August 13, 2019

Department of Health and Human Services
Office for Civil Rights
Attn: Section 1557 NPRM, RIN 0945-AA11
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Re: Proposed Rule at 84 Fed. Reg. 27,846, RIN 0945-AA11 titled "Nondiscrimination in Health and Health Education Programs or Activities"

The American Civil Liberties Union ("ACLU") submits these comments on the proposed rule published at 84 Fed. Reg. 27,846 (proposed June 14, 2019), RIN 0945-AA11, with the title "Nondiscrimination in Health and Health Education Programs or Activities" (the "Proposed Rule" or "Rule").

For nearly 100 years, the ACLU has been our nation's guardian of liberty, working in courts, legislatures, and communities to defend and preserve the individual rights and liberties that the Constitution and the laws of the United States guarantee to everyone in this country. With more than 8 million members, activists, and supporters, the ACLU is a nationwide organization that fights tirelessly in all 50 states, Puerto Rico, and Washington, D.C. for the principle that every individual's rights must be protected equally under the law, regardless of race, religion, gender, sexual orientation, gender identity or expression, disability, national origin, or record of arrest or conviction.

The Proposed Rule is yet another attempt by the Trump Administration (the "Administration") and the Department of Health and Human Services (the "Department" or "HHS") to undermine access to health care for the most vulnerable individuals and communities, while emboldening discriminatory and dangerous denials of care. Instead of combatting discrimination in access to health care and insurance coverage, the Department set out to weaken antidiscrimination protections for transgender, non-binary,

and gender-nonconforming people, who already face threats of violence and discrimination in all aspects of their lives. Further, case after case has confirmed that transgender people are protected under the antidiscrimination statute, Section1557, which the Administration cannot change even if this rule is finalized.

The Proposed Rule also rolls back protections for people who face discrimination on other grounds. The Proposed Rule explicitly narrows the scope of Section 1557's antidiscrimination protections and implicitly invites health care providers to deny access to care. The Department offers these dangerous amendments, despite its original position that discrimination in health care leads to adverse health outcomes and exacerbates existing health disparities in underserved communities. It thus sanctions and completely disregards these harms to individuals trying to access health care and coverage. The proposed changes are contrary to the statutory language and reverse the reasoned policy decisions of the current regulations implementing the statute. As a result, the Proposed Rule will fail to accomplish its stated goal to *decrease* confusion, instead *increasing* the burdens and costs of compliance.

For these reasons, as well as the ones that follow, we recommend that the Department decline to finalize any part of the Proposed Rule.

I. BACKGROUND

A. The Current Rule Faithfully Implements the ACA's Purpose and Explicit Statutory Language to Ensure Robust Antidiscrimination Protections in Accessing Health Insurance and Care.

The rule currently in place implementing Section 1557, titled "Nondiscrimination in Health Programs and Activities" (the "Current Rule"), was developed after years of review and consideration of thousands of comments "from a wide variety of stakeholders." 81 Fed. Reg. 31,375, 31,376 (May 18, 2016). It furthered the most elemental aim of the Affordable Care Act ("ACA"): "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." *Id.* at 31,444.

In the preamble to the Current Rule, the Department noted that the regulation fulfills Congress's intent to provide "equal access to health services and health insurance that all individuals should have, regardless of their race, color, national origin, age, or disability." *Id.* at 31,459. Congress explicitly "extended these protections and rights to individuals seeking access to health services and health insurance without discrimination on the basis of sex." *Id.* Despite comments suggesting that the Department limit the reach of the regulation, it affirmed that

"the government has a compelling interest in ensuring that individuals have nondiscriminatory access to health care and health coverage." *Id.* at 31,380.

In promulgating the Current Rule, the Department was able "to provide consumers and covered entities with a set of standards that will help them understand and comply with the requirements of Section 1557." *Id.* at 31,377. The Department relied on its experience in determining that "providing information and outreach is not sufficient to ensure nondiscrimination in health care programs and activities" and that there was "need for a prescriptive regulation." *Id.* at 31,461. Specifically, the Department noted that it continued to receive complaints and hear of ongoing discrimination. *Id.*

In support of the Current Rule, the Department made detailed factual findings as to the impact of discrimination on access to health care and health insurance coverage:

> 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.

Id. at 31,444. The Department cited several studies establishing the factual basis for those findings. *Id.* at 31,444 n.304.[1] Further, the Department explicitly rejected suggestions that it decline to issue the Current Rule, stating that "we believe the regulation provides substantial benefits to society, net of the costs." *Id.* at 31,461.

The preamble to the Current Rule also describes the need and factual support for expanded regulations regarding the prohibition on sex discrimination. Although the ACA already prohibited discrimination based on sex, the Department found that "many women and transgender individuals continue[d] to experience discrimination

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[1] Citing LaVera M. Crawley, et al., *Perceived Medical Discrimination and Cancer Screening Behaviors of Racial and Ethnic Minority Adults*, 17 Cancer Epidemiology, Biomarkers & Prevention 1937, 1937–44 (2008), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2526181; Timothy Waldmann, *Estimating the Cost of Racial and Ethnic Health Disparities*, Urb. Inst. (2009), http://www.urban.org/sites/default/files/alfresco/publication-pdfs/411962-Estimating-the-Cost-of-Racial-and-Ethnic-Health-Disparities.pdf; Kristen Suthers, *American Public Health Association: Issue Brief: Evaluating the Economic Causes and Consequences of Racial and Health Disparities*, Am. Pub. Health Ass'n (2008), http://hospitals.unm.edu/dei/documents/eval_cause_conse_apha.pdf.

in the health care context," and "demonstrate[d] the need for further clarification regarding the prohibition of discrimination on the basis of sex." *Id.* at 31,460. The Rule provided extensive factual support to demonstrate that transgender individuals in particular face major barriers to receiving care, and concluded that, despite the costs, "provisions prohibiting sex discrimination in the ACA increase the affordability and accessibility of health care for women and transgender individuals." *Id.* at 31,460 & nn.367–76. The Department estimated that "the infrastructure and protocols for providing services or treatment are already in place" and providers would simply have to provide those services in a nondiscriminatory manner, regardless of individuals' sex. *Id.* at 31,455; *see also id.* at 31,456–57 & nn.346–53 (referring to studies finding *de minimis* cost related to covering gender-confirming care).[2]

B. The Proposed Rule is Another Example of the Trump Administration's Intent to Undermine Access to Health Care and Target Transgender Individuals.

Given the statutory purpose of Section 1557 and the extensive factual support for the Current Rule, the Department's stated reasons for the Proposed Rule are suspect. Indeed, the Department has failed to defend key provisions of the Current Rule since the beginning of the Trump Administration.

Nowhere is this more evident than in the Administration's failure to defend the Current Rule's definition of discrimination on the basis of sex in ongoing litigation, to the detriment of transgender people and others protected under the regulations. In December 2016, a Texas federal district court enjoined enforcement of the Current Rule's prohibition against discrimination on the basis of gender identity or termination of pregnancy. *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660, 696 (N.D. Tex. 2016). The Administration did not appeal the decision, instead seeking to stay the case so that it could "reevaluate the regulation"—leaving in place the injunction. Defs' Mot. at 1–2, *Franciscan All.*, 227 F. Supp. 3d 660, ECF No. 92. Most recently, the Administration argued *in favor* of permanently enjoining those provisions of the definition, as well as incorporating Title IX's exemptions (including those addressing religion and abortion), Defs' Mem. in Resp. at 11, *Franciscan All.*, 227 F. Supp. 3d 660, ECF No. 154, just as HHS now proposes to do. Throughout this time, the ACLU of Texas and River City Gender Alliance—which have members who are unable to get adequate health care and insurance coverage due to the injunction—have not been permitted to intervene in the suit, even though they would be the only parties defending the Current Rule.

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[2] The Department provided examples, stating that "a provider could not refuse to treat a patient for a cold or a broken arm based on the patient's gender identity. Similarly, if the provider is accepting new patients, it must accept a new patient request from a transgender individual and cannot decline to accept a transgender individual in favor of a person who is not transgender." 81 Fed. Reg. at 31,455.

Time and again HHS and the Trump Administration have rolled back key protections for access to health care or have proposed new regulations that undermine access to insurance coverage and care—particularly regarding reproductive health care and care for transgender individuals. The Department issued rules that would allow virtually any for-profit company or non-profit organization to deprive people of contraceptive coverage, despite the harm it would cause to their health and well-being and contrary to Congress's explicit intent that the ACA require coverage of contraception. *See* Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,592 (Nov. 15, 2018); Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,536 (Nov. 15, 2018).[3] The Department finalized a rule that would decimate the country's only dedicated federally funded program to provide family planning services and disrupt critical health care for millions of people nationwide. Compliance With Statutory Program Integrity Requirements, 84 Fed. Reg. 7714 (Mar. 4, 2019).[4] The Department finalized a separate rule that aims to dramatically expand the ability of health care institutions and workers to refuse to provide medical services—and even information—from patients if they have a moral or religious objection to the care. Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170 (May 21, 2018).[5] The Administration has also proposed a rule that would penalize and discourage access to health care by immigrant women and children. Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51,114 (Oct. 10, 2018).[6]

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[3] *See* Complaint, *ACLU v. Wright*, No. 3:17-cv-05772 (N.D. Cal. Oct. 6, 2017), https://www.aclu.org/legal-document/american-civil-liberties-union-et-al-v-wright-et-al-complaint; Faiz Shakir & Georgeanna M. Usova, ACLU Comment on Interim Final Rule on Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act (Dec. 5, 2017), https://www.aclu.org/letter/aclu-comments-interim-final-rules-acas-birth-control-benefit-religious-exemptions.

[4] Complaint, *Nat'l Family Planning & Reprod. Health Ass'n v. Azar*, No. 1:19-cv-03045 (E.D. Wash. Mar. 7, 2019), https://www.nationalfamilyplanning.org/file/Title-X-complaint.pdf; *New Restrictions Would Prevent Millions of Low-Income People From Obtaining Contraception And Preventive Care*, ACLU (Mar. 7, 2019), https://www.aclu.org/press-releases/nfprha-cedar-river-clinics-and-aclu-challenge-trump-administrations-harmful-changes-0.

[5] Complaint, *Nat'l Family Planning & Reprod. Health Ass'n v. Azar*, No. 19-cv-5435 (S.D.N.Y. June 11, 2019), https://www.aclu.org/sites/default/files/field_document/complaint_hhs.pdf; Lindsey Kaley, *Patients' Needs, Not Personal Beliefs, Come First in Health Care*, ACLU (June 11, 2019), https://www.aclu.org/blog/reproductive-freedom/religion-and-reproductive-rights/patients-needs-not-personal-beliefs-come.

[6] Faiz Shakir et al., ACLU Comment on Proposed Rule on Inadmissibility on Public Charge Grounds (Dec. 10, 2018), https://www.aclu.org/sites/default/files/field_document/aclu_public_charge_comments_-_12-10-18.pdf.

In each of these new rules and regulations, the Trump Administration and HHS have abdicated responsibility for ensuring that people can access high-quality, evidence-based health care, free from discrimination. The Trump Administration has even gone so far as declining to defend the legality of the ACA in its entirety, despite the monumental impact the ACA has had in increasing access to crucial health care services and coverage for people across the country. DOJ Letter, *Texas v. United States*, No. 19-10011 (5th Cir. Mar. 25, 2019), https://affordablecareactlitigation.files.wordpress.com/2019/03/doj-anti-aca-letter-3-25.pdf.

The Trump Administration has targeted transgender and gender non-conforming individuals in particular. The Administration banned transgender members of the military from openly serving, and prohibited coverage for certain critical medical procedures. Dept. of Defense, Military Service by Transgender Individuals, Feb. 22, 2018, https://media.defense.gov/2018/Mar/23/2001894037/-1/-1/0/military-service-by-transgender-individuals.pdf.[7] Despite a prior position that transgender people are protected from federal law barring employment discrimination, the Trump Administration reversed its position. Brief for the Federal Respondent at 12, *R.G. & G.R. Harris Funeral Homes, Inc. v. EEOC*, No. 18-107 (U.S. Oct. 24, 2018), https://www.aclu.org/sites/default/files/field_document/20181024152750333_18-107_rg_gr_harris_funeral_homes.pdf.[8] Additionally, the Administration has proposed a rule to allow taxpayer-funded shelters to turn away transgender people experiencing homelessness. *Revised Requirements Under Community Planning and Development Housing Programs (FR-6152)*, U.S. Office of Info. & Regulatory Affairs (Spring 2019), https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201904&RIN=2506-AC53.[9]

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[7] Complaint, *Stone v. Trump*, 280 F. Supp. 3d 747 (D. Md. 2017), https://www.aclu.org/sites/default/files/field_document/aclu_complaint_0.pdf; Chase Strangio, *We Are Taking Trump to Court to Stop His Illegal and Cruel Ban on Transgender Service Members*, ACLU (Aug. 28, 2017), https://www.aclu.org/blog/lgbt-rights/transgender-rights/we-are-taking-trump-court-stop-his-illegal-and-cruel-ban.

[8] Brief for Respondent, *R.G. & G.R. Harris Funeral Homes, Inc. v. EEOC*, No. 18-107 (U.S. June 26, 2019), https://www.aclu.org/legal-document/eeoc-v-rg-gr-harris-funeral-homes-brief-respondent-aimee-stephens.

[9] *HUD Moves to Allow Anti-Trans Discrimination in Federally Funded Homeless Shelters*, ACLU (May 22, 2019), https://www.aclu.org/press-releases/hud-moves-allow-anti-trans-discrimination-federally-funded-homeless-shelters.

II. THE PROPOSED RULE SHOULD NOT ROLL BACK AFFIRMATIVE ANTIDISCRIMINATION PROTECTIONS.

Section 1557 provides that "an individual shall not . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance." 42 U.S.C. § 18116. The statute prohibits discrimination in the health care context against people on the grounds of race, color, national origin, age, disability, or sex. *Id.* (citing 42 U.S.C. § 2000d *et seq*. (Title VI of the Civil Rights Act of 1964); 20 U.S.C. § 1681 *et seq*. (Title IX of the Education Amendments of 1972); 42 U.S.C. § 6101 *et seq*. (Age Discrimination Act of 1975); 29 U.S.C. § 794 (Section 504 of the Rehabilitation Act of 1973).

The Department makes clear that the Proposed Rule is primarily intended to roll back protections for transgender individuals. However, transgender, non-binary, and gender-nonconforming individuals are protected against discrimination under Title IX. Additionally, the amendments to the Current Rule that are intended to limit its efficacy, described in further detail *infra* Part III, would also harm others protected under Section 1557. For example, reducing the entities covered by Section 1557 harms people who are discriminated against because of disabilities. Confusion around available enforcement mechanisms under Section 1557 makes it harder for people who face racial discrimination in accessing health care to actualize their rights. The Department must recognize the continued prevalence of discrimination in the health care context and the possible harms people suffer without robust antidiscrimination protections, neither of which is addressed by the Proposed Rule.

A. HHS Should Maintain the Existing Definition of Discrimination on the Basis of Sex and Explicit Protections Against Such Discrimination.

In promulgating the Current Rule, the Department recognized the importance of affirmative and explicit regulatory protections—specifically for all enumerated forms of discrimination. *See* 81 Fed. Reg. at 31,444 (finding that "[d]iscrimination 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"). The Current Rule defines discrimination based on sex to include discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity. *Id.* at 31,467; *see* 45 C.F.R. § 92.4.

Without justification, the Department has reversed course with the Proposed Rule, eliminating this key provision that clarifies what discrimination on the basis of sex covers, and removing explanatory examples of prohibited activity. The

Proposed Rule also amends regulations—and incorporates an abortion exemption—that are unrelated to Section 1557. These changes are without justification and will directly harm patients seeking care. Accordingly, the Department should maintain the Current Rule, and abandon the changes it has proposed.

1. *The Proposed Rule fails to account for the resulting harm to LGBT individuals and people seeking reproductive health care.*

The Department's Regulatory Impact Analysis must address the effect that inviting discrimination will have on public health—particularly the harms to transgender and non-binary individuals, and people seeking or who have obtained reproductive health care. The current Analysis admits that the Department has completely failed to consider the impact on individuals who currently benefit from the Current Rule, 84 Fed. Reg. at 27,876, the very people the statute was intended to protect.

Section 1557 and the Current Rule are intended to protect people from the pervasive problem of sex-based discrimination in health care. Lesbian, gay, bisexual, and transgender ("LGBT") patients, as well as people seeking or who have obtained reproductive health services, face discrimination based on sex in accessing health care.[10] Such discrimination can take the form of providers using harsh or abusive language, being physically rough, blaming the patient for their health status, or refusing to touch them.[11] In some cases, patients are completely refused necessary medical care.[12] As a result, fear of such discrimination causes people to postpone or avoid seeking preventative care, and even decline to access care when they are sick or injured.[13] Failing to seek care due to sex discrimination results in

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[10] Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29 J. L., Med. & Ethics 13 (2001); Judith H. Lichtman et al., *Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction*, 10 J. Am. Heart Ass'n 1 (2015); Liza Baskin, *LGBT Patients Find Little Patience in Health Care*, Daily Rx (July 11, 2012), http://www.dailyrx.com/lgbt- friendly-health-care-remains-out-reach-most; Adam Sonfield, *No One Benefits If Women Lose Coverage for Maternity Care*, Guttmacher Inst. (June 14, 2017), https://www.guttmacher.org/gpr/2017/06/no-one-benefits-if-women-lose-coverage-maternity-care.

[11] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010), http://www.lambdalegal.org/publications/when-health-care-isnt-caring.

[12] Nat'l Gay and Lesbian Task Force and Nat'l Ctr. for Transgender Equality, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* (2011), http://endtransdiscrimination.org/PDFs/NTDS_Report.pdf; Lambda Legal, *When Health Care Isn't Caring*, *supra* note 11.

[13] *National Transgender Discrimination Survey*, *supra* note 12 at 76; Fenway Institute, *Promoting Cervical Cancer Screening Among Lesbians and Bisexual Women* (2013),

serious negative health consequences,[14] which are only further exacerbated when those same individuals are also members of other disadvantaged groups.[15]

Section 1557 also bars discriminatory exclusions from health care coverage, as such exclusions mean that necessary health care is otherwise unaffordable.[16] For example, some transgender and non-binary individuals are subject to discriminatory categorical exclusions for health care related to gender transition that put necessary health care out of financial reach. By eliminating the definition of discrimination on the basis of sex the Proposed Rule will invite such discrimination against LGBT individuals and people seeking reproductive health care.

The Proposed Rule fails to consider these important aspects of discrimination based on sex in health care and should be abandoned as it fails to adequately defend against the physical, financial, and dignitary harms of such discrimination.[17]

2. The proposed amendments foster confusion, not clarity.

The Department contends that the Proposed Rule is needed to reduce confusion and to clarify the scope of Section 1557. But should the Department

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http://www.lgbthealtheducation.org/wp-content/uploads/Cahill_PolicyFocus_cervicalcancer_web.pdf.

[14] *See, e.g.*, Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), https://www.ncbi.nlm.nih.gov/pubmed/22013611; HHS, *Lesbian, Gay, Bisexual, and Transgender Health* (last visited Aug. 6, 2019), http://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health; *Lesbian, Gay, Bisexual, and Transgender Health*, Ctrs. for Disease Control & Prevention (last visited Aug. 6, 2019), http://www.cdc.gov/lgbthealth/about.htm; *When Health Care Isn't Caring*, *supra* note 11.

[15] Institute of Medicine, *supra* note 14; Center for American Progress, *Health Disparities in LGBT Communities of Color: By the Numbers* (Jan. 15, 2010), https://www.americanprogress.org/issues/lgbt/news/2010/01/15/7132/health-disparities-in-lgbt-communities-of-color; Center for Reproductive Rights, et al., *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care* (2014), https://reproductiverights.org/sites/default/files/documents/CERD_Shadow_US_6.30.14_Web.pdf.

[16] Laura E. Durso et al., *LGBT Communities and the Affordable Care Act: Findings from a National Survey*, Ctr. for Am. Progress (Oct. 10, 2013), http://www.americanprogress.org/wp-content/uploads/2013/10/LGBT-ACAsurvey-brief1.pdf.

[17] Indeed, we recommend—and did when the Current Rule was proposed—that discrimination based on sexual orientation be included in the definitional provision, and that it be made explicit that the rule protects access to care for non-binary individuals. *See* Karin Johanson, ACLU Comment on Proposed Rule on Nondiscrimination in Health Programs and Activities at 4–7 (Nov. 9, 2015), https://www.aclu.org/sites/default/files/field_document/11-09-15_aclu_1557_comments.pdf.

delete the definitional provisions, it would actually *cause* confusion and embolden health care and insurance providers to discriminate. The Department's proposal does nothing to clarify what constitutes prohibited sex discrimination under Section 1557, as eliminating the definition does not mean that discrimination on the presently enumerated bases is suddenly permitted. Instead, eliminating the definition invites discrimination and undermines uniformity among providers—to the detriment of covered entities and patients alike.

Because discrimination based on sex would still be prohibited, discrimination based gender identity would remain unlawful under Section 1557 as well. Courts have consistently held that Title IX's prohibition on sex discrimination protects individuals from discrimination based on gender nonconformity. *See EEOC v. R.G. &. G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 572 (6th Cir. 2018), *cert. granted in part*, 139 S. Ct. 1599 (2019); *Whitaker ex rel. Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1046–54 (7th Cir. 2017); *Glenn v. Brumby*, 663 F.3d 1312, 1316 (11th Cir. 2011); *Schwenk v. Hartford*, 204 F.3d 1187, 1201 (9th Cir. 2000); *Rosa v. Park W. Bank & Tr. Co.*, 214 F.3d 213, 215–16 (1st Cir. 2000). District courts across the country have also recognized that discrimination against transgender individuals because their gender identity diverges from their sex assigned at birth violates the plain text of Section 1557. *See Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 953 (D. Minn. 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). The Department has tried to argue that courts are deeply divided on the matter, but failed to address that all five appellate courts to address the question have uniformly held that Title IX and other statutory prohibitions on sex discrimination encompass discrimination against transgender individuals for having a gender identity different from their sex assigned at birth.

Given the extensive legal precedent, the Department cannot simply assert by regulation that covered entities will not be liable for gender identity discrimination claims "because such claims would not be cognizable under the proposed rule." 84 Fed. Reg. at 27,876.[18] Discrimination based on gender identity is prohibited by the statutory text, and the Department's regulations should accurately reflect that fact. Even the parties challenging the Current Rule in *Franciscan Alliance* agree that, because the Proposed Rule does not offer a new definition of discrimination on the basis of sex, they would still be prohibited from discriminating on the basis of gender identity, including providing gender-transition services, should the rule be finalized. Pls.' Resp. at 6, *Franciscan All.*, 227 F. Supp. 3d 660, ECF No. 160.

[18] For example, that there are other HHS regulations that seem to ascribe a narrow definition of sex is inapplicable here, where the question is the definition of *discrimination on the basis* of sex—not what "sex" means as a variable in clinical research studies for the National Institutes of Health. 84 Fed. Reg. at 27,853–54.

Further, while the preamble to the Proposed Rule spends an inordinate amount of time attempting to justify the elimination of gender identity as an identified form of sex discrimination, it does not explain why the other definitional provisions are eliminated as well. Removing the definition of sex discrimination cannot change the underlying legal precedent it was based on, which still prohibits discrimination on the enumerated grounds. For example, Title IX and other civil rights statutes have consistently been interpreted to bar discrimination based on sex stereotyping concerning appearance, behavior, and family role, among other traits.[19] Pregnancy discrimination necessarily constitutes sex discrimination under Section 1557, as it is considered sex discrimination under Title IX[20] and other civil rights statutes including Title VII.[21] These laws prohibit discrimination based on pregnancy itself, as well as pregnancy-related conditions.[22] Given that precedent, none of the definitional provisions should be deleted.

Relatedly, the Department should not delete 45 C.F.R. §§ 92.206–92.209, which provide important clarification of the scope of Section 1557's protections, including examples of prohibited discriminatory actions related to health insurance coverage.[23] Should the Department delete the definitional and explanatory provisions, it would cause confusion and embolden health care and insurance

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[19] *See Nev. Dep't of Hum. Res. v. Hibbs*, 538 U.S. 721, 736 (2003); *Price Waterhouse v. Hopkins*, 490 U.S. 228, 251 (1989) (holding sex stereotyping violates Title VII because "we are beyond the day when an employer could evaluate employees by assuming or insisting that they matched the stereotype associated with their group"); *City of L.A., Dep't of Water & Power v. Manhart*, 435 U.S. 702, 707 n.13 (1978) (Title VII was "intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes" (internal quotation marks omitted)); *Califano v. Goldfarb*, 430 U.S. 199, 216–17 (1977) (striking down as unconstitutional gender discrimination Social Security Act's requirement that male spouses prove financial dependence to claim survivors' benefits, while not imposing such requirement on female spouses); *Weinberger v. Wiesenfeld*, 420 U.S. 636, 653 (1975) (holding that restricting Social Security survivors' benefits to female spouses is unconstitutional gender discrimination); *Frontiero v. Richardson*, 411 U.S. 677, 690–91 (1973) (striking down federal statute awarding military benefits to male spouses only upon showing financial independence, when no such requirement was placed on female spouses).

[20] 34 C.F.R. § 106.40(b)(1) (2012); *see also Pfeiffer v. Marion Ctr. Area Sch. Dist.*, 917 F.2d 779, 784 (3d Cir. 1990); *Hogan v. Ogden*, No. 06-CV-5078, 2008 WL 2954245, at *13 (E.D. Wash. July 30, 2008); *Chipman v. Grant County 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*, No. 90-CV-0128, slip op. (D. Ariz. May 31, 1990); *Wort v. Vierling*, No. 82-3169, slip op. (C.D. Ill. Sept. 4, 1984), *aff'd*, 778 F.2d 1233 (7th Cir. 1985).

[21] 42 U.S.C. § 2000e(k).

[22] *See, e.g., id.*; *see also* 29 C.F.R. pt. 1604; *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669 (1983).

[23] Although 81 C.F.R. § 92.206 addresses equal program access on the basis of sex, the other provisions that the Proposed Rule would delete apply generally to the other protected bases of discrimination, including race and disability, discussed more below.

providers to discriminate. Eliminating the definitions and examples does not mean that discrimination on the presently enumerated bases is suddenly permitted because those definitions and examples simply reflect how discrimination on the basis of sex has been interpreted by the courts. Deleting those provisions will only create greater confusion to the detriment of covered entities and patients alike. Removing the provisions also constitutes a reversal of policy from the Current Rule, that emphasized the "importance of and need for a prescriptive regulation," to "inform stakeholders of their rights so that affected individuals know that they can seek OCR's assistance, and . . . provide clarity for covered entities, limiting uncertainty and promoting compliance." 81 Fed. Reg. at 31,461.

Accordingly, the Department should abandon the Proposed Rule and instead should reinforce that discrimination based on gender identity is a form of sex discrimination, as is discrimination based on pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, and sex stereotyping. Further, the Department should not attempt to exclude discrimination based on gender identity or any of the other enumerated bases from the definition of sex discrimination. Carving out an exemption from Section 1557's statutory prohibition on sex discrimination to permit discrimination against transgender individuals or others protected under the Current Rule would violate the ACA as well as the Equal Protection Clause of the U.S. Constitution. *See, e.g.*, *Romer v. Evans*, 517 U.S. 620, 635 (1996) ("A State cannot so deem a class of persons a stranger to its laws.").

3. *The Department cannot rely on its own failure to appeal the preliminary injunction decision in Franciscan Alliance as a basis for changing the rule.*

The Texas federal district court's preliminary injunction in *Franciscan Alliance*, which enjoined enforcement of the Current Rule's prohibition against discrimination on the basis of gender identity or termination of pregnancy, does not require the issuance of the Proposed Rule. The Department does not explain how a preliminary injunction granted in one district court outweighs the precedent set by several federal appellate courts, as well as numerous other courts that have decided that prohibiting discrimination based on sex also prohibits discrimination based on gender identity and gender nonconformity. Indeed, every other district court to consider the issue has disagreed with the court's analysis in *Franciscan Alliance*. *See Tovar*, 342 F. Supp. 3d at 953; *Flack*, 328 F. Supp. 3d at 951; *Prescott*, 265 F. Supp. 3d at 1098–1100. According to all of these courts, discrimination against transgender individuals is prohibited by the text of Section 1557 itself.

Further, it is wholly inapt for the Department to point to *Franciscan Alliance* to justify the Proposed Rule, where in that case the Trump Administration stopped defending the Current Rule, declined to appeal the preliminary injunction, and

argued in favor of permanently enjoining those provisions of the Current Rule, while impacted individuals have been unable to intervene in the case. A singular case, in which no party is defending the Current Rule, is no reason to undermine statutory protections through the Proposed Rule.

4. HHS provides no basis for repealing other antidiscrimination regulations unrelated to Section 1557.

The Department should not strip protections against discrimination based on gender identity and sexual orientation from other HHS regulations, and has offered no independent reason for the changes. *See* 84 Fed. Reg. at 27,871. If the Department abandons the Proposed Rule, as we urge, there will be no need to amend these other HHS regulations, many of which were in effect long before the Current Rule. Tellingly, the Department has offered no independent reason for changing the regulations, aside from conforming them to Proposed Rule, which itself lacks a reasoned basis. As described above, eliminating the explicit protection does not mean that the discrimination on those bases will not still be prohibited—it will simply lead to more confusion and less certainty for affected entities. Evidently, the Department is less concerned with creating consistency across components of HHS, and more concerned with stripping affirmative protections against discrimination.[24]

Taken together, the proposed changes to regulations implementing Section 1557, along with the proposal to strip explicit protections for LGBT individuals from other HHS regulations, indicates that the underlying purpose for the Proposed Rule is to target transgender and non-binary individuals, as well as other people who face discrimination based on sex in accessing health care. For example, in an

[24] The proposed rescission of 45 C.F.R 86.31, which governs differential rules of appearance, similarly undermines antidiscrimination protections. Gender-differentiated codes of appearance, which are a subset of school disciplinary rules, already violate the more general Title IX regulation prohibiting recipients from "[s]ubject[ing] any person to separate or different rules of behavior, sanctions, or other treatment." 45 C.F.R. § 86.31(b)(4). Moreover, the reasons provided for this regulatory change, *see* 84 Fed. Reg. 27,871, are inaccurate and misleading because they suggest that Title IX does not reach differential treatment based on dress. Courts have found otherwise. *See Hayden ex rel. A.H. v. Greensburg Cmty. Sch. Corp.*, 743 F.3d 569, 577–82 (7th Cir. 2014). Contrary to the suggestion in the preamble, the prior rescission of the regulation governing codes of appearance did not constitute an interpretation by the Department as to the scope of Title IX's substantive protections. *See Nondiscrimination on the Basis of Sex in Education Programs and Activities Receiving or Benefiting from Federal Financial Assistance*, 47 Fed. Reg. 32,526-02 (July 28, 1982). Moreover, *Jespersen v. Harrah's Operating Co.*, 44 F.3d 1004 (9th Cir. 2006) (en banc), the Title VII case on which the Proposed Rule relies, *see* 84 Fed. Reg. 27,871, was wrongly decided under Title VII and should not be used to justify further erosion of the substantive protections afforded under Title IX. The Department should therefore leave the existing regulation undisturbed.

unnecessary swipe at access to public facilities for transgender and non-binary people, the Department implies that permitting people with a gender identity that differs from their sex assigned at birth to use facilities consistent with their gender identity could constitute a hostile environment. 84 Fed. Reg. at 27,874 n.179. That reasoning has been rejected time and again by courts across the country. *See Doe by & through Doe v. Boyertown Area Sch. Dist.*, 897 F.3d 518, 536 (3d Cir. 2018), *cert. denied* 139 S. Ct. 2636 (2019); *Parents for Privacy v. Dallas Sch. Dist. No. 2*, 326 F. Supp. 3d 1075, 1102 (D. Or. 2018) ("The mere presence of a transgender student is insufficient to establish a hostile environment."). In a regulation otherwise devoid of clarity as to what will or will not constitute discrimination based on sex, the Department goes out of its way to include this footnote, sending an ominous signal that it believes that allowing transgender people to access facilities consistent with their identities may violate the rights of cisgender people. The Department has not demonstrated with this Proposed Rule that it is interested and able to protect against discrimination based on sex, particularly for transgender individuals.

5. *HHS must provide opportunity for additional comments following the U.S. Supreme Court's decisions in* Zarda*,* Bostock*, and* Stephens.

The confusion that this rule will cause is further exacerbated by the fact that the U.S. Supreme Court granted three petitions for writs of certiorari as to whether, under Title VII, sex discrimination encompasses discrimination based on sexual orientation, gender identity, and discrimination against transgender individuals due to sex stereotyping. *Altitude Express, Inc. v. Zarda*, 139 S. Ct. 1599 (2019); *Bostock v. Clayton Cty., Ga.*, 139 S. Ct. 1599 (2019); *R.G. & G.R. Harris Funeral Homes, Inc. v. EEOC*, 139 S. Ct. 1599 (2019). Although the cases currently before the Court are Title VII cases, Title IX generally adopts the standards for discrimination under Title VII. As such, it will be necessary to address whether that continues to apply in light of the Court's ruling. Regardless of which way the Court rules, the Department will need to clarify the practical implications of the decision on implementation and enforcement of Section 1557: Should the Court rule in favor of the plaintiffs in those cases, its decision would completely undermine the Department's legal analysis in the Proposed Rule. Even if the Court rules against the plaintiffs, there must be a chance for interested parties to address how its decision should be applied in the context of Section 1557.

The Department acknowledges that these cases will have profound ramifications on the definition of discrimination on the basis of sex under Title IX, but does not explain why it is necessary to amend the existing regulations at this time or how it plans to handle the Court's rulings. 84 Fed. Reg. at 27,855. Accordingly, any comments or final rule on the proper definition of sex discrimination may be mooted by the Court, and a new comment period would be necessary to address the impact of the Court's decisions in the Title VII context on

Section 1557 and its interpretation of protections under Title IX. It is not enough to delay the issuance of a final rule until after the decisions—there must be a chance for new comments at that time, given the many directions the Court's holdings could take.

6. *HHS should not import an abortion exemption into its definition of sex discrimination.*

Abortion care is health care related to pregnancy, and targeting it for exclusion undermines and stigmatizes access to care that is constitutionally protected. The Proposed Rule would unnecessarily incorporate the abortion exemption, known as the Danforth Amendment, from Title IX into regulations implementing Section 1557. Incorporating the abortion exemption violates the text and purpose of Section 1557, which prohibits discrimination "on the *ground[s]* prohibited under" the referenced civil rights statutes, not the attendant exemptions contained in those statutes. 42 U.S.C. § 18116 (emphasis added). Congress has already spoken clearly as to how it intended to regulate abortion care and coverage, through both the ACA itself, *see* 42 U.S.C. § 18023(b), as well as the Weldon, Church, and Coats Amendments.

The Department claims that it is particularly important to incorporate the abortion exemption, because the inclusion of "termination of pregnancy" as a recognized form of sex discrimination exceeds its statutory authority. 84 Fed. Reg. at 27,849. However, the Department then acknowledges that HHS could still consider termination of pregnancy, including "discrimination on the basis of miscarriage or discrimination on the basis of medical complications resulting from a termination of pregnancy" as a form of sex discrimination. 84 Fed. Reg. at 27,870 n.159. The Department's failure to take a position as to whether discrimination based on termination of pregnancy—or other recognized forms of sex discrimination—is prohibited by Section 1557 only adds to confusion around the scope of the law, and prevents entities and individuals from knowing how the Department will enforce Section 1557; it does not demonstrate that the abortion exemption is necessary.

* * *

Taken as a whole, the Proposed Rule strips explicit regulatory protections for LGBT individuals and for people who require reproductive health care, indicating that the underlying purpose for the amendments is to target transgender and non-binary individuals, as well as other people who face sex-based discrimination in accessing health care and insurance coverage. That is neither consistent with the text of the statute, nor the appropriate mission of the Department. Accordingly, the Department should abandon the Proposed Rule and instead leave in place the existing regulation that discrimination based on gender identity is a form of sex

discrimination, as is discrimination based on pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, and sex stereotyping.

B. HHS Should Not Weaken Protections for People with Disabilities.

Historically, people with disabilities in the United States have been unable to access the health care they need because of discrimination by the health insurance industry. Prior to the ACA, people with disabilities were commonly denied health insurance coverage, faced annual and lifetime benefit limits, and could not find affordable coverage. Even if a disabled individual was able to purchase health insurance, the policy would often exclude coverage of pre-existing conditions, fail to offer essential benefits, or otherwise limit benefits based on health status or disability. Access to adequate health care at affordable rates is central to the ability of disabled people to participate fully in society. The reality of disability discrimination in health insurance has long undermined the goal of the Americans with Disabilities Act ("ADA"): the integration of people with disabilities into all areas of civic, social, and economic life.

The passage of the ACA promised to transform access to health insurance coverage for disabled people, as Congress explicitly outlawed longstanding discriminatory policies.[25] Section 1557 provides essential protections as well. Under the Current Rule, actionable discrimination includes discrimination by health insurers and in health plan "benefit designs." 45 C.F.R. § 92.4 (defining "health program or activity" to mean "the provision or administration of health-related services, health-related insurance coverage, or other health-related coverage, and the provision of assistance to individuals in obtaining health-related services or health-related insurance coverage"); *id.* § 92.207(b)(2) (prohibiting, *inter*

[25] There are several provisions within the ACA, separate from Section 1557, which prohibit discrimination against disabled individuals: No longer would people with disabilities be excluded from purchasing insurance based on a "pre-existing condition." 42 U.S.C. § 300gg–3. And as a further, integral component of these reforms, Congress mandated comprehensive health benefit coverage—certain minimum features to meet the basic needs of all Americans—and explicitly prohibited discriminatory practices in the design of those plans. 42 U.S.C. § 18022(b)(4) (directing the Secretary to further define essential health benefits ("EHBs"), and, in doing so, to "take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups[,]" "ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life[,]" and not "design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life"); 42 U.S.C. § 18031(c)(1)(A) (directing that a certified health plan "not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs").

alia, "benefit designs that discriminate on the basis of . . . disability in a health-related insurance plan or policy, or other health-related coverage"). For example, plans that "cover[] bariatric surgery in adults but exclude such coverage for adults with particular developmental disabilities," or "plac[e] most or all prescription medications that are used to treat a specific condition on the highest cost formulary tiers" violate Section 1557.[26] The application of nondiscrimination principles to health insurers and benefit design is essential to the needs and rights of disabled people.

The Proposed Rule would undermine the promise of Section 1557 for people with disabilities, in particular through two amendments to the Current Rule. First, as discussed in more detail *infra* Part III.B., the Department's assertion of which entities are "principally engaged in the business of providing health care," is inconsistent with Section 1557 and would limit its application to entities that provide health insurance. 84 Fed. Reg. at 27,891 ("an entity principally or otherwise engaged in the business of providing health insurance shall not, by virtue of such provision, be considered to be principally engaged in the business of providing health care"). Health insurers play a central role in the provision of health care, including controlling access to health care services through benefit design (which benefits are covered by a plan and under what circumstances),[27] utilization management (whether a plan holder is entitled to receive covered benefits),[28] and other means. A rule purporting to exclude coverage of health insurers would harm the nascent ability of disabled people to secure adequate and affordable health insurance.

Second, the Department proposes to eliminate Section 92.207, which lays out antidiscrimination prohibitions in health-related insurance coverage, in its entirety. The Department claims that the provision is "redundant," and "duplicative of, inconsistent with, or may be confusing in relation to the Department's preexisting . . . regulations," including those promulgated under Section 504. 84 Fed. Reg. at 27,869 & n.147 (citing, *inter alia*, 45 C.F.R. §§ 84.43, 84.52, 84.33). But the ACA was passed because existing laws—including Section 504 and the ADA—were insufficient to dismantle barriers to adequate health insurance, particularly for people with disabilities.[29] None of the Section 504 regulations cited by the

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[26] 81 Fed. Reg. at 31,429, 31,434 n.258.

[27] "Benefit design" are the formal rules that structure health insurance plans and dictate how covered individuals can gain access to health care services and providers.

[28] "Utilization management" includes use of managed care techniques such as prior authorization and case-by-case assessments of whether care is appropriate.

[29] *Cf. Alexander v. Choate*, 469 U.S. 287, 290, 302–04 (1985) (holding that a proposed reduction to fourteen in the number of annual inpatient hospital days covered by the Tennessee Medicaid program did not violate Section 504, but recognizing that other disparate impacts on "meaningful access" to health care for people with disabilities may be actionable); 42 U.S.C. § 12201(c) (providing a safe harbor for insurance underwriting).

Department discusses discriminatory benefit design. The deletion of Section 92.207 would undermine the right of people with disabilities to challenge discriminatory benefit design under Section 1557. The deletion contravenes the statute's plain language.

The ACLU offers the following on other proposed changes for which the Department seeks comment:

- *No exemption* from the auxiliary aids and services requirement for covered entities with fewer than 15 employees should appear in the regulations. The provision of American Sign Language interpreters to Deaf patients preferring this type of communication accommodation has been linked with significantly higher utilization rates of preventative care, including cholesterol screens, colonoscopy, and influenza vaccines.[30] The existing standard, incorporating 28 C.F.R. § 35.164, already exempts "any action that [the covered entity] can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens." There is no need for any further exemption.

- The Department *should not* remove the requirements of the 2010 ADA Standards for Accessible Design for facilities or portions of facilities in which health programs or activities are conducted. The 2010 Standards and the Department's regulation already create a careful balance between the requirements for existing facilities and for newly constructed or altered facilities (here, facilities built or altered after July 18, 2016). 45 C.F.R. § 92.203; 28 C.F.R. § 35.151 (standards for newly constructed buildings of public entities); 42 U.S.C. § 12183 (standards for newly constructed commercial buildings of private entities). Disrupting this balance by excluding telecommunications and elevator requirements would harm the interests of people with disabilities. Deaf people and individuals with mobility disabilities including wheelchair users face

[30] Michael M. McKee et al., *Impact of Communication on Preventive Services Among Deaf American Sign Language Users*, 41 Am. J. Preventative Med. 75 (2011); *see also* Silvia Yee et al., *Compounded Disparities: Health Equity at the Intersection of Disability, Race, and Ethnicity* 43–44 (2017) (discussing research demonstrating that lack of accurate and effective communication can lead to misdiagnosis, erroneous treatment, and negative impacts on the health of the patient), http://nationalacademies.org/hmd/Activities/SelectPops/HealthDisparities/Commissioned-Papers/Compounded-Disparities.

enormous barriers to accessing health care.[31] These are barriers that the ACA was meant to dismantle.

- The Department *should* cross-reference Section 508 in its proposed Section 92.204. The current Rule incorporates the Section 508 regulations in 45 C.F.R. § 92.4 (definition of Electronic and information technology). The proposed rule tracks the concepts of the Section 508 regulations but without including the cross-reference. This will cause confusion if and when the Section 508 regulations are updated.

- The Department *should* retain the current language of Section 92.205, proposed to be redesignated as Section 92.105. The current language tracks the regulations implementing Title II of the ADA, 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."), and the Department's own Rehabilitation Act regulations, 45 C.F.R. § 92.205 (same). The alternative language would create confusion by using phrasing and concepts applicable to the employment setting. 84 Fed. Reg. at 27,868 (discussing alternative phrasing of requiring that a covered entity "shall make reasonable accommodation to the known physical or mental limitations of an otherwise qualified" individual with a disability"). In a health care setting, unlike in an employment setting, there is no expectation of an ongoing, day-to-day relationship, wherein the parties might engage in an interactive process over time to address the known physical or mental limitations of the individual with a disability. Accordingly, covered

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[31] Michael D. Stillman et al., *Healthcare utilization and associated barriers experienced by wheelchair users: A pilot study*, 10 Disability & Health J. 502 (2017) (concluding wheelchair users face persistent barriers to care, may receive less than thorough physical evaluations, receive fewer screenings for cervical cancer, and largely believe they receive incomplete care); Melinda Neri & Thilo Kroll, *Understanding the Consequences of Access Barriers to Health Care: Experiences of Adults with Disabilities*, 25 Disability & Rehab. 85 (2003) (discussing barriers to health care for study participants with spinal cord injury, cerebral palsy, or multiple sclerosis); Lawrence Pick, Health care disparities in the deaf community, Am. Psychological Assoc. (Nov. 2013), https://www.apa.org/pi/disability/resources/publications/newsletter/2013/11/deaf-community ("Deaf users of ASL, through cultural and language barriers, are at high risk for poor health knowledge and inequitable access to medical and behavioral care in our health system. These barriers directly translate to inadequate assessment, limited access to treatment, insufficient follow-up and poorer outcomes."); National Association of the Deaf, *Position Statement On Health Care Access for Deaf Patients*, https://www.nad.org/about-us/position-statements/position-statement-on-health-care-access-for-deaf-patients/ ("Healthcare is routinely inaccessible to deaf people due to communication and linguistic barriers." (citations omitted)).

entities should be prepared—ahead of time—to make reasonable modifications to avoid disability discrimination. The alternative language should be rejected.

The application of antidiscrimination principles to health insurers and to benefit design is essential to the needs and rights of disabled people. The Proposed Rule does not apply those principles and should not be adopted.

C. HHS Should Not Weaken Protections Against Race-Based Discrimination.

It is well-documented that addressing racial disparities in health care is a matter of life and death. In 2003, the Institute of Medicine published the findings of a committee convened at the request of Congress to examine racial disparities in health care.[32] Reviewing a wide body of research, the committee found that "[e]vidence of racial and ethnic disparities in health care is, with few exceptions, remarkably consistent across a range of illnesses and health care services." While socioeconomic factors accounted for a portion of the disparity, the report observed that "[t]he majority of studies . . . find that racial and ethnic disparities remain even after adjusting for socioeconomic differences and other health related factors." The consequences are sobering. For example, "racial disparities in receipt of coronary revascularization procedures are associated with higher mortality among African Americans," "evidence suggests that disparities in cancer care are associated with the higher death rates among minorities," and "differences in the quality of HIV care are associated with poorer survival rates among minorities, even at equivalent levels of access to care."

Little progress has been made since those findings were issued.[33] At the same time, research suggests that many racial and ethnic health disparities could be reduced or even eliminated if identified and addressed. For example, a study addressing how past segregation continued to impact health outcomes led to findings of racial disparities in the treatment of cancer, and proposed a solution involving customized support for individuals diagnosed with cancer.[34] This reform

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[32] Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Brian D. Smedley et al., Eds. (2003) at 5, https://www.nap.edu/read/10260/chapter/1#ii.

[33] *See* Karen M. Anderson, *How Far Have We Come in Reducing Health Disparities?: Progress Since 2000*, Inst. of Med. (2012), https://www.ncbi.nlm.nih.gov/books/NBK100492/pdf/Bookshelf_NBK100492.pdf; Wyatt R. Laderman et al., *Achieving Health Equity: A Guide for Health Care Organizations*, Inst. for Healthcare Improvement (2016), http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx;.

[34] Martha Hostetter & Sarah Klein, *In Focus: Reducing Racial Disparities in Health Care by Confronting Racism*, Commonwealth Fund (Sept. 27, 2018),

benefited all patients while eliminating racial disparities. "Both black and white patients who received customized support were more likely to complete cancer treatment—and the gap in completion between white and black patients disappeared." In another example, by examining the racial disparity in rates of screening for colorectal cancer, researchers were able to identify workable solutions, including providing home colon cancer screens. Screening rates increased for patients of all races, and the racial gap narrowed considerably, from 26.2 percentage points to 7.6 percentage points. Additionally, some Medicare HMOs eliminated racial disparities in controlling high blood pressure, blood sugar, and cholesterol by monitoring disparities and improving quality of care within the HMO.[35]

As described in more detail below, *see infra* Part III.C., the Current Rule's disparate impact enforcement mechanism encourages health care providers to identify these disparities and adopt solutions that make a crucial life difference for individuals. Addressing racial disparities in health care also serves the interests of the regulated community, allowing providers to better meet their own goals of providing better quality care and containing costs. Annually, racial health disparities lead to "an estimated $35 billion in excess health care expenditures, $10 billion in illness-related lost productivity, and nearly $200 billion in premature deaths."[36] Eliminating the effects of discrimination, preventing premature death and improving quality of life, and reducing lost economic productivity all benefit the broader public.

The Current Rule's endorsement of a private right of action, described in more detail below, *see infra* Part III.C., is an important step in overcoming gaps in enforcement by HHS, particularly with regard to racial discrimination. Racial disparities in health care have historic roots. As in other sectors of society, segregated health care was once sanctioned by law[37] and government actions, such as the decades-long medical experiments conducted on African American men

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https://www.commonwealthfund.org/publications/newsletter-article/2018/sep/focus-reducing-racial-disparities-health-care-confronting.

[35] John Z. Ayanian, *The Costs of Racial Disparities in Health Care*, Harv. Bus. Rev. (Oct. 1, 2015), https://hbr.org/2015/10/the-costs-of-racial-disparities-in-health-care.

[36] *Id.* (citing Thomas A. LaVeist et al., *Estimating the Economic Burden of Racial Health Inequalities in the United States*, 41 *Int'l J. Health Services* 231, 234 (Apr. 2011)); *see also* Timothy A. Waidmann, *Estimating the Cost of Racial and Ethnic Health Disparities*, Urban Institute (Sept. 22, 2009), https://www.urban.org/sites/default/files/publication/30666/411962-Estimating-the-Cost-of-Racial-and-Ethnic-Health-Disparities.PDF (finding that the Medicare program would save $15.6 billion each year if health disparities were eliminated).

[37] *See Moses H. Cone Mem'l Hosp. v. Simkins*, 376 U.S. 938 (1964) (denying certiorari from appellate court's ruling holding segregation of hospitals unconstitutional).

affiliated with the Tuskegee Institute[38] and federally-funded forced sterilization of women of color in California,[39] continue to have repercussions for health care.[40] In short, the impacts of government-sanctioned discrimination continue to impact health care systematically and intersect with persistent disparities in housing and other sectors.[41] As in these sectors, the effects of discrimination in the health care context have not and will not correct themselves. A disparate impact private right of action is a crucial enforcement mechanism to confront and redress discrimination, and racial discrimination in particular. The Department's proposal would instead make enforcement more difficult and should not be adopted in the final rule.

D. HHS Should Not Weaken Protections for Individuals with Limited English Proficiency.

The Department should not eliminate the language access protections as proposed. In the United States, there are approximately 27 million persons with limited English proficiency ("LEP"), comprising about nine percent of the population.[42] Language assistance is necessary to ensure that LEP persons are guaranteed meaningful access to health care and coverage, and is essential to combat discrimination on the basis of national origin, which encompasses discrimination on the basis of language.

The Proposed Rule improperly changes the focus of the protections from the individuals with LEP themselves who may be "eligible to be served or likely to be encountered" by covered entities, to the entities' programs—narrowing the considerations in evaluating the accessibility of entities' programs and weakening the standard. *Compare* 45 C.F.R. § 92.201 *with* 84 Fed. Reg. at 27,892 (§ 92.101). Likewise, the Department should not eliminate references to language access plans, which under the Current Rule are voluntary and only a factor to be considered in evaluating entities' compliance with Section 1557. Language access plans are a useful tool for covered entities to fully plan how to meet the needs of LEP patients and consumers, as well as supporting entities' own compliance efforts, benefiting both LEP individuals and covered entities alike.

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[38] *See generally* Ctrs. for Disease Control & Prevention, *Tuskegee Study 1932-1972* (Dec. 14, 2015), https://www.cdc.gov/tuskegee/index.html.

[39] *See* Maya Manian, *The Story of Madrigal v. Quilligan*: *Coerced Sterilization of Mexican-American Women* (Mar. 6, 2018); Alexandra Minna Stern, *STERILIZED in the Name of Public Health*, 95 Am. J. of Pub. Health 1128 (July 2005).

[40] Hostetter & Klein, *supra* note 34.

[41] *See, e.g.*, *id.* (discussing the relationship between housing discrimination, transportation disparities, and health disparities).

[42] Civil Rights Division, Limited English Proficient (LEP) Maps, https://www.lep.gov/maps/#.

The Proposed Rule would also eliminate significant protections for LEP persons by eliminating the requirement that covered entities provide notices of legal rights and in-language taglines on significant publications. The notices and taglines are a cost-effective way to maintain access for LEP individuals without translating entire documents, and the Department's Regulatory Impact Analysis ignores the impact on LEP individuals should these requirements be eliminated. For example, the Analysis relies solely on reports from health plans, with no public outreach to determine the impact of the taglines or to see if there are alternatives that could increase protections for LEP individuals while mitigating burdens on covered entities.

LEP individuals face unique risks and barriers to knowing and asserting their rights in the health care context. The proposed elimination of protections to aid communication with LEP individuals—both while they are accessing services and so that they know their rights—should be abandoned.

III. THE DEPARTMENT SHOULD NOT LIMIT THE BROAD IMPACT OF SECTION 1557.

The Proposed Rule includes several provisions that would so limit Section 1557's application as to render its protections a nullity for the very people Congress sought to protect. As such, the Department should decline to finalize the Proposed Rule, leaving in place the Current Rule.

A. Importing a Religious Exemption into Section 1557 is Contrary to Law.

The proposed rule would unlawfully allow religiously affiliated healthcare providers to discriminate based on sex and to refuse access to necessary medical care by importing Title IX's expansive religious exemptions, 20 U.S.C. §§ 1681(a)(3) and 1687(4), into Section 1557. *See* 84 Fed. Reg. at 27,890; *see also id.* at 27,869–70.

The proposed religious exemption violates the text and purpose of Section 1557. The statute's plain text prohibits discrimination "on the *ground* prohibited under" Title IX. 42 U.S.C. § 18116 (emphasis added). Congress also did not include a religious carve-out. Indeed, in choosing to incorporate the impermissible "ground[s]" of discrimination from other civil rights statutes, Congress expressly declined to incorporate the attendant exemptions contained in those statutes, many of which are wholly inapposite to the health care context. The Department promulgated the Current Rule consistent with Congress's directive, noting that the bases for a capacious religious exemption in the educational context under Title IX are inapplicable to the health care space. *See* 81 Fed. Reg. at 31,380. For example, in the education context, families may select religious educational institutes as a "matter of course," whereas in the healthcare context, as discussed above, many patients (especially those in rural areas) have no alternative to a religious

healthcare provider. *Id.* The Department should not reverse course by incorporating the exemption, having initially rejected invitations to do so.

The Proposed Rule's new exemption swallows Congress's nondiscrimination rule by rendering *unprotected*, via blanket exemption, precisely the patients Congress sought to protect at the hands of any religious healthcare provider. Religiously affiliated healthcare providers make up a significant percentage of the healthcare facilities in the United States. For example, one in six patients is now treated in a Catholic facility each year,[43] and religious hospitals are also increasingly the *only* health care option in many regions. In 2011, at least 30 areas relied on a Catholic provider as their sole community hospital (a designation for hospitals that are at least 35 miles from the next-closest equivalent provider);[44] by 2016, there were 46 such communities.[45]

The threat of a blanket religious exemption is perhaps most concerning for patients in emergency situations. *See* 81 Fed. Reg. at 31,380. The Proposed Rule renders such patients at the mercy of healthcare providers that may refuse to care for them. In that respect, the Proposed Rule fails to explain how its blanket religious exemption would interact with the Emergency Medical Treatment & Labor Act, 42 U.S.C. § 1395dd, a statute that separately requires health care providers to treat and to stabilize patients facing medical emergencies. This new confusion invites healthcare providers to discriminate, including in emergency, life-and-death circumstances.

Fundamentally, the Proposed Rule's approach flies in the face of the careful balance courts have struck between civil rights and religious liberty, running afoul of the Establishment Clause. The Proposed Rule threatens access to critical care for millions of patients, especially transgender patients and patients seeking, or who

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[43] Katie Hafner, *As Catholic Hospitals Expand, So Do Limits on Some Procedures*, N.Y. Times (Aug. 10, 2018), https://www.nytimes.com/2018/08/10/health/catholic-hospitals-procedures.html; *see also Wave of Mergers That Have Widened Reach of Catholic Hospitals Brings Religious-Based Restrictions on Care*, Kaiser Health News (Aug. 13, 2018), https://khn.org/morning-breakout/wave-of-mergers-that-have-widened-reach-of-catholic-hospitals-brings-religious-based-restrictions-on-care/; Julia Kaye et al., *Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives*, ACLU (May 2016), https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied.

[44] Lois Uttley et al., *Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, ACLU & MergerWatch (Dec. 2013), https://www.aclu.org/report/miscarriage-medicine.

[45] Lois Uttley & Christine Khaikin, *Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage of Medicine Report*, MergerWatch (2016), http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf?token=d2akF7NBmYLahVVxD9WehfR2h5s%3D.

have obtained, reproductive health services.[46] The exemption thus elevates the rights of religious healthcare providers over their patients, who may face complete denials of services. Not only does the Proposed Rule fail to consider the harmful consequences of importing a broad religious exemption into the health care context,[47] the First Amendment forbids government action favoring religion to the point of forcing third parties to bear the costs of those beliefs. As the Supreme Court has made clear, "[t]he principle that government may accommodate the free exercise of religion does not supersede the fundamental limitation imposed by the Establishment clause." *Lee v. Weisman*, 505 U.S. 577, 587 (1992). The Proposed Rule's exemption—which would permit harm to patients in the name of religious exercise—is fundamentally at odds with the constitutional commitment to separation of church and state. *See Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 708–10 (1985). For all these reasons, the Department should not import Title IX's broad religious exemption in its final rule.

B. Narrowing the Scope of Entities Covered by Section 1557 is Contrary to Law.

The Proposed Rule would further undercut Section 1557 by limiting the type of entities covered by the provision. First, the Proposed Rule sets health insurance providers as distinct from entities "principally engaged in the business of providing health care." 84 Fed. Reg. at 27,891. Then, the Proposed Rule limits the application of Section 1557 to entities that are not principally engaged in the business of providing health care to the particular operations that receive Federal financial assistance. *Id.*[48] Under the Current Rule, Section 1557 applies to the entirety of an entity, any part of which receives Federal financial assistance, including health insurance providers. 45 C.F.R. §§ 92.2(a), 92.4 (defining "health program or activity"). Limiting the application of Section 1557's protections, as the Proposed Rule aims to do, would sanction discriminatory denials of coverage by entities that are presently covered by Section 1557, causing confusion and serious harm to those unable to access care.

Excluding health insurance from Section 1557's nondiscrimination mandate as distinct from "health program or activity" is contrary to the text of the statute

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[46] *See* Kaye et al., *supra* note 43.

[47] The failure to consider the negative consequences for patients is inexcusable, given that the Department is well aware that religiously-affiliated hospitals deny treatment to patients. Indeed, the Department cited two such cases, *Minton v. Dignity Health*, No. 17-558259 (Calif. Super. Ct. Apr. 19, 2017) and *Chamorro v. Dignity Health*, No. 15-549626 (Calif. Super. Ct. Dec. 28, 2015), as support for the promulgation of their Religious Refusal Rule. 84 Fed. Reg. at 23,176 n.27.

[48] For example, the preamble explicitly states that Section 1557 would not apply to Medicare Part B, self-funded group health plans under ERISA, Federal Employees Health Benefits Program, or short term limited duration insurance plans. 84 Fed. Reg. at 27,863.

and the broader antidiscrimination purpose of the law. Congress spoke clearly in passing Section 1557: "[A]n individual shall not . . . be excluded from participation in, be denied the benefits of, or be subject to discrimination under, *any* health program or activity, *any party of which* is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance . . . ." 42 U.S.C. § 18116 (emphasis added). Congress meant what it said. The purpose of Section 1557 is to provide broad antidiscrimination protections to patients in all aspects of health care delivery. The Proposed Rule's narrowing of Section 1557's reach violates the law's clear text, as well as its overarching purpose.

The false distinction between health insurance and "health program or activity" is exacerbated by the Proposed Rule's new limitation on the application of Section 1557 in cases where the entity is not principally engaged in the provision of health care. In such cases, under the proposal, Section 1557 would apply only to the specific operations of an entity that receive federal financial assistance—whereas Section 1557 covers *all* operations of entities principally engaged in health care that receive federal financial assistance. This distinction, too, is contrary to the text of the statute, which prohibits discrimination for the entirety of a health program or activity, "*any part of which* is receiving Federal financial assistance." 42 U.S.C. § 18116 (emphasis added).

This proposed limit contravenes not only the text of the statute, but also the approach Congress adopted in the Civil Rights Restoration Act of 1987 ("CRRA"), which amended the four civil rights laws referenced in Section 1557. In the CRRA, Congress defined "program or activity" to mean "all of the operations of . . . an entire corporation, partnership, or other private organization, or an entire sole proprietorship . . . which is principally engaged in the business of providing," *inter alia*, a range of social and health services. Pub. L. 100-259, 102 Stat. 28 (1988). Congress thus made clear that if any part of a program or activity receives Federal financial assistance, the *entire* program or activity must comply with the nondiscrimination mandates that form the basis of Section 1557. *See generally* 81 Fed. Reg. at 31,385. The Proposed Rule is thus in tension with the terms of Section 1557 itself, as well as the approach endorsed by Congress in its passage and in parallel civil rights laws. Although the Proposed Rule repeatedly says these changes are intended to bring the regulations into compliance with the CRRA, *see* 84 Fed. Reg. at 27,862, in fact the amendments would undermine that very goal.

The Department should not arbitrarily limit the entities that fall within Section 1557's protections. The proposed limits to the programs and activities to which Section 1557 applies represent a dramatic departure from the statutory purpose and the current regulatory approach. Additionally, the Proposed Rule does not address the potential harm to individuals denied coverage of and access to health care due to the proposed limitations on Section 1557's application.

C. HHS Should Maintain Existing Remedies Available for Section 1557 Claims.

The Current Rule adopts a uniform standard, applicable to all grounds covered by Section 1557, and incorporates enforcement mechanisms that exist under any of the civil rights laws referenced by Section 1557. This includes a private right of action for disparate-impact claims and the availability of compensatory damages for all claims under Section 1557. 81 Fed. Reg. at 31,440. In removing these provisions, the proposed rule creates a scheme in which people are denied certain legal remedies because of the type of discrimination they experience. For example, an individual who experienced age discrimination would be able to pursue a disparate impact claim, but an individual who experienced race discrimination would not. An individual who experienced disability discrimination could seek compensatory damages, while an individual who experienced age discrimination could not.

The Department's justification for eliminating civil rights protections available under the Current Rule are inconsistent with the purpose of the antidiscrimination provision and counter to HHS's mandate to protect individuals from unlawful discrimination. First, the Department states that the current regulations are "confusing to the regulated community, and that the proposed change will "reduce confusion, reduce uncertainty about the scope of Section 1557, . . . and improve the consistency of regulatory requirements between entities required to comply with the civil rights laws as a result of Section 1557 and those directly subject to only to the underlying civil rights laws." 84 Fed. Reg. at 27,860. However, the Current Rule provides certainty by explicitly setting out a single standard for enforcement of Section 1557's antidiscrimination requirements. The removal of this clear rule would leave covered entities and protected individuals alike uncertain as to the law's requirements and protections, instead leaving them to look to four other civil rights laws and various agency implementing regulations for clues. By refusing to specify a standard directly under Section 1557, the Department leaves entities without guidance on the operation of antidiscrimination protections within the unique contexts of health care.

Second, the Department privileges the purported interests of business over those of the public and of individuals seeking health care. The Department states that the Current Rule is "unduly burdensome" and that the proposed change will "relieve regulatory burdens," and "promote substantive compliance." *Id.* The Department provides no further explanation of how eliminating uniform enforcement mechanisms will promote compliance with Section 1557's antidiscrimination requirements. The Proposed Rule creates a patchwork of standards thus imposing a more—not less—complicated antidiscrimination compliance scheme on healthcare providers. Moreover, the Department's justification fails to consider the burdens carried by those who suffer discrimination in the provision of health care.

The Proposed Rule's silence regarding the availability of a private right of action is at best, purposeless, and at worst contrary to the rights-expanding aims of the statute. Parties will continue to litigate, as they have since Section 1557's passage, the private right of action, including whether it exists under the statute. The availability of a private right of action is not determined solely by whether a statute or regulation explicitly provides that one is available. *See, e.g.*, *Lexmark Int'l, Inc. v. Static Control Components, Inc.*, 572 U.S. 118, 128–29 (2014); *Alexander v. Sandoval,* 532 U.S. 275, 286–287 (2001). The Proposed Rule thus will not save covered entities time or money in litigating grievances—that litigation will continue regardless of whether the Department eliminates the Current Rule's endorsement that such a right exists, and without the explicit endorsement, there will simply be one more legal issue before the courts. The Department should accordingly continue to affirm the existence of the private right of action.

Parties asserting private rights of action pursuant to Section 1557 have significantly expanded access to health care and combatted discriminatory health care policies. *See, e.g.*, *Tovar v. Essentia Health*, 342 F. Supp. 3d 947 (D. Minn. 2018); *Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931 (W.D. Wis. 2018); *Prescott v. Rady Children's Hosp.*, 265 F. Supp. 3d 1090 (S.D. Cal. 2017). The Institute of Medicine found that HHS "has suffered from insufficient resources to investigate complaints of possible violations and has long abandoned proactive, investigative strategies."[49] Access to a private right of action is essential to fill the gap in HHS's enforcement of Section 1557 protections.

The Department should also not eliminate the Current Rule's provision for disparate-impact claims, which promotes better compliance with Section 1557's nondiscrimination provisions. The disparate-impact mechanism encourages health care providers to identify disparities and to adopt solutions that make a crucial difference in eliminating those disparities for individuals and improving public health. The Department's proposal would instead make enforcement more difficult, and would increase confusion as to the scope of Section 1557's protections. The Department should accordingly continue to affirm existing enforcement mechanisms, including the private right of action for disparate-impact claims.

D. The Department Should Not Eliminate Grievance Procedures and Notice Requirements.

The Proposed Rule would unnecessarily eliminate the specific grievance procedures established under Section 1557, which would leave covered entities and impacted individuals without cohesive, uniform procedures for investigating grievances. Further, the Current Rule includes the explicit requirement that such procedures "incorporate appropriate due process standards and that provide for the

[49] Institute of Medicine, *Unequal Treatment*, supra note 32 at 15.

prompt and equitable resolution of grievances alleging any action that would be prohibited by Section 1557." 45 C.F.R. § 92.7. The Department should not eliminate this regulation, which provides that the procedures in place are sufficient to address claims of discrimination.

Likewise, the Department should not eliminate the requirement that covered entities provide notice to the public that they do not discriminate, and of the procedures in place to address complaints of discrimination. 45 C.F.R. § 92.8. The current notice procedure is crucial to ensure that individuals are aware of the safeguards in place, and what steps they can take to effectuate the protections under Section 1557. The costs associated with the notice requirement are well worth the benefit of ensuring that individuals protected by Section 1557 receive adequate notice of their rights.

IV. THE PROPOSED RULE VIOLATES SECTION 1554 OF THE ACA.

The Proposed Rule is additionally contrary to law because it violates another provision of the ACA: Section 1554. This provision limits the Department's rulemaking authority, prohibiting HHS from promulgating regulations that create any unreasonable barriers to the ability of individuals to obtain appropriate medical care, impede timely access to health care services, violate the ethical standards of health care professionals, or limit the availability of health care treatment for the full duration of a patient's medical needs—among other restrictions. 42 U.S.C. § 18114.

For all the reasons outlined in this comment, the Proposed Rule violates Congress's command and should be entirely abandoned. The Proposed Rule causes confusion as to what is prohibited sex discrimination, and invites discrimination against transgender individuals and people seeking, or who have obtained, reproductive health care. Contrary to statutory language, the Proposed Rule limits the entities subject to Section 1557 through the religious exemption and the redefinition of entities principally engaged in the business of providing health care. The Proposed Rule also reduces protections in place for people who face discrimination, both by reducing protections for LEP individuals, and by eliminating grievance procedures and notice requirements.

Accordingly, the proposed regulation violates Section 1554 by arbitrarily impeding patients' access to timely, quality health care, and subjecting patients to discriminatory barriers to such care. The Proposed Rule fundamentally contravenes the statutory purpose underlying the enactment of the ACA—to expand and to protect patients' access to healthcare—and should not be finalized as such.

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For all these reasons, the Department should withdraw the Proposed Rule.

Sincerely,

Louise Melling	Ronald Newman	Lindsey Kaley
Deputy Legal Director	National Political Director	Staff Attorney