMINATION AFFECTING LIMITED ENGLISH PROFICIENT PERSONS (2003), http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html.
[49] 42 U.S.C. § 2000d-1 (2012).
[50] *See, e.g., What Qualifies as Federal Financial Assistance for Purposes of Civil Rights Complaints Handled by the HHS Office of Civil Rights?,* U.S. DEP'T OF HEALTH & HUMAN SERVS., http://www.hhs.gov/ocr/civilrights/faq/100.html (last reviewed Apr. 22, 2008).
[51] 42 U.S.C. § 1395kk-1 (2012).
[52] *See, e.g., Jeldness v. Pearce*, 30 F.3d 1220, 1226 (9th Cir. 1994) (recognizing that the recipient of federal financial assistance need not be educational in nature for an education program or activity operated by the non-educational entity to be covered by Title IX); Dep't of Justice, *Title IX Legal Manual* (2001), *available at* http://www.justice.gov/crt/about/cor/coord/ixlegal.php. As the Senate Report for the CRRA explains:

> If a private hospital corporation is extended federal assistance for its emergency room, all the operations of the hospital, including for example, the operating rooms, the pediatrics department, admissions, discharge offices, etc., are covered under Title VI, section 504, and the Age Discrimination Act. Since Title IX is limited to education programs or activities, it would apply only to the students and employees of educational programs operated by the hospital, if any.

under Section 1557 and the Civil Rights Restoration Act, if any part of an entity that has health care or health insurance as its primary purpose receives Federal financial assistance, it may not discriminate in any of its activities. For a covered entity that does not have health as its primary purpose, Section 1557 prohibits discrimination in that entity's health programs or activities, as long as any part of the entity itself receives Federal financial assistance. In order to make clear the scope of "health program or activity," the Center urges that the reference to the Civil Rights Restoration Act be included in the rule itself and not only the preamble.

In addition, as written, the Proposed Rule relies on the term "health" to define "health program or activity" without providing a definition of "health." The Center recommends additional language be added to the definition to make the scope of the application of Section 1557 more instructive. To effectuate Section 1557's nondiscrimination principle, the determination of whether a program is a "health" program or activity should be consistent with existing interpretations of the meaning of the term "health" offered by the World Health Organization (WHO). WHO defines health to include not just the absence of disease but also "physical, mental, and social well-being."[53] Based on this widely accepted definition of health, a health program or activity includes any program or activity that is designed to promote, maintain, or prevent the decline of an individual's or a population's physical, mental, or social well-being.

The definition also should clarify that Medicaid is not the only state or local government program that may be a health program or activity. Additional services or programs operated by state and local governments, such as the Children's Health Insurance Program, public health activities, and health programs at state based universities, are health programs or activities, and the definition should not suggest otherwise. The Center therefore recommends additional language that clarifies that additional state or local government programs may be health programs or activities.

The Center supports the Department's interpretation of "health programs and activities" to include health research. While progress has been made, the discriminatory exclusion of women from medical research continues to harm women's health. Intentional exclusion and under-inclusion of women in clinical trials, including the failure to adequately recruit women to participate in medical research, is a long-standing and well-documented problem.[54]

S. Rep. 100-64, at 18 (1987). The Senate Report provides another example: "If corporation X is a chain of five nursing homes, federal financial assistance to one of the nursing homes will require compliance with the civil rights laws in all of the operations of all five of the nursing homes, subject to the education limitation in Title IX described in the preceding example." *Id*.

[53] Constitution of the World Health Organization, June 22, 1946, 14 U.N.T.S. 185.

[54] *See Barriers to Women's Participation in Clinical Trials and SWHR Proposed Solutions*, SOC'Y FOR WOMEN'S HEALTH RES., http://swhr.org/barriers-to-womens-partipication-in-clinical-trials-and-swhr-proposed-solutions/(last visited Oct. 28, 2015). In 1993, Congress enacted the National Institutes of Health Revitalization Act of 1993 which requires, among other things, that women and minorities be appropriately included in NIH clinical trials. 42 U.S.C. §§ 283-300 (2012). The next year, Congress created the Office of Women's Health in the Food and Drug Administration (FDA) which has a mission of protecting and advancing the health of women through policy, science and outreach, and advocacy for the inclusion of women in clinical trials as well as sex/gender and subpopulation

For example, although heart disease is the leading cause of death for women in the United States,[55] women are inadequately represented in heart disease trials and have been for some time.[56] One study found that male participants outnumbered female participants by a ratio of 3.66-1[57] and another found that only one-third of studies report sex-specific results.[58]

Failure to include sufficient numbers of women in medical research to determine if sex differences in risk factors and responses to treatments exist results in women receiving inadequate care compared to their male counterparts.[59] Research that uses an exclusively male model to evaluate and understand women's health needs means that women cannot receive medical care of the same quality provided to men.

The Center further appreciates the Department's recognition that research protocols may sometimes appropriately exclude or target particular populations based on compelling nondiscriminatory justifications related to health and safety, scientific study design, or legitimate research purposes. However, the Center urges the Department to monitor to ensure that federally funded sex-specific research designs are narrowly tailored to accomplish an essential health goal.

RECOMMENDATION:
The Department should amend § 92.4 by inserting the following language to the definition for health program or activity:

Health program or activity means the provision or administration of health-related services or health-related insurance coverage and the provision of assistance to individuals in obtaining

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analyses. *See* U.S. GEN. ACCOUNTING OFFICE, WOMEN'S HEALTH: WOMEN SUFFICIENTLY REPRESENTED IN NEW DRUG TESTING, BUT FDA OVERSIGHT NEEDS IMPROVEMENT (2001) (describing inclusion of women in FDA activities); PAULA JOHNSON ET AL., MARY HORRIGON CONNORS CTR. FOR WOMEN'S HEALTH & GENDER BIOLOGY, SEX-SPECIFIC MEDICAL RESEARCH WHY WOMEN'S HEALTH CAN'T WAIT (2014), http://www.brighamandwomens.org/Departments_and_Services/womenshealth/ConnorsCenter/Policy/ConnorsReportFINAL.pdf (describing the impact of the NIH Revitalization Act on women's inclusion in clinical trials and where improvement is still needed).

[55] *Leading Causes of Death in Females United States, 2013*, U.S. DEP'T OF HEALTH & HUMAN SERVS., CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/women/lcod/2013/index.htm (last updated July 10, 2015).

[56] JOHNSON ET AL., *supra* note 54, at 12 ("Only 35 percent of clinical trial subjects in cardiovascular research are women, and just 31 percent of those studies report outcomes by sex."); *see also* Esther S.H. Kim & Venu Menon, *Status of Women in Cardiovascular Clinical Trials*, 29 *ARTERIOSCLEROSIS, THROMBOSIS, AND VASCULAR BIOLOGY 279 (2009), http://atvb.ahajournals.org/content/29/3/279.long.*

[57] Nahid Azad & Sania Nishtar, *A Call for a Gender Specific Approach to Address the Worldwide Cardiovascular Burden*, 1 PREVENTION & CONTROL 223, 225 (2005).

[58] Chiara Melloni et al., *Representation of Women in Randomized Clinical Trials of Cardiovascular Disease Prevention*, 3 CIRCULATION: CARDIOVASCULAR QUALITIES AND OUTCOMES 110 (2010); http://circoutcomes.ahajournals.org/content/early/2010/02/16/CIRCOUTCOMES.110.868307.full.pdf (finding that sex-specific results were included in only 31% of primary trial publications).

[59] JOHNSON ET AL., *supra* note 54, at 8.

health-related services or health-related insurance coverage. ***Pursuant to the Civil Rights Restoration Act and consistent with analogous Title IX protections, for example, for*** an entity principally engaged in providing or administering health services or health insurance coverage, all of its operations are considered part of the health program or activity, except as specifically set forth otherwise in this part. Such entities include a hospital, health clinic, group health plan, health insurance issuer, physician's practice, community health center, nursing facility, residential or community-based treatment facility, or other similar entity. A health program or activity also includes all of the operations of a State Medicaid program, ***Children's Health Insurance Program, and all of the operations of other health programs, including public health programs, operated by state and local governments***. "***Health related" means designed to promote, maintain, or prevent the decline of an individual's or population's physical, mental, or social well-being.***

d. On the Basis of Sex

The Center supports the proposed definition of "on the basis of sex" that includes "pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions" and "gender identity." However, the Final Rule must also include sexual orientation in the definition of "on the basis of sex."

i. "On the Basis of Sex" Appropriately Includes Pregnancy and Gender Identity

The Center strongly supports the Proposed Rule's inclusion of "pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions" in its definition of "on the basis of sex." As noted in the preamble, Section 1557's prohibition of sex discrimination necessarily includes discrimination based on pregnancy.[60] Pregnancy discrimination constitutes sex discrimination under Title IX[61] and other civil rights statutes such as Title VII,[62] and it therefore constitutes sex discrimination under Section 1557. And as the Proposed Rule acknowledges, Section 1557, like these laws, not only prohibits discrimination based on pregnancy itself, but also discrimination based on pregnancy-related procedures or conditions.[63]

The Center also commends the Department for clearly stating that discrimination based on sex stereotypes constitutes discrimination on the basis of sex. Title IX has consistently been

[60] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,177.
[61] 34 C.F.R. § 106.40(b)(1). *See also* Pfeiffer v. Marion Ctr. Area Sch. Dist., 917 F.2d 779, 784 (3d Cir. 1990); Hogan v. Ogden, No. CV-06-5078-EFS, 2008 U.S. Dist. LEXIS 58359, at *26 (E.D. Wash. July 30, 2008); Chipman v. Grant Cty. Sch. Dist., 30 F. Supp. 2d 975, 977-78 (E.D. Ky. 1998); Hall v. Lee Coll., 932 F. Supp. 1027, 1033 n.1 (E.D. Tenn. 1996); Cazares v. Barber, Case No. CIV-90-0128-TUC-ACM, slip op. (D. Ariz. May 31, 1990); Wort v. Vierling, Case No. 82-3169, slip op. (C.D. Ill. Sept. 4, 1984), *aff'd*, 778 F.2d 1233 (7th Cir. 1985).
[62] 42 U.S.C. § 2000e(k) (2012).
[63] *See, e.g.*, *Id.*; *see also* Newport News Shipbuilding & Dry Dock v. EEOC, 462 U.S. 669, 684 (1983) ("The 1978 Act makes clear that it is discriminatory to treat pregnancy-related conditions less favorably than other medical conditions."); 29 C.F.R. pt. 1604 app. (2015).

interpreted to bar discrimination based on sex stereotyping—including discrimination based on the assumption that someone conforms to a sex stereotype and discrimination against an individual because he or she departs from a sex stereotype—and Section 1557 must be understood to ban such discrimination.[64]

The Center further strongly supports the Proposed Rule's clear statement that discrimination on the basis of gender identity constitutes discrimination on the basis of sex.
These protections are critically important as transgender individuals encounter high rates of discrimination in health care.[65] Twenty-eight percent of transgender and gender non-conforming individuals report facing harassment in medical settings, and 19 percent report being refused medical care altogether due to their transgender status.[66] As a result, 48 percent of transgender and gender non-conforming individuals report postponing seeking care when sick or injured and 50 percent report postponing or avoiding preventive care.[67]

Furthermore, the Proposed Rule's recognition that discrimination on the basis of gender identity is discrimination on the basis of sex is consistent with decisions by federal courts and federal agencies which have extended critical protections against sex discrimination to include discrimination on the basis of gender identity, gender expression, gender transition, or transgender status. Numerous federal courts have found that federal sex discrimination statutes reach these forms of gender-based discrimination.[68] Furthermore, the EEOC has made clear that "intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination based on sex and such discrimination therefore violates Title VII."[69] The Department of Labor and the Office of Federal Contract Compliance

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[64] *See* DEP'T OF EDUC., OFFICE OF CIVIL RIGHTS, REVISED SEXUAL HARASSMENT GUIDANCE: HARASSMENT OF STUDENTS BY SCHOOL EMPLOYEES, OTHER STUDENTS, OR THIRD PARTIES: TITLE IX (2001), http://www2.ed.gov/about/offices/list/ocr/docs/shguide.html; Dear Colleague Letter from the Dep't of Educ. 7-8 (Oct. 26, 2010), http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201010.pdf. *See also* Price Waterhouse v. Hopkins, 490 U.S. 228, 251 (1989); Lewis v. Heartland Inns of Am., L.L.C., 591 F.3d 1033, 1038-39 (8th Cir. 2010); Smith v. City of Salem, 378 F.3d 566 (6th Cir. 2004); Bibby v. Phila Coca Cola Bottling Co., 260 F.3d 257, 2652-63 (3d Cir. 2001).; Doe v. Brimfield Grade Sch., 552 F. Supp. 2d 816, 823 (C.D. Ill. 2008); Theno v. Tonganoxi Unified Sch. Dist., 377 F. Supp. 3d 952 (D. Kansas 2005); Schroeder v. Maumee Bd. Of Educ., 296 F. Supp. 2d 869, 880 (N.D. Ohio 2003); Montgomery v. Indep. Sch. Dist. No. 709, 109 F. Supp. 2d 1081, 1090-91 (D. Minn. 2000).

[65] *See* JAIME M. GRANT ET AL., NAT'L. GAY AND LESBIAN TASK FORCE & NAT'L CTR. FOR TRANSGENDER EQUALITY, INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 72-84 (2011), http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf.

[66] *Id.* at 72.

[67] *Id.* at 76.

[68] *See, e.g.*, Smith v. City of Salem, 378 F.3d at 572-75; Rosa v. Park West Bank & Trust Co., 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); Schwenk v. Hartford, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act). *See also* Statement of Interest of the United States at 14, Jamal v. Saks, No. 4:14-cv-02782 (S.D. Tex. Jan. 26, 2015).

[69] Macy v. Holder, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, *12 (Apr. 20, 2012).The Attorney General affirmed this interpretation in 2014. Attorney General Memorandum, Treatment of Transgender Employment Discrimination Claims Under Title VII of the Civil Rights Act of 1964 (Dec. 15, 2014).

Programs have also taken this position in proposed regulations.[70] Similarly, the Departments of Education and Justice have clarified that "discrimination based on gender identity, including transgender status, is discrimination based on sex" under Title IX.[71]

iii. Sexual Orientation Should Be Included in the Definition of "On the Basis of Sex"

The Center strongly urges the Department to clarify that the protections against discrimination on the basis of sex in Section 1557 include discrimination on the basis of sexual orientation. The absence of explicit protections from discrimination on the basis of sexual orientation in the Proposed Rule fails to reflect and reinforce important steps that the Department has already taken under the ACA to explicitly protect lesbian, gay, and bisexual people from discrimination on the basis of their sexual orientation. Moreover, the exclusion of sexual orientation from the definition of sex in the Proposed Rule is out of step with emerging legal doctrine concerning sexual orientation discrimination that has been adopted by other federal agencies and federal courts.[72] This emerging doctrine recognizes that discrimination on the basis of sexual orientation is necessarily discrimination against individuals who depart from sex stereotypes and gendered expectations in their choice of intimate partners, and thus discrimination on the basis of sex.

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[70] Department of Labor, Discrimination on the Basis of Sex, Proposed Rule, 80 Fed. Reg. 5246 (Jan. 30, 2015) (to be codified at 41 C.F.R. pt. 60-20); Office of Federal Contract Compliance Programs (OFCCP) Dir. 2015-1, Handling individual and systemic sexual orientation and gender identity discrimination complaints (Apr. 16, 2015); OFCCP Dir. 2014-02, Gender Identity and Sex Discrimination (Aug. 19, 2014); 5 C.F.R. §§ 300.102-300.103, 335.103, 410.302, 537.105 (2015).

[71] Statement of Interest of the United States at 5, G.G. *ex rel.* Grimm v. Gloucester Cty. Sch. Bd., No. 4:15cv54 (E.D. Va. June 29, 2015); Statement of Interest of the United States at 12, Tooley v. Van Buren Pub. Sch., No. 2:14-cv-13466 (E.D. Mich. Feb. 24, 215); DEP'T OF EDUC., TITLE IX RESOURCE GUIDE 1 (Apr. 2015); DEP'T OF EDUC., QUESTIONS AND ANSWERS ON TITLE IX AND SEXUAL VIOLENCE 5 (Apr. 29, 2014).

[72] *See* Baldwin v. Fox, EEOC App. No. 0120133080, 2015 WL 4397641, at *5 (July 16, 2015) (holding that sexual orientation is a "sex-based consideration" and discrimination on the basis of sexual orientation is sex discrimination under Title VII); Hall v. BNSF, 2014 WL 4719007 (W.D. Wash. Sept. 22, 2014) (allowing plaintiff's claim of sex-based discrimination after being denied same-sex spousal coverage on the company health plan to continue under Title VII and the Equal Pay Act); Cote v. Wal-Mart, EEOC Charge No. 523-2014-00916 (Jan. 29, 2015) (holding that Wal-Mart discriminated against an employee when it prohibited employee from enrolling same-sex spouse in company provided health care benefits); *see also* Latta v. Otter, 771 F.3d 456, 479-85 (9th Cir. 2014) (Berzon, J., concurring) (prohibition of same-sex marriage constitutes sex classification subject to heightened scrutiny); Waters v. Ricketts, No. 8:14-cv-356, 2015 WL 852603, at *14-15 (D. Neb. Mar. 2, 2015) (plaintiffs are likely to prevail on the merits of challenge to Nebraska's marriage ban because the law constitutes impermissible gender discrimination); Jernigan v. Crane, No. 4:13-cv-00410 KGB, 2014 WL 6685391, at *23-24 (E.D. Ark. Nov. 25, 2014) (prohibition of same-sex marriage constitutes sex classification subject to heightened scrutiny); Rosenbrahn v. Daugaard, No. 4:14-CV-04081-KES, 2014 WL 6386903, at *10-11 (D.S.D. Nov. 14, 2014) (same claim survived motion to dismiss); Lawson v. Kelly, No. 14-0622-CV-W-ODS, 2014 WL 5810215, at *8 (W.D. Mo. Nov. 7, 2014) (prohibition of same-sex marriage constitutes sex classification subject to heightened scrutiny); Kitchen v. Herbert, 961 F. Supp. 2d 1181, 1206 (D. Utah 2013) (same), *aff'd*, 755 F.3d 1193 (10th Cir.). *See also* OFFICE OF PERSONNEL MGMT., ADDRESSING SEXUAL ORIENTATION AND GENDER IDENTITY DISCRIMINATION IN FEDERAL CIVILIAN EMPLOYMENT (2015), https://www.opm.gov/policy-data-oversight/diversity-and-inclusion/reference-materials/addressing-sexual-orientation-and-gender-identity-discrimination-in-federal-civilian-employment.pdf.

An explicit statement that Section 1557's sex discrimination ban reaches sexual orientation discrimination is sorely needed. Lesbian, gay, and bisexual people continue to face discrimination in health care and health insurance coverage. Fear of discrimination causes many lesbian, gay, and bisexual people to avoid seeking health care, and, when they do seek care, lesbian, gay, and bisexual people are frequently not treated with the respect that all patients deserve.[73] In addition to discrimination in health care, lesbian, gay, and bisexual people also encounter discrimination in health insurance coverage. The Department has already used its regulatory authority under the ACA to take some steps to address these issues by clarifying that the ACA prohibits insurance carrier practices that discriminate on the basis of sexual orientation.[74] To ensure that the protections of Section 1557 reinforce and harmonize with existing nondiscrimination protections under the ACA—and to protect lesbian, gay, and bisexual people not only in gaining access to health insurance coverage but also in successfully accessing health care—the Final Rule should include explicit protection from discrimination on the basis of sexual orientation.

RECOMMENDATION:
The definition of "on the basis of sex" in § 92.4 be revised as follows:

> *On the basis of sex* includes, but is not limited to, on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, ***sexual orientation,*** or gender identity.

Similarly, the Center recommends that language be added to § 92.4 defining sexual orientation as follows:

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[73] Fifty-six percent of LGB people reported experiencing discrimination from health care providers—including refusals of care, harsh language, or even physical abuse—because of their sexual orientation. Almost ten percent of LGB respondents reported that they had been denied necessary health care expressly because of their sexual orientation. LAMBDA LEGAL, WHEN HEALTH CARE ISN'T CARING 9-10 (2010), http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf.

[74] In 2014, for example, the Centers for Medicare and Medicaid Services (CMS) issued guidance under regulations interpreting Section 2702 of the Public Health Service Act (PHSA), as amended by the ACA, to require health insurance carriers offering non-grandfathered group or individual health coverage in all states to offer legally married same-sex couples the same spousal or family benefits available to different-sex couples. DEPT. OF HEALTH AND HUMAN SERVS., CTR. FOR CONSUMER INFO. AND INS. OVERSIGHT, FREQUENTLY ASKED QUESTIONS ON COVERAGE OF SAME-SEX SPOUSES (2014), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/frequently-asked-questions-on-coverage-of-same-sex-spouses.pdf. The plain language of PHSA § 2702 simply requires insurance carriers to guarantee the availability of coverage unless certain exceptions (e.g., open enrollment periods) apply. The regulations promulgated under this section, at 45 C.F.R. 147.104(e), clarify that this requirement means carriers cannot employ marketing practices or benefit designs that discriminate on the basis of factors that include sexual orientation. *See also See* KELLAN BAKER, CTR. FOR AM. PROGRESS, OPEN DOORS FOR ALL: SEXUAL ORIENTATION AND GENDER IDENTITY PROTECTIONS IN HEALTH CARE (2015), https://www.americanprogress.org/issues/lgbt/report/2015/04/30/ 112169/open-doors-for-all/.

Sexual orientation means homosexuality, heterosexuality, or bisexuality.

f. Sex Stereotypes

The proposed definition of "sex stereotypes" appropriately describes the stereotypes regarding self-presentation for males and females that often motivate discrimination against transgender individuals, and the Center supports this language making clear that gendered expectations around clothing, hairstyles, voice, mannerisms, etc., constitute sex stereotypes. The Center is concerned, however, that without more, this proposed definition could be read to imply that discrimination on the basis of sex stereotypes is synonymous and coterminous with discrimination against transgender individuals. The Center therefore urges the Department to expand the definition of "sex stereotypes" to make clearer the range of sex stereotypes that can motivate unlawful sex discrimination, consistent with the Department's previous interpretation of Section 1557's protections.

In addition, the proposed definition of sex stereotypes does not include sexual orientation. However, as discussed in the comments for the definition of "on the basis of sex," discrimination on the basis of sexual orientation constitutes discrimination on the basis of sex stereotypes. The final definition of "sex stereotypes" should therefore make clear that sex stereotypes include the gendered expectations regarding the sex of an individual's sexual or romantic partner.

The Proposed Rule's definition also does not adequately encompass non-binary individuals. The necessity of recognizing non-binary identities in the provision of health care is widely accepted among medical organizations.[75] Further, federal agencies such as the Department of Labor have recognized that sex discrimination protections extend to non-binary individuals as well as to transgender and non-transgender men and women.[76] However, given that gender has often been assumed to be binary, a definition without explicit reference to non-binary identities may leave room for doubt or misinterpretation as to whether Section 1557's protections reach those with non-binary identities. The Center proposes language to clarify the definition.

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[75] AM. PSYCHOLOGICAL ASS'N, GUIDELINES FOR PSYCHOLOGICAL PRACTICE WITH TRANSGENDER AND GENDER NONCONFORMING PEOPLE 6 (2015), https://www.apa.org/practice/guidelines/transgender.pdf; ELIE COLEMAN ET AL., WORLD PROF. ASS'N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER AND GENDER-NONCONFORMING PEOPLE 171, 175 (2012), http://www.wpath.org/uploaded_files/140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf (requiring physicians to provide affirming care for both binary and non-binary transgender and gender non-conforming patients); AM. COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, COMMITTEE OPINION NO. 512: HEALTH CARE FOR TRANSGENDER INDIVIDUALS (2011), http://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co512.pdf?dmc=1&ts=20141102T1908581640. *See also* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 451-53 (5th ed. 2013) (defining gender identity to include identities other than male or female, and specifying diagnostic criteria for gender dysphoria to include such identities).

[76] *See, e.g.*, Department of Labor, Job Corps Program Instruction Notice No. 14-31, Ensuring Equal Access for Transgender Applicants and Students to the Job Corps Program (May 1, 2015).

RECOMMENDATION:
The Department should, therefore, revise the definition of sex stereotypes in § 92.4 as follows:

Sex stereotypes refers to stereotypical notions of gender, including expectations of how an individual represents or communicates gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics. These stereotypes can include the expectation ~~that gender can only be constructed within two distinct opposite and disconnected forms (masculinity and femininity), and that gender cannot be constructed outside of this gender construct (individuals who identify as neither, both, or a combination of male and female genders)~~ ***that individuals permanently identify with one and only one of two genders (male or female), and that they act in conformity with the gender expressions stereotypically associated with that gender. Sex stereotypes also include gendered expectations related to the appropriate roles or behavior of men and women, such as the expectation that women are primary caregivers, and gendered expectations related to aspects of an individual's sexual orientation identity, such as the sex of an individual's sexual or romantic partners.***

IV. § 92.7 Designation of Responsible Employee and Adoption of Grievance Procedures

Under the Proposed Rule, only covered entities with 15 or more employees will be required to designate a responsible employee or adopt grievance procedures, excluding many health care providers. The Final Rule should eliminate this exception and require all covered entities to designate a responsible employee and adopt grievance procedures. As the preamble to the Proposed Rule notes, applying this requirement to all covered entities will lead to a broader application that will benefit more people and will allow covered entities to address compliance issues at an earlier stage.[77] Such an approach is consistent with Title IX, which requires all recipients that operate education programs to designate a responsible employee and adopt a grievance procedure.[78]

Many health care services are provided through solo or small group medical practices. In 2014, 40 percent of physicians in the United States were in a practice of 4 or fewer physicians.[79] These small practices often have fewer than 15 employees.[80]

Under the Proposed Rule, as a result, a large portion of these small practices would not have to designate a responsible employee to coordinate efforts to comply with Section 1557 or adopt grievance procedures under Section 1557. The requirement to designate a responsible

[77] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at at 54,178.
[78] 34 C.F.R. § 106.8 (2015).
[79] Carol K. Kane, *Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership*, AM. MED. ASS'N 12 (July 2015), http://www.ama-assn.org/ama/pub/advocacy/health-policy/policy-research.page.
[80] The average ratio of non-physician staff to physician staff was 5.32 for practices with 2 or fewer full time equivalent physicians and 3.92 for practices with more than 2, but less than 4, full time physicians. Deborah N. Peikes et al., *Staffing Patterns of Primary Care Practices in the Comprehensive Primary Care Initiative*, 12 ANNALS OF INTERNAL MED. 142, 146 (2014), http://www.annfammed.org/content/12/2/142.full.

employee and adopt grievance procedures helps ensure that medical practices are aware of their obligations under Section 1557, take active steps to comply with those requirement, and are able to address compliance issues in a less formal manner than an OCR investigation.

In addition, it ensures that patients are aware of Section 1557's protections. By exempting small medical practices from this requirement, the Proposed Rule would leave those who receive care at these small practices without this important safeguard. Moreover, smaller practices are already accustomed to providing privacy notices pursuant to the HIPAA, for example, and are already required to designate a privacy official responsible for receiving complaints and providing individuals with information about the entity's privacy practices.[81] Providing notice of rights pursuant to Section 1557 and identifying an individual responsible for Section 1557 coordination is consistent with these existing requirements. The Center therefore recommends that the Department adopt language similar to the regulatory language under Title IX,[82] so that all covered entities are required to designate a responsible employee and adopt and publish grievance procedures.

RECOMMENDATION:
The Department should revise § 92.7as follows:

(a) Designation of responsible employee. Each covered entity ~~that employs 15 or more persons~~ shall designate at least one employee to coordinate its efforts to comply with and carry out its responsibilities under Section 1557 and this part, including the investigation of any grievance communicated to it alleging noncompliance with Section 1557 or this part or alleging any action that would be prohibited by Section 1557 or this part. For the Department, including the Federally-facilitated Marketplaces, the Office for Civil Rights (OCR) will be deemed the responsible employee under this section.
(b) Adoption of grievance procedures. Each covered entity ~~that employs 15 or more persons~~ shall adopt grievance procedures that incorporate appropriate due process standards and that provide for the prompt and equitable resolution of grievances alleging any action that would be prohibited by Section 1557 or this part. For the Department, including the Federally-facilitated Marketplaces, the procedures for addressing complaints of discrimination on the grounds covered under Section 1557 or this part will be deemed grievance procedures under this section.

V. § 92.8 Notice Requirement

As proposed, § 92.8(a) does not delineate the full scope of protections under Section 1557. Specifically, the notice should delineate the full scope of "on the basis of sex," as described in § 92.4. To ensure that individuals seeking care or services at covered entities, seeking or receiving coverage from covered entities, and the public at large are aware of the full scope of

[81] 45 C.F.R. §§ 164.520(a) and (b), 164.530(a).
[82] 34 C.F.R. § 106.8.

the applicable nondiscrimination protections under § 1557, the language in § 92.8(a)(1) and the proposed Appendix to Part 92 ("Sample Notice Informing Individuals about Nondiscrimination and Accessibility Requirements") must reflect the full scope of protected classes described in § **92.4.**

RECOMMENDATION:
The Department should revise § 92.8(a)(1) as follows:

> The covered entity does not discriminate on the basis of race**;** color**;** national origin, sex, ***including but not limited to, pregnancy, gender identity, or sexual orientation;*** age**;** or disability.

And, the Department should similarly revise Appendix to Part 92 ("Sample Notice Informing Individuals about Nondiscrimination and Accessibility Requirements"):

> [Name of covered entity] complies with applicable federal civil rights laws and does not discriminate on the basis of race**;** color**;** national origin***;*** age**;** disability**;** or sex (including***, pregnancy, pregnancy, false pregnancy, termination of pregnancy or recovery therefrom, childbirth or related medical conditions***,** sex stereotypes**,** ~~*and*~~ gender identity, ***and sexual orientation).*** [Name of covered entity] does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

VI. § 92.101 Discrimination Prohibited

a. Section 1557 Reaches Employment Discrimination

Under the Proposed Rule, Section 1557's nondiscrimination protections would not apply to discrimination by a covered entity against its own employees, except for discrimination in certain employee health benefit programs.[83] The Center strongly urges that the Final Rule eliminate this exclusion and make clear that Section 1557's prohibition against discrimination applies to employment discrimination by a covered entity.

The plain meaning of Section 1557 includes employment discrimination without limitation.[84] The Department references Title VI's employment discrimination exclusion to justify the proposed exemption,[85] but Title VI's exemption is set out in the language of the statute.[86] Section 1557, in contrast, prohibits *all* discrimination against *any "*individual" under "any health

[83] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,180.
[84] Section 1557 provides that an individual shall not "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 this title (or amendments)." 42 U.S.C. § 18116(a) (2012).
[85] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,219.
[86] 42 U.S.C. § 2000e-1 (2012).

program or activity" receiving funds under the ACA.[87] The Supreme Court has interpreted similar statutory language in Title IX and Section 504 to include employment discrimination.[88] The Court reasoned that it should not read an exception for employee coverage where one was not "expressly nor impliedly" provided because Congress could have "easily" adopted narrower language if it chose to restrict the scope of the antidiscrimination mandate.[89] The same logic applies here—particularly given Congress' awareness of these prior statutory interpretations when drafting Section 1557.[90] To carve out employment discrimination, without any statutory language doing so, would go against the plain meaning of the statute and prior judicial interpretation that is applicable here.[91] Section 1557 clearly reaches employment discrimination by all covered entities.[92]

Nor is there any justification for the Department to read an exclusion of employment discrimination into Section 1557 that is broader than the Title VI model it purports to rely upon. While Title VI limits the application of its anti-discrimination rule in the employment context, it prohibits employment discrimination where the "primary objective of the Federal financial assistance is to provide employment."[93] Further, Title VI regulations provide that even when employment is not the primary objective of federal funding, the statute bars discriminatory employment practices that "tend[] . . . on the grounds of race, color, or national origin, to exclude persons from participation in, to deny them the benefits of or to subject them to discrimination under the program receiving Federal financial assistance."[94] The wholesale exclusion for employment discrimination proposed for Section 1557 goes far beyond this model, without justification.

Nor would including employment discrimination within Section 1557's scope create significant administration problems for the Department. Under Executive Order (EO) 12250, the Attorney General coordinates the implementation and enforcement of the nondiscrimination provisions of Title IX, Title VI, Section 504, and "any other provision of Federal statutory law which provides, in whole or in part, that no person in the United States shall, on the ground of race,

[87] 42 U.S.C. § 18116(a) (2012).

[88] North Haven Bd. of Educ. v. Bell, 456 U.S. 512 (1982); Consol. Rail Corp. v. Darrone, 465 U.S. 624, 635 (1984). The court found the use of "person" in Title IX – as opposed to "student" or "beneficiary" – indicated an inclusive Congressional purpose. 456 U.S. at 520-23.

[89] North Haven Bd. of Educ., 456 U.S. at 521 (1982); *see also* Consol. Rail Corp., 465 U.S. at 635 (1984) (finding the same with respect to Section 504 and noting that it would be "anomalous" to conclude that Section 504 "silently adopted a drastic limitation on the handicapped individual's right to sue federal grant recipients for employment discrimination.").

[90] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,219; 42 U.S.C. § 2000e-1 (2012).

[91] *See* Swarts v. Siegel, 117 F. 130 (8th Cir. 1902) ("There is no safer nor better settled canon of interpretation than that when language is clear and unambiguous it must be held to mean what it plainly expresses . . . .").

[92] *See Schrader v. Ray*, 296 F.3d 968 (2002) (holding employer with fewer than 15 employees subject to the requirements of Section 504); *Roberts v. Progressive Indep., Inc*., 183 F.3d 1215 (10th Cir. 1999) (upholding a Section 504 judgment against employer with 5 employees).

[93] 42 U.S.C. § 2000d-3 (2012).

[94] 28 C.F.R. § 42.104(c)(2) (2015); *see* United States v. Jefferson Cty. Bd. of Educ., 372 F.2d 836, 883 (5th Cir. 1966) ("Faculty integration is essential to student desegregation.").

color, national origin, handicap, religion, or sex, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance"—thus including Section 1557.[95] Pursuant to this coordination mandate, in 1983 the Department of Justice promulgated "Procedures for Complaints of Employment Discrimination Filed Against Recipients of Federal Financial Assistance" jointly with the Equal Employment Opportunity Commission,[96] in order to "reduce duplicative efforts by different Federal agencies . . . reduce the burden on employers [and] allow . . . agencies to focus their resources on allegations of services discrimination."[97] These procedures reach complaints of employment discrimination filed against recipients of Federal financial assistance under "provisions similar to title VI and title IX in Federal grant statutes."[98] Similar procedures provide for coordination of employment discrimination complaints filed under Section 504 against recipients of Federal financial assistance.[99] Under these procedures, agencies receiving employment discrimination complaints under the relevant statutes can typically refer the complaint (other than pattern and practice complaints) to the EEOC for investigation in cases in which the EEOC also has jurisdiction under Title VII, the Equal Pay Act, or the ADA. A similar regulatory approach would permit EEOC investigation of the great majority of employment discrimination complaints brought under Section 1557. Indeed, sex, race, and national origin complaints brought under Section 1557 are already covered by the terms of the regulations permitting EEOC referral for employment discrimination complaints under Title IX, Title VI, and similar statutes.

Section 1557 coverage would strengthen existing protections against employment discrimination by giving employers dependent on Federal financial assistance an additional incentive to follow the law. Although much progress has been made since passage of Title VII, the Equal Pay Act, and other protections against sex-based employment discrimination, women earn less than men in almost every job or industry in which they work,[100] including the health field.[101] Millions of families rely on women's wages and therefore suffer when women are not paid equally.[102] Female health providers also report harassment and pressure to conform to sex stereotypes.[103] Section 1557 provides important protections against these discriminatory practices, and the Final Rule must reflect this.

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[95] Exec. Order No. 12,250, 3 C.F.R. 298 (1980).
[96] 28 C.F.R § 42.601 *et seq*. (2015); 29 C.F.R. § 1691.1 *et seq.* (2015).
[97] Procedures for Complaints of Employment Discrimination Filed Against Recipients of Federal Financial Assistance, 48 Fed. Reg. 3570 (Jan. 25, 1983) (to be codifed at 28 C.F.R. pt. 4229, 1691).
[98] 28 C.F.R § 42.601 *et seq.*; 29 C.F.R.§ 1691.1.
[99] 28 C.F.R. § 37.1 *et seq* (2015).; 29 C.F.R. § 1640.1 *et seq.* (2015).
[100] *Women's Earnings and Employment by Industry, 2009,* U.S. DEP'T OF LABOR, BUREAU OF LABOR STATISTICS (Feb. 16, 2011), http://www.bls.gov/opub/ted/2011/ted_20110216.htm.
[101] *See* Seth A. Seabury, et al., *Trends in the Earnings of Male and Female Health Care Professionals in the United States, 1987 to 2010,* 173 JAMA INTERNAL MED. 1748 (Oct. 14, 2013).
[102] NAT'L WOMEN'S LAW CTR., HOW THE WAGE GAP HARMS WOMEN AND FAMILIES (Apr. 3, 2013), http://www.nwlc.org/sites/default/files/5.11.15_how_the_wage_gap_hurts_women_and_families.pdf.
[103] *See, e.g.,* Liz Kowalczyk, *Female Surgeons Note Gains, Subtle Gender Bias,* BOSTON GLOBE (Feb. 25, 2013), http://www.bostonglobe.com/lifestyle/health-wellness/2013/02/25/female-surgeons-say-explicit

Addressing employment discrimination in health programs and activities is also especially important given that covered entities are particularly likely to employ low-wage women who are especially vulnerable to sexual harassment and other forms of overt discrimination. Women make up the majority of low-wage workers in the health care industry. For example, women make up 93 percent of medical assistants,[104] who make on average $15.01 per hour,[105] and 64 percent of physical therapist aides,[106] who make on average $12.82 per hour.[107] Women in low-wage jobs of this sort are at particular risk of discrimination due to their lack of bargaining power in the workplace and their economic vulnerability.

b. The Final Rule Must Further Specify the Forms of Sex Discrimination Prohibited.

Regulations, guidance, and case law under Title VII, including the Pregnancy Discrimination Act (PDA), and Title IX appropriately inform the interpretation of what constitutes sex discrimination under Section 1557, particularly to the extent that these sources address issues specifically relevant to health programs and activities. Section 1557 must provide at least as much protection against discrimination as these laws which already directly bind many of the entities covered by Section 1557.[108] In addition, as the statutory text of Section 1557 makes clear, it may not be interpreted to narrow existing interpretations of and protections against sex discrimination.[109]

The Proposed Rule sets out core antidiscrimination principles drawn from implementing regulations for Title VI, Section 504, the Age Act, and Title IX. However, the Title IX regulations cross-referenced for the purpose of setting out the specific discriminatory actions prohibited on the basis of sex reflect the different educational context for which they were created. Accordingly, they do not reach the full breadth of discriminatory actions that are prohibited by Section 1557. For example, the Title IX regulations prohibit "[s]ubject[ing] any person to separate or different rules of behavior, sanctions, or other treatment" and "[d]iscriminat[ing] against any person in the application of any rules of appearance" on the basis of sex[110]—forms

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-gender-bias-rare-but-subtler-obstacles-still-exist-boston/U5044WUVVCKbxlqX0OLTRI/story.html; Phyllis S. Carr et al., *Faculty Perceptions of Gender Discrimination and Sexual Harassment in Academic Medicine*, 132 ANNALS OF INTERNAL MED. 889 (2000).

[104] U.S. DEP'T OF LABOR, BUREAU OF LABOR STATISTICS, HOUSEHOLD DATA: ANNUAL AVERAGES 4, www.bls.gov/cps/cpsaat11.pdf (last visited Nov. 9, 2015).

[105] *Occupational Employment and Wages, May 2014: 39-3021 Personal Care Aids*, U.S. DEP'T OF LABOR, BUREAU OF LABOR STATISTICS, http://www.bls.gov/oes/current/oes399021.htm (last modified Mar. 25, 2015).

[106] U.S. DEP'T OF LABOR, BUREAU OF LABOR STATISTICS, *supra* note 104.

[107] *Occupational Employment and Wages, May 2014: 31-9092 Medical Assistants*, U.S. DEP'T OF LABOR, BUREAU OF LABOR STATISTICS, http://www.bls.gov/oes/current/oes399021.htm (last modified Mar. 25, 2015). http://www.bls.gov/oes/current/oes319092.htm

[108] Title VII, for example, covers employers who have fifteen or more employees. 42 U.S.C. § 2000e(b) (2012). Title IX prohibits an education program or activity that receives Federal financial assistance from discriminating against individuals on the basis of sex. 20 U.S.C. § 1681 et seq. (2012).

[109] 42 U.S.C. § 18116(b) (2012).

[110] *See* 45 C.F.R. § 86.31(b)(4), (5) (2015).

of discrimination far more likely to arise in educational institutions' treatment of students than in health care providers' treatment of patients or health insurance providers' treatment of beneficiaries. The referenced Title IX regulation also prohibits "[a]pply[ing] any rule concerning the domicile or residence of a student or applicant, including eligibility for in-state fees and tuition" on the basis of sex[111]—another rule that has clear applicability to education programs and activities and limited relevance for health programs and activities. Therefore, in addition to the referenced Title IX provisions, the Final Rule should also draw from the Title VI, Section 504, and Age Act incorporated prohibitions, and principles reflected in other Title IX regulations, in order to more fully address discrimination in health programs and activities, as set out below.

RECOMMENDATION:
The Department should revise § 92.101(b)(3) by adding the following language drawn from the Title VI,[112] Section 504,[113] and Age Act[114] regulations and consistent with Title IX principles[115]:

In addition, each covered entity must comply with the following provisions:

(i) A covered entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination on the basis of their sex, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals on the basis of sex.

(ii) In determining the site or location of a facility, a covered entity may not make selections with the effect of excluding individuals from, denying them the benefits of, or subjecting them to discrimination under any programs to which this regulation applies, on the basis of sex; or with the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the program or activity on the basis of sex.

(iii) In the absence of a finding of discrimination, a covered entity in administering a program may take affirmative action to overcome the effects of conditions which resulted in limiting participation by persons on the basis of sex.

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[111] *See* 45 C.F.R. § 86.31(6) (2015).
[112] The Center proposes that § 92.101(b)(3)(i) mirror language from Title VI implementing regulations 45 C.F.R. § 80.3(b)(2) (2015); § 92.101(b)(3)(ii) mirror language from Title VI implementing regulations 45 C.F.R. § 80.3(b)(3) (2015); and § 92.101(b)(3)(iii) mirror language from Title VI implementing regulations 45 C.F.R. § 80.3(b)(6)(ii) (2015).
[113] The Center proposes that § 92.101(b)(3)(i) mirror language from Section 504 implementing regulations 45 C.F.R. § 84.4(b)(4) (2015) and § 92.101(b)(3)(ii) mirror language from Section 504 implementing regulations 45 C.F.R. § 84.4(b)(5) (2015).
[114] The Center proposes that § 92.101(b)(3)(i) mirror language from the Age Act implementing regulations 45 C.F.R. 91.11(b) (2015) and § 92.101(b)(3)(iii) mirror language from the Age Act implementing regulations 45 C.F.R. § 91.16 (2015).
[115] The Center proposes that § 92.101(b)(3)(iii) mirror language from Title IX implementing regulations 45 C.F.R. § 86.3(b) (2015).

In addition, the Center recommends that the Department interpret these standards to prohibit actions by covered entities that have the effect of denying or restricting women's timely access to providers specializing in women's health care. Restrictions on the participation of otherwise eligible women's health providers in federal health programs place serious obstacles on women seeking timely access to care. When trusted, well-qualified women's health providers are arbitrarily eliminated from participating in federal health programs, the many women who depend on such providers for their usual care may be forced to seek federally-supported services from geographically remote providers, settle for inferior care, or forgo care altogether. Women in need of services that reside in areas that lack adequate medical resources are likely to face significantly increased wait times and disproportionate increases in travel along with other associated costs, rendering access to a comparable alternative provider inconvenient if not prohibitively expensive. The costs and delays imposed by such restrictions harm the health and well-being of women as a class.

RECOMMENDATION:
The Center requests that the Department insert the following language in the preamble of the Final Rule discussing §§ 92.101(b)(3)(i)-(iii) to reinforce the rule's application in the context of protecting women's access to health care.

The standards we propose in 92.101(b)(3)(i)-(iii) are intended to reach a variety of circumstances in which the actions of covered entities undermine the ability of individuals to participate in and benefit from health programs and activities on the basis of sex. For example, a covered entity engages in unlawful sex discrimination when it employs criteria that have the effect of disfavoring or disqualifying otherwise eligible providers of women's health care for participation in federal health programs, resulting in reduced access to federally supported health care for women in a region.

c. The Final Rule Must Explicitly Prohibit Harassment

Sexual harassment in health care can discourage people from seeking care, thus undermining the ACA's broader goals of ensuring access to health care. A provider who uses derogatory language when talking to unmarried, sexually active, or pregnant women may be creating a hostile environment[116] that could keep women from accessing needed health care.[117] A

[116] Factors to "evaluate hostile environment" include the severity of the effect on the individual, the type, frequency and duration of the conduct, the age and sex of the people involved, whether the harasser is in a position of authority over the individual, and other context such as location and non-sexual threats or intimidation. Even one act of harassment can create a hostile environment. U.S. DEP'T OF EDUC., OFFICE FOR CIVIL RIGHTS, REVISED SEXUAL HARASSMENT GUIDANCE: HARASSMENT OF STUDENTS BY SCHOOL EMPLOYEES, OTHER STUDENTS, OR THIRD PARTIES 5-7 (2001), http://www2.ed.gov/about/offices/list/ocr/docs/shguide.pdf.

[117] When patients do not feel comfortable as a result of harassment or because of a provider's perceived implicit or explicit bias, they are less likely to get comprehensive medical care. *See, e.g.,* Irene Blair et al., *Clinicians' Implicit Ethnic/Racial Bias and Perceptions of Care Among Black and Latino Patients*, 11 ANNALS OF FAMILY MED. 43, 43 (2013) (finding that "clinicians' implicit bias may jeopardize their clinical relationships with black patients, which could have negative effects on other care processes."); GRANT ET AL., *supra* note 65, at 76 (showing nearly 30% of

persistent and intentional refusal to use a patient's preferred name and pronoun rather than those corresponding to the patient's gender assigned at birth may constitute illegal gender identity-based harassment if it creates a hostile environment.[118]

The Proposed Rule does not explicitly provide that Section 1557 prohibits all forms of harassment based on a protected characteristic, such as sexual harassment and other forms of sex-based harassment, which include harassment based on gender identity and sexual orientation. Title IX has been interpreted to protect individuals from sex-based harassment that limits their ability to participate in or benefit from the education program or that creates a hostile or abusive educational environment.[119] Section 1557 too prohibits harassment that limits individuals' ability to participate in or benefit from a health program or activity or that creates a hostile or abusive health care environment.

RECOMMENDATION:
The Center recommends that a new section, § 92.210 be added**.**

§ 92.210 Harassment

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transgender individuals reported postponing or avoiding medical care when they were sick or injured due to discrimination and disrespect, and over 30% delayed or did not try to get preventive care); TEXAS POLICY EVALUATION PROJECT, BARRIERS TO FAMILY PLANNING ACCESS IN TEXAS 1 (May 2015), http://www.utexas.edu/cola/txpep/_files/pdf/TxPEP-ResearchBrief_Barriers-to-Family-Planning-Access-in-Texas_May2015.pdf (showing that 30% of respondents reported "Don't feel comfortable with healthcare providers" as a barrier to accessing reproductive health care); Valerie Ulene, *Doctors and Nurses' Weight Biases Harm Overweight Patients*, L.A. TIMES (Dec. 13, 2010), http://articles.latimes.com/2010/dec/13/health/la-he-the-md-weight-bias-20101213 (discussing negative health implications of providers' weight bias on overweight patients).

[118] *See* Lusardi v. McHugh, EEOC Appeal No. 0120133395, 2015 WL 1607756, at *11 (Apr. 1, 2015) ("Persistent failure to use [a transgender] employee's correct name and pronoun may constitute unlawful, sex-based harassment . . . ."); Jameson v. U.S. Postal Service, EEOC Appeal No. 0120130992, 2013 WL 2368729, at *2 (May 21, 2013) ("[S]upervisors and coworkers should use the name and pronoun of the gender that the employee identifies with . . . Intentional misuse of the employee's new name and pronoun may cause harm to the employee, and may constitute sex based discrimination and/or harassment."); *see also* OFFICE OF PERS. MGMT, GUIDANCE REGARDING THE EMPLOYMENT OF TRANSGENDER INDIVIDUALS IN THE FEDERAL WORKPLACE, *available at* www.opm.gov/policy-data-oversight/diversity-and-inclusion/reference-materials/gender-identity-guidance ("Continued misuse [of a transitioning employee's] new name and pronouns, and reference to the employee's former gender by managers, supervisors, or coworkers is contrary to the goal of treating transitioning employees with dignity and respect, and creates an unwelcoming work environment.").

[119] *See* U.S. DEPT OF EDUC., OFFICE FOR CIVIL RIGHTS, SEXUAL HARASSMENT GUIDANCE (1997), http://www2.ed.gov/about/offices/list/ocr/docs/sexhar01.html. Similarly, Title VII protects employees from sex-based harassment that creates an intimidating, hostile, or abusive environment or that becomes a condition of continued employment. U.S. EQUAL EMP'T OPPORTUNITY COMM'N, HARASSMENT, http://www.eeoc.gov/laws/types/harassment.cfm; *see also* 29 C.F.R. § 1604.11(a) (2015) ("Harassment on the basis of sex . . . has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.").

Harassment that denies or limits an individual's ability to participate in or benefit from a health program or activity on the basis of an individual's race, color, national origin, age, disability, sex (including pregnancy, false pregnancy, termination of pregnancy or recovery therefrom, childbirth or related medical conditions, sex stereotyping, sexual orientation or gender identity) is a form of discrimination prohibited by § 92.101.

§ 92.201 Meaningful Access for Individuals with Limited English Proficiency

The Proposed Rule properly includes specific requirements to ensure that covered entities understand their obligations to ensure meaningful access for people with limited English proficiency (LEP) and have clear instructions on how to comply with those obligations. As the Proposed Rule notes, these requirements are necessary to ensure that individuals with limited English proficiency are able to access health care and health insurance coverage.[120] The Center supports the approach in the Proposed Rule as it is consistent with Title VI and existing HHS guidance.[121] Furthermore, the Center also emphasizes that, consistent with the Proposed Rule, discrimination on the basis of limited English proficiency creates unequal access to health care and health insurance coverage. Limited English proficiency is often compounded with the "cumulative effects of race and ethnicity, citizenship status, low education, and poverty," resulting in more barriers to access.[122] The Final Rule must ensure that covered entities do not allow an individual's cultural background or limited English proficiency to impede access to health care or health insurance coverage.[123]

VII. § 92.206 Equal Program Access on the Basis of Sex

The Center supports the requirement that covered entities provide equal access to health programs or activities without discrimination on the basis of sex and that they treat individuals consistently with their gender identity. In addition, the Final Rule should state that access without discrimination on the basis of sex includes equal access without discrimination on the basis of pregnancy or related conditions. Pregnant women have experienced considerable discrimination in accessing certain health care services, such as mental health care and drug treatment services.[124]

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[120] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,178.

[121] *See* U.S. DEPT. OF HEALTH AND HUMAN SERVS., OFFICE FOR CIVIL RIGHTS, GUIDANCE TO FEDERAL FINANCIAL ASSISTANCE RECIPIENTS REGARDING TITLE VI PROHIBITION AGAINST NATIONAL ORIGIN DISCRIMINATION AFFECTING LIMITED ENGLISH PROFICIENT PERSONS (2003), http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/lepguidance.pdf.

[122] KAISER COMM'N. ON MEDICAID AND THE UNINSURED, OVERVIEW OF HEALTH COVERAGE FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY 3 (2012), http://kff.org/disparities-policy/fact-sheet/overview-of-health-coverage-for-individuals-with/.

[123] *See,* comments submitted by the National Health Law Program for a detailed analysis.

[124] *See, e.g.*, J. Marsh et al., *Increasing Access and Providing Social Services to Improve Drug Abuse Treatment for Women with Children*, 95 ADDICTION 237 (2000). In 2011, only 12.7% of substance abuse treatment facilities in the U.S. included programs for pregnant or postpartum women. U.S. DEPT. OF HEALTH AND HUMAN SERVS., 2011 NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES 4 (2011), http://wwwdasis.samhsa.gov/webt/state_data/US11.pdf. In addition, only 19 states have drug treatment programs specifically targeted to women. GUTTMACHER INST. , STATE POLICIES IN BRIEF: SUBSTANCE ABUSE DURING PREGNANCY (OCT. 1, 2015), http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf. *See also* Andrew Solomon, *The Secret Sadness of*

In addition, the Department should make clear that sex-specific programs and activities will only be considered nondiscriminatory in very narrow circumstances. Consistent with Section 1557's broad nondiscrimination purpose, sex-specific programs may be permissible only when they are narrowly tailored and necessary to accomplish an essential health purpose. For example, sex specific programs that are clinically necessary, such as a female-only clinical trial of a drug designed to treat a disease that only affects women, would not violate Section 1557.

RECOMMENDATION:
The Department should clarify in the preamble that equal program access on the basis of sex must include equal program access on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth, or related medical conditions.

The Department should also revise § 92.206 by adding the following language:

A covered entity shall provide individuals equal access to its health programs or activities without discrimination on the basis of sex, and shall treat individuals consistent with their gender identity, except that any health services that are ordinarily or exclusively available to individuals of one gender may not be denied or limited based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded in a medical record is different from the one to which such health services are ordinarily or exclusively available. ***Sex-specific health programs and activities are permissible when necessary to accomplish an essential health purpose*.**

VIII. § 92.207 Non-discrimination in Health Related Insurance and Other Health-Related Coverage

a. 92.207(a) Third-Party Administrators

The Proposed Rule should clarify that Section 1557 protections apply broadly to activities taken by covered entities in their role as third-party administrators. All covered entities are barred from providing assistance to an entity, program, or activity that discriminates on the basis of race, color, national origin, sex, age, or disability. Specifically, Section 1557 prohibits a covered entity from "[a]id[ing] or perpetuat[ing] discrimination against any person by providing aid or assistance to any agency, organization or person which discriminates on the basis of sex in providing any aid, benefit, or service" to an individual."[125] An institution that provides aid or assistance to an independent discriminatory entity essentially adopts the discriminatory policies as its own. For example, in *Iron Arrow Honor Society v. Heckler*, the Fifth Circuit found that the University of Miami violated the parallel Title IX regulation when it allowed an all-male honor

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Pregnancy with Depression, N.Y. TIMES (May 28, 2015), http://www.nytimes.com/2015/05/31/magazine/the-secret-sadness-of-pregnancy-with-depression.html?_r=0 (discussing doctors' reluctance to treat pregnant women suffering from depression).

[125]Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,181.

society to hold a "tapping" ceremony on University property, in which "tapees" were removed from class before participating in the ceremony.[126] As is demonstrated by the *Iron Arrow* case, the assistance does not have to be monetary to implicate the antidiscrimination rule. Because third-party administrators provide such assistance to insurers when they administer discriminatory insurance plans, and because this relationship is a common way in which covered entities will provide assistance to discriminatory health programs and activities, the Center recommends that the Final Rule include language that explicitly states that a covered entity may not provide aid or assistance to discriminatory health-related insurance or coverage.

In addition, the Center recommends that the Final Rule delineate various activities that a covered entity may perform that are considered "administering health-related insurance or other health-related coverage." Including a non-exhaustive list of administrative activities in the definition would provide clarity to covered entities acting as third-party administrators. The list of activities should include a variety of services covered entities may provide as third-party administrators that makes clear that the activities are broader than the activities that make an entity a plan fiduciary or plan administrator for purposes of the Employee Retirement Income Securities Act (ERISA).[127] The Center also recommends specifically including "acting as a plan fiduciary or a plan administrator" as activities that are considered administrating health-related insurance or coverage.

The Center also supports the Department's recognition that a third-party administrator that is legally separate from the issuer may still be a covered entity.[128] The Center recommends language below that will prevent covered entities from creating separate legal entities in order to circumvent the Section 1557 protections against discrimination.

RECOMMENDATION:
The Department should revise § 92.207(a) by inserting the following language in subparagraphs (1) and (2):

General. A covered entity shall not in providing or administering health-related insurance or other health-related coverage, discriminate on the basis of race, color, national origin, sex, age, or disability

(1) Administering health-related insurance or other health-related coverage may include, but is not limited to, any of the following activities: claims processing,

[126] Iron Arrow Honor Society v. Heckler, 702 F.2d 549, 561 (5th Cir. 1983), *vacated as moot* 464 U.S. 67 (1983) (holding the case is moot because the President of the University wrote a letter to Iron Arrow's Chief stating that, regardless of the outcome of the case, the University would not allow Iron Arrow to resume its discriminatory practices on the University campus).
[127] *See* 29 U.S.C. § 1002(21)(a) (2012) for the definition of plan fiduciary and 29 U.S.C. § 1002(16)(a) (2012) for the definition of plan administrator under ERISA.
[128] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,189 n.73.

rental of a provider network, designing plan benefits or policies, drafting plan documents, processing or adjudicating appeals, administering disease management services, pharmacy benefit management, acting as a plan fiduciary as defined in the Employee Retirement Income Security Act of 1974 (ERISA, at 29 U.S.C. 1002),or acting as a plan administrator as defined in the Employee Retirement Income Security Act of 1974 (ERISA, at 29 U.S.C. 1002). A separate legal entity associated with a covered entity that provides or administers health-related insurance or other health-related coverage will be considered a covered entity if the legal separation exists for the purpose of permitting the entity to continue to administer discriminatory health-related insurance or other health-related coverage or as a subterfuge for discrimination.

b. 92.207(b) Discriminatory Actions Prohibited

The ACA has many provisions that address historical inequities in the health care marketplace, including the failure to provide contraceptive coverage to women, the exclusion of maternity care from health insurance plans, and gender rating in the individual health insurance market. Section 1557 further addresses inequities by applying longstanding sex discrimination principles to aspects of health-related insurance coverage and other health-related care not otherwise addressed explicitly by the ACA. These protections are sorely needed: the Center found numerous instances of discrimination on the basis of sex and on other prohibited bases in benefit designs in its review of qualified health plans offered on the health insurance exchanges in 2014 and 2015.[129] Among the instances of discrimination, the Center found:

- Plans discriminating based on sex by excluding maternity coverage for dependent children;
- Plans discriminating based on sex by excluding coverage for some emergency pregnancy care when pregnant women traveled out of the service area;
- Plans discriminating based on sex by excluding coverage for gender-transition-related services;
- Plans discriminating based on sex and age by limiting infertility services to women under the age of 40 and limiting the coverage of prenatal vitamins and folic acid to women under age 42; and
- Plans discriminating based on disability by excluding coverage of services for chronic pain.

The Center supports the Department's effort to clarify that Section 1557 applies to various aspects of health-related insurance coverage and other health-related coverage. While the proposed language will provide important protections related to the issuance and renewal of

[129] NAT'L WOMEN'S LAW CTR., STATE OF WOMEN'S COVERAGE: HEALTH PLAN VIOLATIONS OF THE AFFORDABLE CARE ACT , http://www.nwlc.org/sites/default/files/pdfs/stateofcoverage2015final.pdf (last visited Oct. 26, 2015).

insurance or other health-related coverage, as well as many aspects of insurance design and administration that affect how much an enrollee must pay for health-related services and what services are available to enrollees, it falls short in some areas.

i. Waiting Periods

Subparagraph § 92.207(b)(1) should be strengthened by identifying waiting periods as one of the forms of denial or limitation of coverage that is prohibited if discriminatory. Waiting periods, in effect, deny coverage of services. Health insurance plans have historically discriminated against women by applying waiting periods for pregnancy-related services, for example.[130] While the ACA ended this particular practice by requiring all plans to cover maternity and ending pre-existing condition exclusions, the Center remains concerned that other waiting periods may be used in a discriminatory manner. For example, waiting periods have been imposed for transplant-related services, which the Department has recognized may discriminate against people with present or predicted disability.[131] While the Department has stated through guidance that plans required to offer the essential health benefits may not impose waiting periods for these benefits, there may be plans with waiting periods for non-essential health benefits or plans not required to cover the essential health benefits that impose waiting periods that have a similarly discriminatory result. For example, a waiting period would be discriminatory if it applied only to gender-transition-related services. Similarly, a plan that applies a waiting period to birth control drugs but no other drugs would discriminate based on sex, in addition to being a potential violation of other laws. Given that waiting periods effectively deny coverage for a period of time, a discriminatory waiting period would violate Section 1557. Section 92.207(b)(1) should make this clear.

ii. Harm Because of a Protected Status

The Center also recommends strengthening subparagraph (1) by clarifying that, in addition to actions being disallowed when they are on the basis of an enrollee's or prospective enrollee's race, color, national origin, sex, age, or disability, the actions are also prohibited if they have a discriminatory effect. For example, if a plan created a higher cost sharing tier for chemoprevention drugs used to prevent breast cancer, such a design would discriminate against women.

RECOMMENDATION:
The Center recommends § 92.207(b)(1) be rewritten as follows:

[130] NAT'L WOMEN'S LAW CTR., NOWHERE TO TURN: HOW THE INDIVIDUAL HEALTH INSURANCE MARKET FAILS WOMEN 11 (2008), http://www.nwlc.org/sites/default/files/pdfs/NWLCReport-NowhereToTurn-81309w.pdf.
[131] U.S. DEP'T. OF HEALTH AND HUMAN SERVS., FREQUENTLY ASKED QUESTIONS ON HEALTH INSURANCE MARKET REFORMS AND MARKETPLACE STANDARDS 1 (2014), https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/final-master-faqs-5-16-14.pdf ("For example, a plan that includes a waiting period for any type of transplant would discriminate against those whose conditions make it likely that they would need a transplant . . . .").

(b) Discriminatory actions prohibited. A covered entity shall not, in providing or administering a health-related insurance or other health-related coverage:

(1) Deny, cancel, limit, or refuse to issue or renew a health insurance plan or policy, or other health coverage, or deny or limit coverage of a claim, or impose ***a waiting period or*** additional cost sharing or other limitations or restrictions, on the basis of an enrollee's or prospective enrollee's race, color, national origin, sex, age, or disability***, or in a manner that deprives or tends to deprive an enrollee or prospective enrollee of coverage or otherwise adversely affects an enrollee or prospective enrollee because of the enrollee's or prospective enrollee's race, color, national origin, sex, age, or disability***.

iii. Categorical Exclusions for Maternity Coverage

Section 92.207(b) identifies certain coverage exclusions that constitute discrimination but fails to make clear that a categorical exclusion of maternity coverage constitutes prohibited discrimination. Such clear statements are necessary to counter ongoing discrimination in insurance plans. For example, it remains a common practice for group health plans to exclude enrolled dependent children from maternity coverage.[132]

It is well established under civil rights laws such as Title IX and Title VII that a health insurance plan that fails to provide coverage for gynecological and maternity care in the same manner or on the same basis as coverage for other conditions is discriminating on the basis of sex.[133] For example, under Title IX and Title VII a plan would be prohibited from excluding doctor's visits related to maternity care if it otherwise covers doctor's visits. Likewise, under Section 1557, treating pregnancy differently, including by excluding maternity care from an otherwise comprehensive insurance plan, is sex discrimination.

A plan that categorically excludes maternity coverage for any beneficiary will need to eliminate the exclusion and offer maternity coverage to all enrollees, including child dependents, in order to comply with Section 1557. This is particularly important because Title VII's protections do

[132] *See Section 1557 Complaints*, NAT'L WOMEN'S LAW CTR. (June 3, 2013), http://www.nwlc.org/resource/nwlc-section-1557-complaint-sex-discrimination-complaints-against-five-institutions. *See also* DEP'T OF HEALTH AND HUMAN SERV., CTR. FOR CONSUMER INFO. AND INS. OVERSIGHT INFORMATION ON ESSENTIAL HEALTH BENEFITS (EHB) BENCHMARK PLANS, https://www.cms.gov/cciio/resources/data-resources/ehb.html#South Carolina (last visited Oct. 26, 2015); SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY, INSURANCE BENEFIT GUIDE 71 (2015), http://www.eip.sc.gov/ibg/publications/2015_!BG.pdf.

[133] *See, e.g.*, 34 C.F.R. §§ 106.39, 106.40 (2015) (stating that Title IX requires comprehensive gynecological care when a recipient provides full coverage for health services and that a recipient must treat pregnancy in the same manner it treats other conditions); 29 C.F.R. pt. 1604 app. (2015) (stating that Title VII, as amended by the Pregnancy Discrimination Act, requires that any employer-provided health insurance must cover expenses for pregnancy related conditions on the same basis as expenses for other medical conditions); Newport News Shipbuilding & Dry Dock v. EEOC, 462 U.S. 669 (1983) (holding that Pregnancy Discrimination Act, which amended Title VII, required employer health plan to cover pregnancy-related conditions for employees' spousal dependents on the same basis as other conditions covered for dependent spouses).

not reach dependents of employees. While Title VII, through the Pregnancy Discrimination Act, ensures that most employers that provide health insurance include maternity coverage for employees and enrolled dependent spouses, this protection has not been extended to dependent children. The EEOC has stated that such exclusions represent sex discrimination against the dependent child, who is not protected by Title VII, rather than sex discrimination against the employee, who is protected.[134] In contrast, dependent children *are* protected by Section 1557 when enrolled in a covered plan. The Center provides recommended language below to make clear that covered entities must provide maternity coverage to all enrollees, including all dependents.

In addition, limitations in coverage that result in discrimination against an individual affected by pregnancy, false pregnancy, termination of pregnancy or recovery therefrom, childbirth or related medical conditions, should be explicitly prohibited. For example, if a covered plan excludes coverage for certain medical conditions associated with pregnancy, such as pelvic floor injury or postpartum depression, the plan may be discriminating based on sex. A plan design that excludes coverage of complications resulting from a pregnancy termination could constitute discrimination based on sex.

Finally, the Center notes that the preamble to the Proposed Rule states that "[t]he proposed rule does not require plans to cover any particular benefit or service."[135] However, the preamble to the Final Rule should clarify that the solution to a discriminatory benefit design, such as the ones discussed here, could be the addition of coverage for a benefit or service.

RECOMMENDATION:
The Center recommends that the preamble state, "The remedy for a discriminatory benefit design could be the addition of coverage for a benefit or service." In addition, the Center recommends the following language be added in a new subparagraph to § 92.207(b).

(b) Discriminatory actions prohibited. A covered entity shall not, in providing or administering a health-related insurance or other health-related coverage:

(6) Categorically or automatically exclude from coverage, or limit coverage, for maternity services to any enrollee, including enrolled dependents.

(7) Otherwise deny or limit coverage, or deny a claim, for specific health services if such denial or limitation results in discrimination against an individual affected by pregnancy, false pregnancy, termination of pregnancy or recovery therefrom, childbirth or related medical conditions.

[134] 29 C.F.R. § 1604.10(b) (2015); 29 C.F.R. pt. 1604 app. (2015) (question 22).
[135] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,189.

iv. Transgender Individuals

The Center strongly supports the Proposed Rule enumerating and prohibiting a range of insurance carrier and coverage program practices that discriminate against transgender individuals by arbitrarily singling them out for categorical denials of coverage for benefits provided to non-transgender people. Transgender individuals need preventive care to stay healthy and acute care when they become sick. Some may also seek medical treatment to physically transition from their assigned sex at birth to the sex that reflects their gender identity.

The procedures that may be medically necessary for a transgender individual as part of gender transition care are regularly prescribed for other medical indications for non-transgender individuals. The hormone therapy involved in gender transition, for example, is the same as that prescribed for endocrine disorders, such as hypogonadism, or to address side-effects of menopause.[136] The reconstructive surgical procedures that may be used in gender transition are regularly covered by insurance companies for non-transgender individuals.[137]
Despite the fact that the services used in care related to gender transition, including hormone therapy, mental health services, and surgeries, as well as anatomically appropriate preventive screenings, are regularly covered for non-transgender individuals, many insurance carriers categorically deny coverage of the same—and equally medically necessary—services for transgender people. The vast majority of health plans reviewed by the Center in twelve states excluded care related to gender transition for transgender individuals. In some states, such as Ohio, the EHB benchmark excludes transition-related care. Some issuers broadly exclude all transition-related services, such as those services related to "sex transformation; gender dysphoric disorder; gender reassignment" or "treatment leading to or in connection with transsexualism." Other issuers specifically exclude transition-related surgery, sometimes referred to as "transgender surgery" or "transsexual surgery," or exclude hormone therapy for transgender individuals.[138]

The multifaceted nature of insurance discrimination against transgender individuals means that the provisions at § 92.207(b)(3), (4), and (5) are all vital to ensuring that transgender people are able to access the health coverage and care they need. The Center very strongly urges the Department to preserve all three of these provisions in the Final Rule, with the clarifying modifications suggested below.

[136] Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3132 (2009).
[137] Dep't. of Health and Human Servs., Transsexual Surgery, NCD 140.3 No. A-13-87 12 (2014), http://www.hhs.gov/dab/decisions/dabdecisions/dab2576.pdf.
[138] NAT'L WOMEN'S LAW CTR., STATE OF WOMEN'S COVERAGE: HEALTH PLAN VIOLATIONS OF THE AFFORDABLE CARE ACT, *supra* note 129, at 20.

RECOMMENDATION:
Maintain § 92.207(b)(3) without any changes and amend the proposed provisions at § 92.207(b)(4) and (5) as follows:

> (4) Categorically or automatically exclude from coverage, or limit coverage for, ~~all~~ health services related to gender transition***, including gender reassignment surgeries and other services or procedures described in the most current version of the recognized professional standard of medical care for transgender individuals***; or
>
> (5) Otherwise deny or limit coverage, or deny a claim, for specific health services related to gender transition if such denial or limitation results in discrimination against a transgender individual ***by denying the individual access to medically necessary health services in accordance with the most current version of the recognized professional standard of medical care for transgender individuals***.

v. Medical Management Techniques

Medical management techniques are used by insurance plans and other health coverage to control access to covered services. There are reasonable uses of medical management, such as attempting to reduce duplication of services. However, medical management can also be used in a discriminatory manner. For example, the Department has previously noted that, if a plan places most or all drugs needed to treat specific conditions on the highest drug tier on the formulary, such plans discriminate against people with chronic conditions.[139] Similarly, a formulary could discriminate in violation of Section 1557 if the placement in the formulary resulted in women being forced to pay more for drugs than men, if the formulary was more restrictive for drugs that mostly women use, or if drugs that are used to treat conditions that primarily affect women were not covered at all while drugs used to treat conditions that primarily affect men were covered.

Other medical management techniques may be used in a discriminatory manner, such as placing prior authorization requirements on benefits used only by women or by applying facially allowable medical management procedures in a discriminatory manner, such as if steps in the process are waived for men but not for women. Medical management procedures may be applied in a discriminatory manner because the procedures themselves are discriminatory or because of a failure to provide adequate training or oversight to employees following the procedures. For example, the Center has found that women face numerous barriers to accessing breast pumps and lactation counseling services. Some of these barriers are the result of medical management techniques, such as requiring prior authorization or a letter of medical

[139] HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70,674, 70,723 (proposed Nov. 26, 2014) (to be codified at 45 C.F.R. pt. 144-48, 153-56, 158).

necessity for access to a breast pump.[140] Given the barriers to accessing services that medical management techniques can create, the Center recommends the addition of a subparagraph that specifically prohibits discriminatory medical management techniques.

RECOMMENDATION:
The following language should be added to a new subparagraph under § 92.207(b):

(b) Discriminatory actions prohibited. A covered entity shall not, in providing or administering a health-related insurance or other health-related coverage:
…
(8) Utilize medical management techniques including, but not limited to, prior authorizations, formulary design, step therapy, or use of case management or disease management in a way that limits or restricts coverage on the basis of an enrollee's or prospective enrollee's race, color, national origin, sex, age, or disability, or that otherwise adversely affects an enrollee or prospective enrollee because of the enrollee's or prospective enrollee's race, color, national origin, sex, age, or disability.

vi. Determining Whether a Particular Health Service Is Covered

Section 92.207(d) states that nothing in the section is intended to restrict a covered entity from determining whether a service is medically necessary or meets coverage requirements in an individual case; however, there may be instances in which the process the covered entity uses to determine whether a service is medically necessary or otherwise covered is discriminatory. In such cases, the Final Rule should prevent the covered entity's use of such processes. For example, women often experience different symptoms of heart disease from men. If a health insurance plan relied on guidelines based on typical male symptoms of heart disease to determine whether a test to diagnose a heart condition is medically necessary, such a determination could discriminate against women.[141] Similarly, if a plan were to rely on age rather than an individual's medical need to determine if services were necessary, such as only approving treatment of menopause symptoms for women above age 55, such a reliance would be discriminatory against people that need the service but do not meet the age restriction. The Center therefore recommends the Final Rule clarify that subparagraph (d) addresses determinations that are not discriminatory.

RECOMMENDATION:
The Department should rewrite § 92.207(d) as follows:

(d) Nothing in this section is intended to determine, or restrict a covered entity from determining, whether a particular health service is medically necessary or otherwise meets

[140] *See* NAT'L WOMEN'S LAW CTR., STATE OF BREASTFEEDING COVERAGE: HEALTH PLAN VIOLATIONS OF THE AFFORDABLE CARE ACT 5 (2015), http://www.nwlc.org/sites/default/files/pdfs/final_nwlc_breastfeedingreport2015_0.pdf.
[141] *What Are the Signs and Symptoms of Heart Disease?*, U.S. DEP'T OF HEALTH AND HUMAN SERV., NAT'L INST. OF HEALTH, http://www.nhlbi.nih.gov/health/health-topics/topics/hdw/signs (last updated Apr. 21, 2014).

applicable coverage requirements in any individual case, ***if the determination of medical necessity or meeting applicable coverage requirements is not based on discriminatory criteria and does not result in discrimination.***

vii. Plan Review and Revision

The Center urges the Department to include a more detailed guide for plans regarding their review and revision responsibilities under this section in the Final Rule. Our experience in reviewing qualified health plans offered on the health insurance exchanges indicates that plans frequently include language that is not allowed under the ACA.

RECOMMENDATION:
To ensure that plans offered or administered by entities covered under Section 1557 do not continue to include discriminatory plan design language or other discriminatory language in plan documents, the Department should include the following language in the preamble discussing § 92.207:

To be considered in compliance with this section, all health coverage programs and plans issued or administered by a covered entity will be required to:

- ***Revise current health plan documents to remove discriminatory benefit and coverage exclusions, limitations or medical management;***
- ***Implement protocols for determining medical necessity that are nondiscriminatory; and***
- ***Revise current health plan documents to clarify that individuals in all protected classes seeking coverage for services will be treated in the same manner as other enrollees, including with regard to access to internal and external appeals processes.***

In enforcing Section 1557, the Center urges OCR to work closely with the Centers for Medicare and Medicaid Services– including Medicare, Medicaid, and the Center for Consumer Information and Insurance Oversight – to coordinate a robust enforcement scheme that incorporates the Qualified Health Plan certification process, guidance related to the Essential Health Benefits, and analysis of federal and state data on insurance appeals and complaints filed under Section 1557 and other relevant laws, such as state laws prohibiting transgender exclusions under the rubric of unfair trade practices.

IX. § 92.208 Employer Liability for Discrimination in Employee Health Benefit Programs

The Center commends the Department for recognizing that Section 1557 addresses discrimination in employee health benefit programs. Given that employee health benefit programs are health programs and activities, however, they should be covered by Section 1557 in the same manner as any other health program or activity operated by a covered entity. Therefore, rather than addressing employee health benefit programs separately in § 92.208, the Department should amend the definition of "health program or activity" to include employee health benefit programs.

Under the Proposed Rule, Section 1557 would not impose liability on employers for offering certain discriminatory employee health benefit programs. Specifically, an employer would not be liable for offering a discriminatory employee health benefit program if (1) the employer's primary purpose is not providing or administering health services or health insurance coverage, (2) the primary purpose of the Federal financial assistance received by the employer is not to fund the employee health benefit program, and (3) the employer is not operating another health program or activity that receives Federal financial assistance. Moreover, even if an employer meeting conditions 1 and 2 *is* operating another health program or activity that receives Federal financial assistance, the employer would only be liable for providing a discriminatory health benefit program to the particular employees in that health program or activity. Under the Proposed Rule, therefore, some employees of a covered entity and their dependents will be protected against discrimination under Section 1557 while other employees and their dependents will not be protected.

While most health insurance issuers will be prohibited from offering discriminatory plans or providing services to discriminatory plans as a third-party administrator even if the employer is not covered directly,[142] under the Proposed Rule self-funded plans would not be reached directly in these circumstances.[143] As a result, many employers receiving Federal financial assistance will be permitted to continue to offer discriminatory health benefits to some or all of their employees, such as plans that exclude dependent children from maternity coverage or exclude transition related services for transgender individuals.

RECOMMENDATION:
The Department should strike § 92.208 and amend 92.4 so the definition of "health program or activity reads as follows (incorporating the additional language to the definition suggested above):

Health program or activity means the provision or administration of health related services or health related insurance coverage and the provision of assistance to individuals in obtaining health related services or health-related insurance coverage. "Health related" means designed to promote, maintain, or prevent the decline of an individual's or population's physical, mental, or social well-being. Consistent with the Civil Rights Restoration Act an entity principally engaged in providing or administering health services or health insurance coverage, all of its operations are considered part of the health program or activity, except as specifically set forth otherwise in this part. Such entities include a hospital, health clinic, group health plan, health insurance issuer, physician's practice, community health center, nursing facility, residential or

[142] *See* Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,191 n.93.
[143] The Proposed Rule would prohibit discrimination by third-party administrator services provided by a covered entity to self-insured plans, as recognized in footnote 73 of the proposed regulations. *Id.* at 54,189 n.73. However, because the Proposed Rule does not currently cover all employee health benefits provided by covered entities, a non-covered self-insured plan could simply select a third-party administrator that is not covered by Section 1557 in order to continue to offer discriminatory benefits.

community-based treatment facility, or other similar entity. A health program or activity also includes all of the operations of a State Medicaid program and all of the operations of other health programs, including public health programs, operated by state and local governments. **A health program or activity also includes employee health benefit programs.**

Should the Department nevertheless retain § 92.208, the Center recommends incorporating the substance set out in footnote 93 of the preamble into the Final Rule, making clear that whether or not an employer is liable for a discriminatory employee health benefits plan, an issuer that is a covered entity will be liable for discrimination in plans offered by employers. It is important to include this language in the Final Rule so that it is readily accessible in the Code of Federal Regulations and thus broadly understood and to ensure that § 92.208 does not undermine the intent and operation of § 92.207.

X. 92.209 Nondiscrimination in Association

The Center applauds the inclusion of the explicit prohibition against nondiscrimination on the basis of association. The Proposed Rule's language mirrors that of Title I and Title III of the Americans with Disabilities Act (ADA), which protect against discrimination based on association or relationship with a disabled person.[144] Section 1557 should be interpreted to provide at least the same protections for patients and provider entities. In accord with the ADA, the Final Rule should extend this protection to providers, who are at risk of associational discrimination due to their professional relationships with patients, including those patient classes protected under Section 1557.[145] For these purposes, the Final Rule should state that unlawful discrimination based on association occurs when a provider is subject to adverse treatment because it is known or believed to furnish services that are medically appropriate for, ordinarily available to, or otherwise associated with a patient population protected by Section 1557. This interpretation would, for instance, prohibit covered entities from using the provision of sex-specific services, such as abortion, as a disqualifying factor in recruiting otherwise eligible and qualified providers for participation in health programs supported by the Department. Providers should not be discriminated against for offering to competently care for a class of individuals with particular medical needs.

RECOMMENDATION:

[144] 42 U.S.C. § 12112 (2012) ("excluding or otherwise denying equal jobs or benefits to a qualified individual because of the known disability of an individual with whom the qualified individual is known to have a relationship or association); 42 U.S.C. § 12182 (2012) ("it shall be discriminatory to exclude or otherwise deny equal goods, . . . to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.").

[145] 28 C.F.R. pt. 35 app. B at 675 (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 . . . .").

The Center recommends amending § 92.209 to include the following additional language consistent with the ADA's prohibition on associational discrimination and the broad, remedial purposes of Section 1557.

§ 92.209 Nondiscrimination on the Basis of Association.

(a) General. 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, age, disability, or sex of an individual with whom the individual or entity is known or believed to have a relationship or association.

(b) Providers of health care or other related professional services. For the purposes of this section, the term "individual or entity" shall include individuals or entities that provide health care and other related professional services to individuals. Discrimination on the basis of association shall include any action by a covered entity to exclude from participation in, deny the benefits of, or otherwise discriminate against a provider in its health programs or activities based on the services the provider is known or believed to provide that are medically appropriate for, ordinarily available to, or otherwise associated with individuals of a certain race, color, national origin, age, disability, or sex.

XI. §§ 92.301-92.303 Enforcement Mechanisms

The Center strongly supports the Proposed Rule's inclusion of administrative remedies, as well as the recognition of a private right of action to challenge discrimination by recipients of Federal financial assistance and Title I entities.

Because all of the statutes referenced in Section 1557 have been interpreted to provide a private right of action for a full range of relief, including equitable relief and monetary damages, Section 1557 does so as well.[146] A private right of action is crucial for ensuring that individuals receive the robust protection Section 1557 promises them. Thus, Section 1557's explicit language and its statutory purpose require recognition of a private right of action.

However, as proposed, § 92.302 improperly provides that individuals with claims of race, sex, or disability discrimination may pursue the administrative remedies provided for by Title VI

[146] In *Cannon v. University of Chicago*, the Supreme Court emphasized the importance of the private right of action to enforcing antidiscrimination statutes. 441 U.S. 677, 704-05 (1979). The Court later determined that money damages are available for intentional discrimination, relying on the longstanding principal that all remedies are presumed to be available to accompany a federal right of action "unless Congress has expressly indicated otherwise." *Franklin v. Gwinnett County Public Schs.*, 503 U.S. 60, 66 (1992). There, the Court stated "Congress surely did not intend for federal monies to be expended to support the intentional actions it sought by statute to proscribe." *Id.* at 74. *See also* Guardians Assn. v. Civil Service Comm'n of New York City, 463 U.S. 582 (1983) (damages available under Title VI for intentional violations); Consolidated Rail Corporation v. Darrone, 465 U.S. 624 (1984) (awarding backpay for violation of Section 504 of Rehabilitation Act).

while individuals claiming age discrimination are limited to the administrative remedies provided by the Age Act, which requires mediation and the exhaustion of administrative remedies. A plain reading of Section 1557 makes clear that it cannot be interpreted to include such limitations on the remedies available to those making an age discrimination claim. Supreme Court precedent establishes that when one Spending Clause antidiscrimination statute references the enforcement provisions of another, it adopts the other statute's enforcement mechanisms but not its limitations.[147] Thus the Age Act's limitation cannot be incorporated into Section 1557.

As a practical matter, this parsing of remedies would mean that an elderly, African American woman who wanted to complain of intersecting forms of discrimination in health care or health insurance would have to bring separate administrative claims and different court actions. It simply makes no sense to distinguish the administrative and judicial remedies available if the disability is based on age from the relief available if it is based on race, color, national origin, disability or sex. We refer the Department to comments submitted by the Leadership Conference on Civil and Human Rights for a more detailed analysis.

XII. Conclusion

The Center appreciates the efforts by the Department of Health and Human Services and the Office of Civil Rights to end discrimination in health care. Following the recommendations set forth above will ensure that Section 1557 provides strong anti-discrimination protections.

Thank you for your consideration of our comments.

Sincerely,

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[147] Section 504 expressly makes available to victims of discrimination the "remedies, procedures, and rights set forth in Title VI." 29 U.S.C. § 794a(a)(2) (2012). In *Consolidated Rail Corp. v. Darrone*, the Court considered whether the Section 504 reference to Title VI limited the Rehabilitation Act's broad application. 465 U.S. 624 (1984). Although the Court held that the Rehabilitation Act's reference to the remedies, procedures, and rights set forth in Title VI allowed for enforcement similar to Title VI, it did not import limitations from Title VI not expressly provided in the Rehabilitation Act. *Id.* at 635. In so doing, the Court emphasized the broad purpose behind the Rehabilitation Act to support its conclusion that a limitation contrary to that broad purpose that was not expressly set forth in the statute should not be read into the statute. *Id.* at 632 n.13.