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October 3, 2022

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: Comments in Response to Nondiscrimination in Health Programs and Activities (Section 1557 NPRM), RIN 0945-AA17**

Dear Director Fontes Rainer:

The National Women's Law Center ("the Center") appreciates the opportunity to comment on the Department of Health and Human Services' ("the Department") proposed rule "Nondiscrimination in Health Programs and Activities" ("Proposed Rule") implementing Section 1557 of the Affordable Care Act (ACA).<sup>1</sup> Since 1972, the Center has worked to protect and advance the progress of women and their families in core aspects of their lives, including health, income security, employment, education, and reproductive rights, with an emphasis on the needs of low-income individuals and those who face multiple and intersecting forms of discrimination. To that end, the Center has long worked to end sex discrimination and ensure that all people, including women of color, disabled women, low-income women, and LGBTQI+ people, have equal access to the full range of health care.

Section 1557 provides broad federal protections against discrimination in health care and health insurance. It is the first federal law to broadly prohibit sex discrimination in health care and is properly understood to include discrimination based on gender identity, sexual orientation, sex characteristics (including intersex traits), sex stereotypes, and pregnancy related care, including termination of pregnancy and adverse pregnancy outcomes. Section 1557 also importantly expands existing protections against health care discrimination based on race, color, national origin, age, and disability. It also properly recognizes intersectional discrimination,

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<sup>1</sup> Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47,824 (proposed August 4, 2022) (to be codified at 45 C.F.R. pts. 80, 84, 86, 91, 92, 147, 155, and 156) [hereinafter Proposed Rule].

which is critically important for those living at the intersection of impacted communities. For example, it recognizes that discrimination based on sex can often intersect with discrimination based on other protected characteristics in ways that disparately impact people of color, young people, and transgender people.

In 2016, after considerable public comment and deliberate consideration, including numerous meetings with stakeholders and two public comment periods with over 25,000 comments, the Department issued strong and effective regulations (“2016 Rule”) implementing and enforcing Section 1557 of the ACA.<sup>2</sup> Only four years later, on June 19, 2020, the Department finalized revised regulations implementing Section 1557 (“2020 Rule”) that repudiated the 2016 Rule by deleting most substantive provisions, adding unlawful exemptions, and dramatically narrowing the scope of Section 1557’s regulations in contravention of what the statute requires.<sup>3</sup> The 2020 Rule is illegal, harmful, and discriminatory, and the rule’s rollback of the 2016 Rule’s protections created confusion and increased the risk of discrimination in health care.

The Department has now proposed new regulations for implementing Section 1557 that seek to remedy the problems created by the 2020 Rule, to reflect developments in recent case law, and “to better address issues of discrimination that contribute to negative health interactions and outcomes”.<sup>4</sup> We strongly support the Proposed Rule. The Department once again properly implements the ACA’s text and purpose by undoing the illegal and harmful provisions of the 2020 Rule, and reestablishing in regulation many of the protections necessary to give full effect to Section 1557 and its goal of ending discrimination in health care and health insurance. The Department provides several critical clarifications regarding the scope of protections, including as to the entities subject to the law and the forms of discrimination prohibited by it. The Department takes care to explain the ways discrimination—particularly intersectional discrimination—shows up in people’s lives. Critically, the Department seeks to make clear the strong protections against discrimination based on sex, and the Department properly has decided *not* to incorporate harmful religious and anti-abortion provisions in these protections.

Nevertheless, we urge the Department to strengthen the Final Rule. It must provide more clarity and do more to ensure that Section 1557’s regulations align with the broad scope of protections provided by the underlying law. This is especially critical now, when individuals are being targeted when seeking health care for who they are and the kinds of services they seek.

The primary recommendations provided within this comment include, but are not limited to: a revised definition of sex discrimination that explicitly enumerates “transgender or nonbinary status” and “termination of pregnancy” as protected statuses; incorporation of a separate provision outlining the scope of protections

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<sup>2</sup> Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,375 (May 18, 2016) [hereinafter 2016 Rule].

<sup>3</sup> Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) [hereinafter 2020 Rule].

<sup>4</sup> Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47,824, 47,892 (proposed August 4, 2022) (to be codified at 45 C.F.R. pt. 92) [hereinafter Proposed Rule].

against discrimination on the basis of pregnancy and related conditions and the need for this provision in light of the *Dobbs v. Jackson Women’s Health Organization* decision;<sup>5</sup> additional language within §§ 92.206 and 92.207 that acknowledges forms of discrimination in sexual and reproductive health care and more robustly protects against anti-LGBTQI+ discrimination; non-incorporation of Title IX exceptions; and acknowledgment that Section 1557 reaches employment discrimination by covered entities.

## Subpart A—General Provisions

### I. §92.1 Purpose

Section 1557 is a groundbreaking statute, enacted to remedy discrimination in health care. Section 1557 established groundbreaking reforms to health care and health insurance, providing protections for those who face discrimination in health care on the basis of race, color, national origin, sex, age, or disability. 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.”<sup>6</sup>

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 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.

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,<sup>7</sup> health plans could no longer exclude coverage of transition-related care for transgender individuals,<sup>8</sup> an individual could not be denied fertility services because of their

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<sup>5</sup> *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228 (2022).

<sup>6</sup> 156 CONG. REC. S1842 (daily ed. Mar. 23, 2010) (Sen. Leahy).

<sup>7</sup> 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-release/victory-in-sex-discrimination-complaints-brought-by-nwlc-after-investigation-by-hhs-employers-change-policies/>.

<sup>8</sup> See *Tovar v. Essentia Health*, 342 F. Supp. 3d 947 (D. Minn. 2018) (holding that a health plan containing a categorical exclusion for all services related to gender transition violated Section 1557).

age,<sup>9</sup> and health insurance companies would have to provide information about their services in a range of languages and accessible formats.<sup>10</sup>

While there has always been need for protections against discrimination in health care, Section 1557 is particularly important right now, as states across the country rapidly enact and enforce laws that discriminate on the basis of sex, including laws targeting gender-affirming care for transgender youth and banning access to abortion.

## II. § 92.2 Application

### a. **The Department has government-wide enforcement authority.**

The Center commends the Proposed Rule’s assertion that Section 1557’s protections apply to all health programs and activities of an entity if any part of that entity receives Federal financial assistance (FFA). This is not only consistent with the Department’s broad congressionally delegated authority, but critically important to the Proposed Rule’s aim to “address issues of discrimination that contribute to negative health interactions and outcomes.”

The Proposed Rule’s FFA language is crucial to protect against discrimination in health insurance-like products, such as short-term limited duration insurance. These insurance-like products are marketed, often misleadingly and fraudulently, as an alternative to comprehensive coverage but have significant gaps<sup>11</sup> that lead to high out-of-pocket costs and little financial protection for consumers. These products—which are medically underwritten and include significant benefit gaps—discriminate on the basis of age, sex, and disability. For example, these products discriminate against women by denying basic medical services such as Pap smears, maternity care, and newborn care.<sup>12</sup> Many of the plans’ exclusions appear designed to avoid enrolling women of child-bearing age and otherwise discriminate against women through gender rating, coverage exclusions,

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<sup>9</sup> See Press Release, Nat’l Women’s Law Ctr., Connecticut Ends Discriminatory Limit on Infertility Coverage (Aug. 14, 2015), <https://nwlc.org/press-release/connecticut-insurance-department-corrects-discriminatory-and-illegal-insurance-practices-with-policy-that-secures-essential-infertility-benefits/>.

<sup>10</sup> Off. of Civ. Rts., *Section 1557: Ensuring Effective Communication with and Accessibility for Individuals with Disabilities*, U.S. DEP’T OF HEALTH & HUMAN SERV., <https://www.hhs.gov/civil-rights/for-individuals/section-1557/fs-disability/index.html> (last updated Aug. 25, 2016); Off. of Civ. Rts., *Enforcement Success Stories Involving Persons with Limited English Proficiency*, U.S. Dep’t of Health & Human Serv., <https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/examples/limited-english-proficiency/index.html> (content last reviewed July 26, 2013).

<sup>11</sup> See PARTNERSHIP TO PROTECT COVERAGE, UNDER-COVERED: HOW “INSURANCE-LIKE” PRODUCTS ARE LEAVING PATIENTS EXPOSED (2021), [https://www.lls.org/sites/default/files/National/undercovered\\_report.pdf](https://www.lls.org/sites/default/files/National/undercovered_report.pdf).

<sup>12</sup> HOUSE COMM. ON ENERGY & COM., SHORTCHANGED: HOW THE TRUMP ADMINISTRATION’S EXPANSION OF JUNK SHORT-TERM HEALTH INSURANCE PLANS IS PUTTING AMERICANS AT RISK 8, 59-61 (2020), <https://energycommerce.house.gov/newsroom/press-releases/ec-investigation-finds-millions-of-americans-enrolled-in-junk-health>.

and other plan limitations. The Proposed Rule makes clear that those products would be subject to Section 1557 if any part of the entity receives FFA.

The Proposed Rule also correctly clarifies that Section 1557 protections apply broadly to activities taken by covered entities in their role as third party administrators (“TPA”). Serving as a TPA does not absolve a covered entity from complying with Section 1557’s prohibition against discrimination. Yet, studies have shown that TPAs often administer plans that discriminate on prohibited bases<sup>13</sup>; moreover, TPAs are often responsible for discriminatory benefit design and plan administration.<sup>14</sup> As discussed in detail in Subpart C, Section II(a)(iii), the Final Rule must make clear that a TPA is subject to Section 1557 and is liable if it originates a plan with a discriminatory benefit design, administers a discriminatory plan, or applies plan terms in a discriminatory manner.

**b. The Final Rule should reflect that Section 1557 reaches employment discrimination by covered entities.**

Under § 92.2(b) of the Proposed Rule, the Department will not enforce Section 1557’s protections as to discrimination by a covered entity against its own employees, in either employment practices—such as hiring, firing, promotions, or terms and conditions of employment—or in the provision of employee health benefits.<sup>15</sup> This proposed enforcement exclusion strips away the already too-limited protections provided by the Department in both the 2016 and 2020 Rules.<sup>16</sup> And while the preamble explains that this carve out applies only to OCR enforcement,<sup>17</sup> the Proposed Rule fails to clarify that Section 1557 itself protects against employment discrimination, including against discriminatory employee health benefits policies, and that individuals may bring a private action under Section 1557 to vindicate those rights.

The Center strongly urges that the Final Rule eliminate this enforcement exclusion. The Department justifies this proposal by contending that it will “minimize confusion” and “promote clarity” regarding the processes for filing

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<sup>13</sup> See Anna Kirkland et al., *Transition Coverage and Clarity in Self-Insured Corporate Health Insurance Benefit Plans*, 6 TRANSGENDER HEALTH 207 (Aug. 2021), <https://www.liebertpub.com/doi/10.1089/trgh.2020.0067>, <https://www.liebertpub.com/doi/10.1089/trgh.2020.0067> (discussing results from a study examining some of the biggest corporate employers in the United States and what transgender health care coverage they offered compared to international standards for transgender insurance coverage).

<sup>14</sup> See Anna Kirkland, et al., *Transition Coverage and Clarity in Self-Insured Corporate Health Insurance Benefit Plans*, 64 TRANSGENDER HEALTH 207, 214 (Aug. 2021), <https://www.liebertpub.com/doi/full/10.1089/trgh.2020.0067> (showing that self-funded plans had three times as many categorical exclusions for gender affirming health care).

<sup>15</sup> Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47,824, 47,911.

<sup>16</sup> As the Proposed Rule notes, the “2016 Rule did not apply to hiring, firing, promotions, or terms and conditions of employment, but did address employee health benefit programs at former §92.208,” whereas the 2020 Rule repealed those sections as “duplicative of, inconsistent with, or confusing in relation to the Department’s preexisting regulations.” Nondiscrimination in Health Programs and Activities 87 Fed. Reg. 47,824, 47,838.

<sup>17</sup> Nondiscrimination in Health Programs and Activities 87 Fed. Reg. 47,824, 47,838.

administrative complaints to federal agencies about employment discrimination.<sup>18</sup> Yet by including this carveout and failing to clarify that Section 1557 prohibits discrimination in employment, including in employee benefits, the Department injects unnecessary confusion about Section 1557's protections. As the Department itself recognizes, this is no small matter: The majority of the U.S. population receives health benefits through their employer.<sup>19</sup> Insulating certain employer plan sponsors from liability for discriminatory benefit design or administration under Section 1557 would frustrate the law's objective of ensuring "coverage of health care in a nondiscriminatory manner."<sup>20</sup> At the very least, the Final Rule must make clear that this provision concerns *only* the filing and processing of administrative complaints by OCR, that Section 1557's prohibition against discrimination applies to all employment discrimination by a covered entity, and that the Department's decision not to enforce Section 1557 against employers under this regulation does not preclude employees from vindicating their Section 1557 rights in court.

The plain meaning of Section 1557 includes all forms of discrimination by a covered entity, without limitation for discrimination in the employment context. 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..."<sup>21</sup> The Supreme Court has interpreted similarly broad statutory language in Title IX and Section 504 to include employment discrimination.<sup>22</sup> The Court reasoned that it should not read an exception for employment discrimination where one was not "expressly nor impliedly" provided because Congress could have "easily" adopted narrower language if it preferred to restrict the scope of the antidiscrimination mandate.<sup>23</sup> In particular, when assessing Title IX, the Court determined the use of "person" in the statute's text—as opposed to "student" or "beneficiary"—indicated an inclusive congressional purpose.<sup>24</sup> Like Title IX, Section 1557 protects "an individual": It does not specify that the individual must be "a patient" or "a beneficiary" of Federal financial assistance. Thus, the same principle of statutory interpretation applies here—particularly given Congress' awareness of these longstanding precedents when drafting Section 1557.<sup>25</sup> Indeed, the day after the Department issued this Proposed Rule, the U.S. Court of Appeals for the Seventh Circuit recognized in *T.S. v. Heart*

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<sup>18</sup> Nondiscrimination in Health Programs and Activities 87 Fed. Reg. 47,824, 47,838.

<sup>19</sup> Nondiscrimination in Health Programs and Activities 87 Fed. Reg. 47,824, 47,838.

<sup>20</sup> Nondiscrimination in Health Programs and Activities 87 Fed. Reg. 47,824, 47,825.

<sup>21</sup> 42 U.S.C. § 18116(a) (2012).

<sup>22</sup> See *North Haven Bd. of Educ. v. Bell*, 456 U.S. 512 (1982); *Consol. Rail Corp. v. Darrone*, 465 U.S. 624, 635 (1984) (reasoning that it would be "anomalous" to conclude that Section 504 "silently adopted a drastic limitation" on the right of protected individual to sue for discrimination).

<sup>23</sup> *North Haven Bd. of Educ. v. Bell*, 456 U.S. 512, 521 (1982).

<sup>24</sup> *North Haven Bd. of Educ. v. Bell*, 456 U.S. 512, 520-23 (1982).

<sup>25</sup> See, e.g., *Gomez-Perez v. Potter*, 553 U.S. 474, 485 (2008) (presuming that Congress was aware of a Supreme Court decision delivered just five years prior to the enactment of a new law).

of *CarDon* that a covered entity could be liable under Section 1557 for discriminating in its provision of health benefits to its employees.<sup>26</sup>

Eliminating OCR enforcement of Section 1557's protections against employment discrimination entirely is a more drastic step than necessary to achieve the Department's stated goal of "minimiz[ing] confusion" and "decreas[ing] the likelihood that individuals seeking relief under Federal Equal Employment Opportunity laws will miss strict time limits for filings complaints."<sup>27</sup> Those who do miss another agency's filing deadline for relief under a separate law will be deprived of an avenue of administrative relief if OCR enforcement of their Section 1557 claim is unavailable. Moreover, as the Proposed Rule already suggests, if the Department receives a complaint alleging discrimination that might raise a claim for relief under Federal Equal Employment Opportunity laws, it can typically refer the complaint to the EEOC for simultaneous investigation.<sup>28</sup> Such a procedure would be in line with Executive Order 12250 and the Department of Justice's "Procedures for Complaints of Employment Discrimination Filed Against Recipients of Federal Financial Assistance," which, 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,"<sup>29</sup> permit agencies to refer discrimination 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.<sup>30</sup>

The Department's proposal to eschew administrative enforcement of employment discrimination complaints under Section 1557, coupled with its failure to clarify that Section 1557 itself reaches employment discrimination, will have particularly devastating consequences with respect to employee health benefits. Although discrimination in the provision of employee health benefits may also be challengeable under other employment discrimination statutes like Title VII and the Age Discrimination Act, it is unacceptable to force plan participants to rely on other statutes to vindicate rights that Section 1557 protects. Other employment discrimination laws are not coextensive with Section 1557. For example, Title VII and the Age Discrimination Act, unlike Section 1557, require that a claimant first file a complaint with a federal agency before privately enforcing their rights, prolonging potential relief. This delay in relief is wholly inappropriate and particularly burdensome when an individual is experiencing pretreatment discrimination in coverage under an employee health benefit plan because the individual will languish without health care while the administrative process remains pending.

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<sup>26</sup> *T.S. by and through T.M.S. v. Heart of CarDon, LLC*, 43 F.4th 737, 740 (7th Cir. 2022) (affirming denial of motion to dismiss claim by an employee of an assisted-living facility that his employer violated Section 1557's prohibition on disability discrimination by sponsoring a self-funded employee benefit plan that categorically excludes coverage for autism treatment).

<sup>27</sup> Nondiscrimination in Health Programs and Activities 87 Fed. Reg. 47,824, 47,838.

<sup>28</sup> Nondiscrimination in Health Programs and Activities 87 Fed. Reg. 47,824, 47,838.

<sup>29</sup> Procedures for Complaints of Employment Discrimination Filed Against Recipients of Federal Financial Assistance, 48 Fed. Reg. 3570 (Jan. 25, 1983) (to be codified at 28 C.F.R. pt. 4229, 1691).

<sup>30</sup> Exec. Order No. 12,250, 3 C.F.R. 298 (1980); 28 C.F.R. § 42.601 *et seq.*; 29 C.F.R. § 1691.1 *et seq.*

Further, some claims for relief for discrimination in employee health benefits can only be asserted under Section 1557. For example, in *Tovar v. Essentia Health*, the U.S. Court of Appeals for the Eighth Circuit affirmed the dismissal of a nurse practitioner’s Title VII claim against her covered-entity employer challenging her employee health benefit plan’s exclusion of medical benefits for gender affirming health care needed by her transgender son.<sup>31</sup> The Court concluded that, because the employee’s son was a dependent on the plan—not an employee—his rights were not in the “zone of interests” protected by Title VII.<sup>32</sup> However, the employee’s son was permitted to proceed in his challenge to the exclusion of benefits under Section 1557.<sup>33</sup> Additionally, Title VII applies to employers with fifteen or more employees, a limitation not likewise applicable to Section 1557.<sup>34</sup>

Section 1557’s protection against employment discrimination serves Congress’s intent of broadly eliminating discrimination in health care. The majority of health care workers are women.<sup>35</sup> Black women and Latinas also make up more than eight in ten of those working as home health aides, personal care aides, and nursing assistants.<sup>36</sup> Yet, in the health care field—as in nearly every other industry—women earn less than men and hold fewer leadership positions.<sup>37</sup> Further, many health care providers report harassment and pressure to conform to

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<sup>31</sup> *Tovar v. Essentia Health*, 857 F.3d 771, 774 (8th Cir. 2017) (*Tovar I*); see also *Scott v. St. Louis University Hospital*, 4:21-cv-01270-AGF, 2022 WL 1211092, at \*3–6 (E.D. Mo. Apr. 25, 2022) (dismissing Title VII claim of cover-entity employee about discriminatory denial of benefits for her dependent on the basis of sex, but permitting her to proceed under Section 1557).

<sup>32</sup> *Tovar v. Essentia Health*, 857 F.3d 771, 775–77 (8th Cir. 2017) (*Tovar I*); see also *Newport News Shipbuilding & Dry Dock v. EEOC*, 462 U.S. 669, 684 n.25 (1983) (commenting that an employee health benefit plan that excluded maternity benefits for dependent children discriminates on the basis of pregnancy but would not violate Title VII because “the exclusion affects male and female employees equally since both may have pregnant dependent daughters.”); 29 C.F.R. app § 1604 (1979).

<sup>33</sup> See *Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 956 (D. Minn. 2018).

<sup>34</sup> 42 U.S.C. § 2000e(b).

<sup>35</sup> See Jennifer Cheeseman Day & Cheridan Christnacht, *Women Hold 76% of All Health Care Jobs, Gaining in Higher-Paying Occupations*, CENUS.GOV (Aug. 14, 2019), <https://www.census.gov/library/stories/2019/08/your-health-care-in-womens-hands.html>.

<sup>36</sup> See Claire Ewing-Nelson, Nat’l Women’s Law Ctr. *More Than Three in Four of the Health Care Workers Fighting COVID-19 Are Women* (Dec. 2020), <https://nwlc.org/wp-content/uploads/2020/12/HealthCareWorkersFS.pdf>.

<sup>37</sup> See, e.g., Brianne Bostian Yassine et al., *Gender Inequity in the Public Health Workforce*, 28 J. PUB. HEALTH MGMT. PRACTICE E390 (2022) (describing disparities between men and women in public health in terms of unequal representation in leadership positions, persistence in wage discrimination, and disparities in scholarly publication and citations, and noting that these disparities are more pronounced for women of color); Christopher M. Whaley et al., *Female Physicians Earn an Estimated \$2 Million Less Than Male Physicians Over a Simulated 40-Year Career*, 40 HEALTH AFFAIRS 1856 (Dec. 2021) (2020 study showing that, over the course of a forty-year career, women physicians earn about 25% less than their male-counterparts—a pay gap that emerges early in newly trained physicians careers); Mary Pat Frintner et al., *Gender Differences in Earnings of Early- and Midcareer Pediatricians*, 144 PEDIATRICS e20183955 (2019) (2016 survey finding that female pediatricians earned annually 76% of what male pediatricians did, and differences persisted even after adjustment for important labor force, physician-specific job and work-family characteristics); *Mundell v. Acadia Hosp. Corp.*, --- F. Supp. 3d ----, 2022 WL 375832, at \*1 (D. Maine Feb. 8, 2022) (describing undisputed record evidence that three female licensed clinical psychologists at a nonprofit hospital in Bangor, Maine, were paid \$50 per hour while their two male counterparts—who possessed the “same fundamental qualifications” as their female colleagues—were paid at a rate of \$90 and \$95 per hour).



sex stereotypes.<sup>38</sup> Our nation’s health care providers—including the disproportionate number of women of color public health workers who put their lives at risk while serving on the front lines of the COVID-19 pandemic<sup>39</sup>—deserve the fullest enforcement of Section 1557’s protections, including its protections against employment discrimination.

### III. § 92.3 Relationship to Other Laws

- a. **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.**

The Center strongly supports the Proposed Rule’s reiteration that Section 1557 does not apply a lesser standard for the protection from discrimination than the standards applied under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, or the regulations issued pursuant to those laws, nor does it invalidate or limit the rights, remedies, procedures, or legal standards available under those laws. The Center asserts that §92.3(c), however, is superfluous and without strong guardrails on the applicability of federal refusal of care or religious freedom laws, its inclusion could encourage unlawful behavior.

- b. **The Final Rule must include the Proposed Rule’s clarification that EMTALA protects emergency care for pregnancy or related conditions, including termination of pregnancy.**

In the preamble to the Proposed Rule, the Department explains that the Emergency Medical Treatment and Active Labor Act (EMTALA) protects the care a person needs when presenting with an “emergency medical condition.” Both the Proposed Rule’s preamble and guidance the Department provided on July 11, 2022 (“July guidance”) makes clear that the EMTALA statute preempts any state laws or mandates that employ a more restrictive definition of an emergency medical

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<sup>38</sup> See, e.g., Woldegebriel Gebregziabher Kahsay et al., *Sexual Harassment Against Female Nurses: A Systemic Review*, 19 BMC NURSING 58 (2020) (systemic review of quantitative research finding that approximately 43% of nurses experienced sexual harassment—by coworkers and patients—in the workplace); Reshma Jagsi et al., *Sexual Harassment and Discrimination Experiences of Academic Medical Faculty*, 315 JAMA 2120 (2016) (finding 30% of women in a sample of clinical researchers reported experiencing sexual harassment in the workplace); Kathreen P. Lee et al., *Attitude and Perceptions of the Other Underrepresented Minority in Surgery*, 71 J. SURGICAL EDUC. 47 (2014) (survey showing that 30% of LGBT general surgery residents did not reveal their sexual orientation in their residency application owing to fear of not being accepted).

<sup>39</sup> See Chabeli Carrazana, *Most of the COVID-19 Workforce Were Women of Color. What Happens Now as Those Jobs End?*, THE 19TH (June 2, 2022), <https://19thnews.org/2022/06/covid-19-workforce-women-of-color-jobs/>.

condition.<sup>40</sup> In the July guidance, the Department clarifies that “emergency medical conditions involving pregnant patients may include, but are not limited to, ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features.”<sup>41</sup> This clarification should also be incorporated into the Final Rule’s discussion of EMTALA. Additionally, the Department should be clear that EMTALA and Section 1557 provide reinforcing protections to patients needing emergency care, especially when it comes to termination of pregnancy.

That EMTALA is preserved as part of the ACA’s provisions is made clear in Section 1303 of the ACA – the section that provides rules related to abortion coverage. After clarifying that the ACA will not have an effect on harmful federal laws that allow certain health care entities to refuse to provide abortion care, including the Weldon, Church, and Coats-Snowe Amendments,<sup>40</sup> Section 1303(d) states clearly: “Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1395dd of this title (popularly known as “EMTALA”).”<sup>42</sup> The Final Rule must clarify that Section 1557 protects against discrimination in emergency situations, including related to termination of pregnancy and other pregnancy-related care and that if covered entities otherwise offer emergency care but not emergency pregnancy-related care, that would constitute a Section 1557 violation.

#### **IV. § 92.4 Recommended Definitions**

##### **a. We urge the Department to provide clearer guidance on Section 1557 protections for language access and availability of language assistance services and auxiliary aids and services.**

The ability for all individuals to receive health care information and services in their primary language or through language assistance and auxiliary aids and services is vital to living and sustaining healthy lives. Approximately 67.7 million people in the U.S. speak a language other than English at home.<sup>43</sup> More than 25.5 million people have Limited English Proficiency (LEP) and speak English less than “very well.”<sup>44</sup> And approximately 36 million U.S. women are living with a

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<sup>40</sup> U.S. DEPT. OF HEALTH & HUM. SERVS., HHS SECRETARY LETTER TO HEALTH CARE PROVIDERS ABOUT EMERGENCY MEDICAL CARE (Jul. 11, 2022), <https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-care-providers.pdf>.

<sup>41</sup> U.S. DEPT. OF HEALTH & HUM. SERVS., HHS SECRETARY LETTER TO HEALTH CARE PROVIDERS ABOUT EMERGENCY MEDICAL CARE (Jul. 11, 2022), <https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-care-providers.pdf>.

<sup>42</sup> 42 U.S.C. § 18023(d).

<sup>43</sup> U.S. Census Bureau, *American Community Surv.*, tbl. S1601 (2021), <https://data.census.gov/cedsci/table?q=language>.

<sup>44</sup> U.S. Census Bureau, *American Community Surv.*, tbl. S1601 (2021), <https://data.census.gov/cedsci/table?q=language>.

disability.<sup>45</sup> A person's language proficiency or physical disability should not determine their access to or the quality of care they receive. We urge the Department to provide clarity on Section 1557 protections for language access and availability of language assistance services and auxiliary aids and services.

- i. The Final Rule must ensure language access protections for individuals with communication barriers.

For individuals with LEP, communication barriers make it more difficult to navigate an already complicated health care system and exacerbate existing inequities in access to culturally and linguistically appropriate care. Moreover, these barriers are often compounded by other forms of discrimination based on national origin, immigration status, race, ethnicity, disability, and sex, including sexual orientation and gender identity. Discriminatory care contributes to the pervasive culture of fear and distrust in the health care system. For example, undocumented pregnant people may postpone prenatal care or give birth at home to avoid interaction with clinical environments. Moreover, discussions about sexual and reproductive care can be sensitive and raise concerns regarding privacy, confidentiality, and state-based violence. It is critical that individuals have access to adequate language services, in a private and confidential setting, permitting information about and access to sexual and reproductive health care in a culturally and linguistically competent manner.

- ii. Communication and accessibility plans must be included in § 92.8.

The Department must clarify in § 92.8 that covered entities must affirmatively develop a communication and accessibility plan before developing relevant policies and procedures. Protections around language access have long included recommendations around development of language access plans to help covered entities meet the needs of people with LEP.<sup>46</sup> The 2016 Rule did not require covered entities to develop language access plans but said if an entity has a language access plan, OCR must consider it when evaluating compliance. The proposed rule requires that entities implement written policies and procedures in its health programs and activities that demonstrate compliance with § 1557 language access requirements.

Requiring development of policies and procedures, and then requiring relevant staff to receive training as in § 92.9, will hopefully ensure that covered

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<sup>45</sup> U.S. CTRS. FOR DISEASE CONTROL, DISABILITY AND HEALTH INFORMATION FOR WOMEN WITH DISABILITIES, <https://www.cdc.gov/ncbddd/disabilityandhealth/women.html> (Sep. 16, 2020).

<sup>46</sup> Dep't of Health and Hum. Serv., *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, (Aug. 4, 2003), <https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-vi/index.html>.

entities are better able to meet the requirements of § 1557. It is unclear, however, whether the requirements to develop policies and procedures incorporate advance planning to identify what services might be required. We suggest that OCR either clarify this or specifically require covered entities to develop a communication and accessibility plan. For example, the 2022 Proposed Rule discusses the need for “language access procedures” which discuss how to schedule an interpreter, how to identify whether an individual is LEP, etc. But no requirement exists for a covered entity to think *in advance* of what types of language services it may need. That is, without gathering data about the populations in its service area and their communication needs, the entity may not be able to develop effective policies and procedures. Further, covered entities should plan to ensure accessibility for individuals with physical and/or behavioral health disabilities. This should include compliance with the Medical Diagnostic Equipment Accessibility Standards that were finalized by the Access Board in 2016.<sup>47</sup> But it should not end there—adequate nondiscrimination protections under Section 1557 must go beyond physical accessibility.

The Department should clarify that covered entities must affirmatively develop a communication and accessibility plan informed by developing relevant policies and procedures. This could be done as a modification to § 92.8 or it could be a new provision. OCR should also develop and include a “model access plan,” and explain how covered entities should develop one, similar to the language access plan included in its 2013 LEP Guidance. It is imperative that covered entities have proactive insights into the particular needs of the community they are serving and develop procedures to meet those needs.

- iii. Notices of nondiscrimination and availability of language assistance services are vital to ensuring individuals have access to the protections and services they need.

We strongly support the Department’s proposed requirements in §§ 92.10 and 92.11 to strengthen nondiscrimination notice and availability of language assistance services and auxiliary aids and service. The Final Rule must provide clearer direction on these protected services.

1. *§ 92.10 Notice of nondiscrimination*

We strongly support the requirements related to a notice of nondiscrimination. When this provision was removed in the 2020 Rule, it had a harmful effect. Many individuals did not receive information about their rights; did not know how to access interpreters, auxiliary aids, and services; and did not know how to file a complaint or a grievance. We also recommend including a requirement that any entity receiving a religious exemption under proposed § 92.302 include the existence and scope of such exemption in its required notices. If a covered entity is

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<sup>47</sup> Standards for Accessible Medical Diagnostic Equipment, 36 C.F.R. § 1195 (2017).

granted an exemption to 1557's protections under the federal refusal laws or the Religious Freedom Restoration Act (RFRA), it must include that information, including the scope of 1557's protections from which it is exempt and what health care services the entity refuses to provide.

2. *§ 92.11 Notice of availability of language assistance services and auxiliary aids and service*

We strongly support § 92.11 of the Proposed Rule and the requirements for when this notice must be made available. The regulatory requirements as outlined in the Proposed Rule provide a helpful and important minimum standard and list of specific electronic and written communications that must be accompanied by the notice; however, the notice of availability requirements must be clearly visible in order to raise awareness of the right to access language assistance and auxiliary aids and services.

The Department must include language mandating the notice be positioned toward the front, or on the first page, of these vital and significant publications. If notices are placed at the middle or end of multi-page publications containing important information relevant to the patient, they can be easily missed or buried among other information, and individuals with LEP will be less likely to see the notice and know that they can get language assistance services. We also recommend that the notice include a large print statement, at least 18-point font. Additionally, we suggest that OCR develop and provide covered entities with model notices and translated information in the relevant languages that will be needed across the country. These notices should be related to the different types of publications they are included on; that is, a notice would likely be different for a consent form versus information about a public health emergency versus a notice about one's rights or benefits.

We recommend that the top 15 languages requirement not be aggregated between states and take into consideration the language needs of the particular state within which an entity is operating. We recommend that if a covered entity operates across multiple states, that the covered entity has to provide the notice in not merely the top 15 languages in the aggregate (that is, adding to the top 15 languages across all the states), rather the top 15 languages in each state.

iv. § 92.201 Meaningful access for limited English proficient individuals

We strongly support the rule's specific requirements to ensure meaningful access to care for individuals with limited English proficiency, including the requirements related to machine translation. Regarding the section on "evaluation of compliance," we raise similar concerns to the ones above related to the lack of a requirement to develop a language access plan. We appreciate that OCR will evaluate the entity's written language access procedures, but those procedures will

only be as good as the information on which they are based. And the Proposed Rule does not seem to require a covered entity to gather information about the needs of LEP individuals in its service area prior to developing policies and procedures.

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.

We also support the clarification in the 2022 Proposed Rule related to the restricted use of certain persons to interpret or facilitate communication. The prior regulations recognized that an LEP individual cannot be required to provide their own interpreter. And that a minor can only be used to interpret in an emergency and that an adult accompanying an adult should not act as an interpreter without the person's consent or in an emergency. The 2022 Proposed Rule adds an expectation that in an emergency situation, the reliance on an accompanying adult or minor should be "a temporary measure." We support this addition.

#### **b. Federal Financial Assistance and Covered Entities**

The Center strongly supports the Proposed Rule's designation of Medicare Part B payments as FFA and Part B providers and suppliers as recipients under 1557, Title VI, Title IX, Section 504, and the Age Act. As the Proposed Rule outlines, Medicare Part B providers cannot rationally be distinguished from other providers who are treated as recipients of FFA. This change is particularly needed since the longstanding determination that Medicare Part B did not constitute FFA was driven by the racism of white physicians who did not want Black patients in their waiting rooms. The Proposed Rule now defines Federal financial assistance as "any grant, loan, credit, subsidy, contract (other than a procurement contract but including a contract of insurance), or any other arrangement by which the Federal Government provides assistance or otherwise makes assistance available," which is consistent with the plain language and purpose of the Section 1557 statute. Medicare Part B's inclusion also ensures those with Medicare receive identical protections and rights regardless of the Medicare provider, the Medicare-covered service received, or whether they are in Original Medicare or Medicare Advantage. We commend the Department on its inclusion.

#### **V. § 92.7 Designation and Responsibilities of a Section 1557 Coordinator, § 92.8 Policies and Procedures, and § 92.7 Training**

##### **a. The Department should eliminate the exceptions for covered entities with fewer than 15 employees from**

**complying with the designated responsible employee and grievance procedure requirements.**

Under the Proposed Rule, only covered entities with 15 or more employees are required to designate a Section 1557 coordinator and develop a grievance procedure.<sup>48</sup> This exception will leave many patients without informal recourse for complaints of discrimination—even though these informal remedies are potentially the quickest means of resolving pretreatment discrimination and will save the Department substantial enforcement resources. The Center strongly urges that the Final Rule require *all* covered entities to designate a responsible employee and adopt grievance procedures.

Many health care services are provided by solo or small group medical practices. In 2020, about one-third (33.6%) of physicians worked in practices with fewer than 5 physicians.<sup>49</sup> These small practices often have fewer than 15 total employees.<sup>50</sup> Thus, under the Proposed Rule, 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 a grievance procedure under Section 1557. Further, the Proposed Rule may perversely disincentivize these small practices from expanding their support staff in order to remain below the 15-employee threshold—even though support staff has proven vital to physician job satisfaction and quality of patient care.<sup>51</sup>

It is consistent with other federal laws to require every recipient of Federal financial assistance to establish informal grievance procedures. Under Title IX, all recipients that operate education programs are required to designate a coordinator to oversee the recipient’s compliance with Title IX and adopt a grievance procedure for prompt and equitable resolution of complaints.<sup>52</sup> Moreover, smaller practices are already accustomed to complying with HIPAA, which requires that they designate a privacy official responsible for receiving complaints and providing individuals with information about the entity’s privacy practices.<sup>53</sup> And unlike Title VII, there is nothing in the text of Section 1557 that limits its application based on the size of the covered entity.<sup>54</sup>

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<sup>48</sup> Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47,824, 47,846–47.

<sup>49</sup> Carole K. Kane, *Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020*, AM. ME. ASS’N, May 2021, at 1, 5, <https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf>.

<sup>50</sup> 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>.

<sup>51</sup> See Thomas Bodenheimer & Christine Sinsky, *From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider*, 12 ANNALS OF FAMILY MEDICINE 573, 575 (2014), <https://www.annfammed.org/content/annalsfm/12/6/573.full.pdf> (highlighting one study that found 4.25 FTE staff per physician was necessary to address physician burnout and increase the quality of patient care).

<sup>52</sup> 34 C.F.R. § 106.8 (2020).

<sup>53</sup> 45 C.F.R. §§ 164.520(a) and (b), 164.530(a).

<sup>54</sup> See 42 U.S.C. § 2000e(b) (defining the term “employer” as “a person engaged in an industry affecting commerce who has fifteen or more employees...”).

The Center urges the Department to adopt language similar to the regulatory language under Title IX, requiring all covered entities to designate a Section 1557 coordinator and adopt and publish grievance procedures. Applying the coordinator and grievance procedure requirements to all covered entities will lead to more prompt resolutions of complaints of discrimination, which will benefit more patients in a timely manner and allow more covered entities to address compliance issues at an earlier stage. The requirement to designate a coordinator and adopt a grievance procedure helps ensure that medical practices are aware of their obligations under Section 1557, take active steps to comply with those requirements, and are able to address compliance issues without the time and burden of the formal OCR investigation process. In addition, it ensures that patients are aware of Section 1557's protections.

**b. The Department should suggest that covered entities adopt procedures for expedited review of pretreatment grievances.**

While the Proposed Rule requires certain covered entities to develop a grievance process, the Proposed Rule does not differentiate between grievance procedures for pretreatment discrimination and other forms of discrimination.<sup>55</sup> The Center urges the Department to recommend that all covered entities' grievance procedures include a policy for expedited review of pretreatment complaints of discrimination.

Oftentimes, discrimination in health care looks like a provider at a covered entity refusing to perform a procedure or providing substandard care, or a health plan denying coverage of care.<sup>56</sup> These denials of care and coverage can be emotionally devastating, as well as financially costly, for a patient; while a patient seeks a remedy for this discrimination, they will often be forced to postpone necessary care unless they are able to find an alternative provider, at which point they may need to pay for and undergo duplicative pretreatment procedures.<sup>57</sup> And finding an alternative provider can be difficult, especially when the patient lives in a rural area or needs treatment from a specialist. In the case of coverage denials, patients will often be forced to forgo needed care entirely.

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<sup>55</sup> Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47,824, 47,848–49.

<sup>56</sup> See, e.g., *Hammons v. University of Maryland Med. Sys. Corp.*, 551 F. Supp. 3d 567, 574 (D. Md. 2021) (describing that “[a]pproximately 7–10 days before [the claimant]’s surgery was scheduled to take place”—after the claimant had undergone extensive pre-operative health screenings and arranged time off from work and school—an administrator for the covered entity “ordered the surgery canceled” based on the covered entity’s policy that “gender dysphoria did not qualify as a sufficient medical reason to authorize” a hysterectomy); *T.S. by and through T.M.S. v. Heart of CarDon, LLC*, 43 F. 4th 737 (7th Cir. 2022) (describing that after a plan administrator denied plaintiff’s request for continued coverage of autism-related therapies, the child was forced to forgo treatments “[b]ecause his parents could not afford to pay for treatment out-of-pocket.”).

<sup>57</sup> *Hammons v. University of Maryland Med. Sys. Corp.*, 551 F. Supp. 3d 567, 574 (D. Md. 2021) (describing that the claimant was “shocked, angry, afraid, and devastated” by the denial of care and forced to “spend more money on an additional round of pre-operative tests” and to wait six months before receiving the needed surgery).



Expedited procedures for the final resolution of pretreatment complaints of discrimination can help patients avoid the burdens of unnecessarily finding an alternative provider. This will hopefully mitigate those burdens by providing the covered entity an opportunity to informally redress the discriminatory denial of care and ensure that the patient quickly receives the treatment they deserve.

**c. The Department should require covered entities to retain records of grievances and trainings for at least the statute of limitations period.**

The Proposed Rule would require covered entities with 15 or more employees to retain records related to Section 1557 grievances and documentation of employee trainings for no less than 3 years.<sup>58</sup> The Center urges the Department to require that *all* covered entities retain such records for at least 4 years—in line with the statute of limitations period recognized by two federal circuit courts—to ensure that private litigants have the evidence they may need to vindicate their rights.

The U.S. Courts of Appeals for the Second and Sixth Circuits—the only federal circuit courts to have addressed the question—have both held that the general 4-year statute of limitations for federal claims applies to Section 1557.<sup>59</sup> This is because the ACA is “an Act of Congress enacted after” the December 1990 enactment date of the catch-all statute of limitations under 28 U.S.C. § 1658(a), and Section 1557 does not provide for an alternative limitations period.<sup>60</sup> Further, Congress intended § 1658(a) to apply broadly, so federal courts and litigants could avoid “trying to untangle competing statutes of limitations where the federal statute on which the plaintiff’s claim is based lacks its own limitations period.”<sup>61</sup>

The records retention period should at least match the statute of limitations to ensure that documents relevant to a Section 1557 claim are properly preserved for litigation.

## **Subpart B—Nondiscrimination Provisions**

### **I. § 92.101 Discrimination Prohibited**

Although we strongly support the Proposed Rule, we urge the Department to take additional steps in the Final Rule to strengthen the regulatory framework

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<sup>58</sup> Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47,824, 47,848–49 (grievance retention requirement), 47,851–52 (documentation of trainings retention requirement).

<sup>59</sup> *Tomei v. Parkwest Medical Center*, 24 F.4th 508, 515 (2022); *Vega-Ruiz v. Northwell Health*, 992 F.3d 61, 66 (2d Cir. 2021); see also *Palacios v. MedStar Health, Inc.*, 298 F. Supp. 3d 87, 91 (D.D.C. 2018); *Doe v. Pennsylvania*, No. 1:19-CV-2193, 2021 WL 1212574, at \*4–5 (M.D. Pa. Mar. 31, 2021); but see *Solis v. Our Lady of the Lake Ascension Cmty. Hosp., Inc.*, No. CV 18-56-SDD-RLB, 2020 WL 2754917, at \*4 (M.D. La. May 27, 2020) (applying the Rehabilitation Act statute of limitations to a Section 1557 claim of disability discrimination).

<sup>60</sup> See *Tomei v. Parkwest Medical Center*, 24 F.4th 508, 511 (2022).

<sup>61</sup> *Vega-Ruiz v. Northwell Health*, 992 F.3d 61, 66 (2d Cir. 2021) (citing *Jones v. R.R. Donnelley & Sons Co.*, 541 U.S. 369, 382 (2004)).

implementing Section 1557, including providing more clarity with respect to certain protections. Our comments below have a particular focus on the ways the Department can improve the protections relating to sex discrimination, especially in response to the crisis in access to abortion and other reproductive health care following the *Dobbs* decision.

*Dobbs* has caused legal and medical uncertainty. It has placed health care providers in untenable positions, fearing legal liability for providing necessary health care to patients in states where abortion is illegal or being forced by their institutions to refuse care to abortion patients because of the institution's own determinations of potential legal liability.<sup>62</sup> It has impacted patients who need care, related or unrelated to a pregnancy outcome. It has opened the door to attacks on contraception, emboldening health care providers and entities to refuse contraceptive care. In a time of such great fear, legal uncertainty, and potential harm to patients, the Department needs to be absolutely clear about the kinds of actions that constitute sex-based discrimination that Section 1557 protects against. Among other recommendations, we urge the Department to be explicit in its regulatory framework about Section 1557 protecting against discrimination on the basis of termination of pregnancy.

**a. The Department correctly clarifies that sex discrimination includes discrimination based on sexual orientation, gender identity, and sex characteristics.**

The Department's recognition that discrimination based on sexual orientation, gender identity, and sex characteristics is inherently sex-based is consistent with both the statutory language of Section 1557 and the Supreme Court's decision in *Bostock v. Clayton County*.<sup>63</sup> The Department is correct to conclude that the same logic that animated the *Bostock* Court's decision on Title VII applies with equal force to Title IX and Section 1557. As the Department of Justice has explained, Title IX, like Title VII, prohibits sex discrimination against individuals, using language that is "sufficiently similar" to that in Title VII "as to be considered interchangeable,"<sup>64</sup> an interpretation also adopted in regulation by the Department of Education.<sup>65</sup> Indeed, Courts have generally shared the view that Title IX's prohibition on discrimination "on the basis of sex" is functionally identical

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<sup>62</sup> Reese Oxner & María Méndez, *Texas Hospitals are Putting Pregnant Patients at Risk by Denying Care Out of Fear of Abortion Laws, Medical Group Says*, TEXAS TRIBUNE (July 15, 2022), <https://www.texastribune.org/2022/07/15/texas-hospitals-abortion-laws/>.

<sup>63</sup> *Bostock v. Clayton Cnty.*, *Georgia*, 140 S. Ct. 1731 (2020).

<sup>64</sup> Memorandum from Principal Deputy Assistant Attorney General Pamela S. Karla, Civil Rights Division, to Federal Agency Civil Rights Directors and General Counsels, Re: Application of *Bostock v. Clayton County* to Title IX of the Educational Amendments of 1972 (Mar. 26, 2021), <https://www.justice.gov/crt/page/file/1383026/download>.

<sup>65</sup> Enforcement of Title IX of the Educational Amendments Act of 1972 With Respect to Discrimination Based on Sexual Orientation and Gender Identity in Light of *Bostock v. Clayton County*, 86 Fed. Reg. 117, 32637 (June 22, 2021).

to Title VII’s prohibition on discrimination “because of” sex.<sup>66</sup> Accordingly, numerous federal courts have applied the reasoning in *Bostock* to Title IX<sup>67</sup> as well as directly to Section 1557.<sup>68</sup> While the 2020 Rule was in conflict with the overwhelming weight of the case law at the time it was adopted, *Bostock* and other court rulings issued since promulgation leave no doubt that a comprehensive overhaul of the 2020 Rule’s approach to sex discrimination is vital.

This clarification is crucial for many reasons, including addressing discriminatory practices facing LGBTQI+ people, such as refusals to provide treatment because of an individual’s sexual orientation, gender identity, or sex characteristics. Such practices exacerbate health disparities, both by decreasing access to quality care and by compounding the broader health impacts of discrimination.<sup>69</sup> For example, LGBTQI+ people are more likely to report being in poor health than non-LGBTQI+ people, and they experience higher rates of conditions like substance use disorders, mental health conditions, HIV, cancer, and cardiovascular disease.<sup>70</sup> For Black, Latinx, and Native American LGBTQI+ people, who experience higher rates of health discrimination, the concomitant health disparities are particularly pronounced.<sup>71</sup> These health disparities and the discriminatory practices that compound them underscore the urgent need for robust nondiscrimination protections based on sexual orientation, gender identity, and sex characteristics.

In order to ensure greater clarity, we recommend that the Department explicitly enumerate “transgender or nonbinary status” in addition to “gender

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<sup>66</sup> See, e.g., *Jackson v. Birmingham Board of Education*, 544 U.S. 167, 174 (2005) (“[W]hen a funding recipient retaliates against a person *because* he complains of sex discrimination, this constitutes intentional ‘discrimination’ on the basis of sex, in violation of Title IX”); *Meritor Savings Banks v. Vinson*, 477 U.S. 57, 64 (“[W]hen a supervisor sexually harasses a subordinate because of the subordinate’s sex, that supervisor ‘discriminate[s]’ on the basis of sex.”).

<sup>67</sup> See, e.g., *Grimm v. Gloucester County School Board*, 972 F.3d 586, 616 (4th Cir. 2020), *as amended* (Aug. 28, 2020), *reh’g en banc denied*, 976 F.3d 399 (4th Cir. 2020), *petition for cert filed*, No. 20-1163 (Feb. 24, 2021); *Adams v. School Board of St. Johns County*, 968 F.3d 1286, 1305 (11th Cir. 2020), *petition for reh’g en banc pending*, No. 18-13592 (Aug. 28, 2020); *Koenke v. Saint Joseph’s University*, No. CV 19-4731, 2021 WL 75778, at \*2 (E.D. Pa. Jan. 8, 2021); *Doe v. University of Scranton*, No. 3:19-CV-01486, 2020 WL 5993766, at \*11 n.61 (M.D. Pa. Oct. 9, 2020); *B.E. v. Vigo County School Corporation*, No. 2:21-CV-00415-JRS-MG, 2022 WL 2291763, at \*5 (S.D. Ind. June 24, 2022); *Dimas v. Pecos Independent School District Board of Education*, No. 121CV00978KWRJFR, 2022 WL 816501, at \*4 (D.N.M. Mar. 17, 2022).

<sup>68</sup> See, e.g., *Doe v. Snyder*, 28 F.4th 103, 114 (9th Cir. 2022); *Fain v. Crouch*, No. CV 3:20-0740, 2022 WL 3051015, at \*11 (S.D.W. Va. Aug. 2, 2022).

<sup>69</sup> See, e.g., Cornell University, *What Does the Scholarly Research Say About the Effects of Discrimination on the Health of LGBT People?* (2019), <https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-scholarly-research-say-about-the-effects-of-discrimination-on-the-health-of-lgbt-people> (discussing findings of a systematic literature review of peer-reviewed articles that assessed the effects of discrimination on the health of LGBT people in the U.S.).

<sup>70</sup> See, e.g., Hilary Daniel et al., *Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper from the American College of Physicians*, *Annals of Internal Medicine* (July 21, 2015), <https://www.acpjournals.org/doi/full/10.7326/M14-2482?journalCode=aim>; Amy Rosenwohl-Mack et al., *A National Study on the Physical and Mental Health of Intersex Adults in the U.S.*, 15 PLOS ONE, Oct. 9, 2020, at 1, <https://doi.org/10.1371/journal.pone.0240088>.

<sup>71</sup> See, e.g., Lindsay Mahowald, *LGBTQ People of Color Encounter Heightened Discrimination*, *CTR. FOR AM. PROGRESS* (June 24, 2021), <https://www.americanprogress.org/article/lgbtq-people-color-encounter-heightened-discrimination>.

identity,” including in §§ 92.101(a)(2), 92.206(b)(1), (b)(2), and (b)(4), and 92.207(b)(3). While these terms are frequently used interchangeably, entities seeking to undermine nondiscrimination protections have sought to distinguish the two concepts.<sup>72</sup> For example, some have argued that a policy that discriminates against transgender people of all genders equally does not discriminate based on “gender identity,” even if it clearly discriminates based on transgender or nonbinary status. Including “transgender or nonbinary status,” and clarifying in the preamble that this term includes nonbinary identities, would avoid confusion regarding the scope of the prohibition on discrimination.

**b. The Final Rule must standardize and explicitly recognize that Section 1557’s protections against sex discrimination include pregnancy or related conditions and make clear that this includes termination of pregnancy.**

In the Proposed Rule, the Department properly recognizes that discrimination based on sex includes pregnancy and other related care, which includes reproductive health care, including abortion. We urge the Department to explicitly name these forms of sex discrimination and the following section contains recommendations to further that goal.

- i. The Proposed Rule properly recognizes that sex-based discrimination includes discrimination based on pregnancy or related conditions, but it must standardize the definition wherever sex discrimination is named in the regulatory text.

The Proposed Rule correctly clarifies that Section 1557 prohibits recipients of federal funding from discriminating against individuals with respect to their sex, including discrimination based on pregnancy or related conditions. Specifically, consistent with long-standing interpretations of Title IX<sup>73</sup> and other civil rights statutes like Title VII,<sup>74</sup> the Proposed Rule includes “pregnancy or related conditions” in the definition of sex discrimination.<sup>75</sup>

While we support the Department’s inclusion of “pregnancy or related conditions,” the Department does not consistently use this definition in the Proposed Rule. The Department should standardize how it defines sex

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<sup>72</sup> See, e.g., Making Admission or Placement Determinations Based on Sex in Facilities Under Community Planning and Development Housing Programs, 85 Fed. Reg. 44,811 (proposed July 24, 2020) (to be codified at 24 C.F.R pts. 5, and 576).

<sup>73</sup> The Department of Education’s Title IX regulations prohibit discrimination on the basis of “pregnancy and related conditions.” 34 C.F.R. § 106.40(b).

<sup>74</sup> For example, several court decisions make clear that Title VII’s protection against discrimination on the basis of sex, including “pregnancy . . . or related medical conditions,” reaches abortion. See, e.g., *Doe v. C.A.R.S. Prot. Plus, Inc.*, 527 F.3d 358, 364 (3d Cir.), order clarified, 543 F.3d 178 (3d Cir. 2008); *Turic v. Holland Hosp., Inc.*, 85 F.3d 1211 (6th Cir. 1996).

<sup>75</sup> Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, 47858.

discrimination throughout the regulatory text. For example, at § 92.8(b) and § 92.10(a)(1)(i), the Department must add “or related conditions” after “pregnancy.”

- ii. The Final Rule must be explicit in recognizing that Section 1557 protects against discrimination based on termination of pregnancy.

While the Department acknowledges that discrimination based on “pregnancy or related conditions” includes protections against discrimination based on termination of pregnancy, the Department does not make that explicit in the regulatory text.<sup>76</sup> Even though there is no ambiguity on whether termination of pregnancy is a part of Section 1557’s protections,<sup>77</sup> the Final Rule must nevertheless make this protection explicit. This is important because those opposed to abortion are likely to point to a lack of explicit language in an attempt to undermine Section 1557’s protections for termination of pregnancy.<sup>78</sup> Clarity on these protections is also particularly urgent in light of the public health crisis unfolding across the country, where large geographical regions no longer have access to legal abortion care.

Discrimination in health care based on termination of pregnancy can show up in many ways. For example, patients needing emergency abortion care have been denied care at hospitals. Patients have reported being denied medical care unrelated to abortion because their medical history includes a prior abortion. Pharmacies have refused to fill prescriptions needed to manage a miscarriage or complications from pregnancy loss because these medications can also be used to terminate a pregnancy. These experiences are precisely the discriminatory conduct that Section 1557 protects against.

Often, discrimination based on termination of pregnancy is rooted in abortion stigma.<sup>79</sup> This stigma is experienced by a majority of people seeking abortion<sup>80</sup> and is rooted in sex-based conventions that women are: inherently nurturing and

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<sup>76</sup> In the preamble to the proposed rule, the Department already recognizes that the 2016 Rule included in its definition of sex discrimination “pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions.” The Department notes that although it does not propose restoring the 2016 language that the 2020 rule eliminated, the protections still apply because of the Department’s underlying Title IX regulations. We agree with the Department that the protections apply whether or not they are specifically outlined in the Final Rule.

<sup>77</sup> The Department of Education’s Title IX regulations prohibit discrimination related to “termination of pregnancy or recovery therefrom.” 34 C.F.R. § 106.40(b)(1).

<sup>78</sup> See, e.g., Justice Alito’s holding in *Dobbs v. Jackson Women’s Health Organization*, in which despite nearly 50 years of precedent that the Constitution includes the right to abortion, he said, “The Constitution makes no reference to abortion, and no such right is implicitly protected by any constitutional provision. . .” 142 S. Ct. 2228, 2242 (2022).

<sup>79</sup> Alison Norris et al., *Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences*, 21 WOMEN’S HEALTH ISSUES 1, 6 (2011), <https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/Abortion-Stigma.pdf>; Anuradha Kumar et al., *Conceptualising Abortion Stigma*, 11 CULTURE, HEALTH & SEXUALITY 625, 628–29 (2009).

<sup>80</sup> See Paula Abrams, *The Scarlet Letter: The Supreme Court and the Language of Abortion Stigma*, 19 MICH. J. GENDER & L. 293, 328–29 (2013); M. ANTONIA BIGG ET AL., PERCEIVED ABORTION STIGMA AND PSYCHOLOGICAL WELL-BEING OVER FIVE YEARS AFTER RECEIVING OR BEING DENIED AN ABORTION 2 (Whitney S. Rice ed., 2020) (finding that most people considering abortion perceive some stigma related to their decision).

maternal; expected by society to be chaste (which an unwanted pregnancy is seen as diametrically opposed to); and expected to biologically desire to birth children and fulfill traditional roles of homemaker and child caretaker within the nuclear family structure.<sup>81</sup> The stigmatization of abortion also stems from a universal misperception that abortion is an immoral act as opposed to a personal medical decision.<sup>82</sup> Abortion stigma often shapes the experiences of patients seeking all forms of medical care, simply because they present as capable of pregnancy.<sup>83</sup> Sex-based discrimination in health care—including abortion care—has a disproportionate impact on women and transgender and nonbinary individuals in comparison to cis men.<sup>84</sup>

The Department must make clear that “termination of pregnancy” is specifically included wherever the definition of “pregnancy or related conditions” is repeated in the Final Rule. For example, in § 92.101(a)(2), where the Proposed Rule defines protections against discrimination on the basis of sex to include discrimination based on “pregnancy or related conditions,” the Department should amend that provision to include “termination of pregnancy.” The Department should also include this same text in the other places “pregnancy or related conditions” is named, including § 92.8(b) and § 92.10(a)(1)(i).

### c. Recommended language to implement recommendations

Explicitly incorporating “termination of pregnancy” as well as “transgender or nonbinary status” would mean the new language would then read as follows:

Discrimination on the basis of sex includes, but is not limited to, discrimination on the basis of sex stereotypes; sex characteristics, including intersex traits; pregnancy or related conditions, **including termination of pregnancy**; sexual orientation; **transgender or nonbinary status**; and gender identity.

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<sup>81</sup> Alison Norris et al., *Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences*, 21 WOMEN’S HEALTH ISSUES 1, 6 (2011), <https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/Abortion-Stigma.pdf>; Anuradha Kumar et al., *Conceptualising Abortion Stigma*, 11 CULTURE, HEALTH & SEXUALITY 625, 628–29 (2009).

<sup>82</sup> COCKRILL K ET AL., ADDRESSING ABORTION STIGMA THROUGH SERVICE DELIVERY: A WHITE PAPER 17 (2013), <https://www.ibisreproductivehealth.org/publications/addressing-abortion-stigma-through-service-delivery-white-paper>.

<sup>83</sup> Transgender, nonbinary, and gender-expansive people who were assigned female or intersex at birth experience pregnancy, have abortions, and are underrepresented and underserved in abortion policy discourse. See e.g. Heidi Moseson et al., *Abortion Experiences and Preferences of Transgender, Nonbinary, and Gender-expansive People in the United States*, AM. J. OBSTET GYNECOL, Sep. 2020, at 1, 1-2.

<sup>84</sup> See Emily Paulsen, *Recognizing, Addressing Unintended Gender Bias in Patient Care*, DUKE HEALTH (Jan. 14, 2020), <https://physicians.dukehealth.org/articles/recognizing-addressing-unintended-gender-bias-patient-care>.

**d. The Final Rule should also include a stand-alone provision to specifically address discrimination on the basis of pregnancy or related conditions, including termination of pregnancy.**

In the Proposed Rule’s discussion of § 92.208, the Department asks whether there should be a provision to “specifically address discrimination on the basis of pregnancy-related conditions.”<sup>85</sup> While a separate provision is not needed to ensure that pregnancy-related discrimination is prohibited under Section 1557, the Department should nevertheless include it. In this stand-alone provision, which should be separate from but could follow § 92.208, we urge the Department to include language outlining the full scope of pregnancy or related conditions protected by Section 1557. The stand-alone provision must clarify that sex discrimination based on pregnancy or related conditions includes, but is not limited to, pregnancy, childbirth, termination of pregnancy, other pregnancy outcomes, miscarriage, miscarriage management, ectopic pregnancy, or recovery from any of these conditions or related conditions, contraception, and fertility treatment.

**e. The Final Rule must enumerate specific forms of discrimination related to pregnancy or related conditions, including termination of pregnancy.**

We urge the Department to specifically name and include—both in the rule text and preamble—examples of discrimination that patients can experience related to the full range of reproductive health care that Section 1557 protects against. This is especially important in the post-*Dobbs* reality, because there is widespread confusion and uncertainty on the part of both patients and providers. The Department must be clear and unequivocal in identifying existing protections and defining what constitutes prohibited discrimination against patients seeking reproductive health care.

- i. The Final Rule should make clear that Section 1557 prohibits discrimination relating to treating pregnancy emergencies and complications, including termination of pregnancy, miscarriage management, and other pregnancy outcomes.

Patients needing emergency abortion care or miscarriage management can face discrimination from health professionals who object to such care.<sup>86</sup> Examples abound of individuals who present with emergency pregnancy complications only to be denied critical, time-sensitive, and often life-saving medical care because a

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<sup>85</sup> Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, 47878.

<sup>86</sup> *Tamesha Means v. United States Conference of Catholic Bishops*, ACLU, <https://www.aclu.org/cases/tamesha-means-v-united-states-conference-catholic-bishops> (last visited September 8, 2022).

provider considers this care to be abortion.<sup>87</sup> These tragic circumstances have occurred both before and after passage of the ACA, and have been increasingly documented since the *Dobbs* decision. The Department should make clear that such behavior constitutes discrimination on the basis of pregnancy or related conditions, including termination of pregnancy, under Section 1557. And as described above, the Department should elucidate how EMTALA works together with Section 1557 to protect patient access to reproductive health care in emergency situations.

- ii. The Final Rule should make clear that Section 1557 protects against discriminatory refusals to provide information or referrals about abortion and other reproductive health care.

When health care providers refuse to provide information, resources, or referrals about abortion care and other reproductive health care, they may be unlawfully discriminating against patients in violation of Section 1557’s protection for pregnancy or related conditions. For example, many Indigenous individuals rely on the Indian Health Service for health care, but IHS facilities often fail to provide information to patients about abortion care or counseling about pregnancy options.<sup>88</sup> One patient reported that at one IHS hospital, health care providers were explicitly told not to talk about abortions, while at another IHS facility, patients seeking information about abortion were instructed to “Google it.”<sup>89</sup> These are forms of sex discrimination that Section 1557 prohibits. Providers who operate in states where abortion is banned may be emboldened to deny information about abortion, even though such information is not unlawful to provide. The Department should clarify that Section 1557 prohibits discriminatory refusals to provide information and referrals relating to a pregnancy, including termination of pregnancy.

- iii. The Final Rule should make clear that Section 1557 protects against discrimination based on a person’s actual or perceived decision relating to abortion care.

In the Final Rule’s preamble discussion of § 92.206, the Administration should include examples making clear that it is discriminatory to refuse to provide health care because of a patient’s actual or perceived abortion care history. Such discriminatory treatment may occur when a provider discovers and objects to a patient’s history of having had an abortion, and therefore refuses to provide any care whatsoever to the patient—even when the health care the patient now seeks is not abortion care. Sometimes a provider may suspect that a patient has previously had or will have an abortion and will refuse to provide the patient any health care on this basis as well.

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<sup>87</sup> Brief of Amici Curiae Rachael Lorenzo, Mindy Swank and Meghan Eagen in Support of Appellees and for Affirmance, *New York et al. v. Dept’ Health & Human Servs.*, No. 19-4254, Doc. 323, 7–20 (3d Cir. Aug. 3, 2020) (collecting stories of individuals denied life-saving care to treat emergency pregnancy complications).

<sup>88</sup> Ex. F Decl. of Rachael Lorenzo 15, Nov. 18, 2020, 1:20-cv-11297-PBS.

<sup>89</sup> Ex. F Decl. of Rachael Lorenzo 15, Nov. 18, 2020, 1:20-cv-11297-PBS.



These scenarios are not hypothetical. The Center’s Legal Network for Gender Equity has received intakes of people who have faced such discrimination. For example, one Ohio patient contacted the legal network after seeking care for a painful nasal condition in January 2022. The doctor discovered information in her electronic medical file related to a past abortion and refused to care for her unrelated nasal condition, stating, “There is nothing I can do for you based on your life choices.” The patient was forced to seek care from a second doctor, and the denial and delay in care from the first doctor resulted in significant pain and nose bleeds. The Final Rule must clearly identify this kind of situation as discrimination under Section 1557.

- iv. The Final Rule should make clear that Section 1557 protects people against being targeted for their behavior while pregnant or their pregnancy outcomes.

The *Dobbs* decision has created chaos in our health care system, increasing the risk that patients will experience discrimination based on their behavior while pregnant or their pregnancy outcomes. This kind of discrimination is not new. Even before the Supreme Court overturned *Roe*, restrictions and limitations on abortion care had resulted in surveillance and criminalization of pregnancy outcomes, falling hardest on individuals with intersecting marginalized identities.<sup>90</sup> Such criminalization was not limited to abortion, but extended to other pregnancy outcomes, including miscarriage.<sup>91</sup> People have been surveilled and prosecuted for pregnancy outcomes such as suffering a miscarriage from accidentally falling down stairs, experiencing a stillbirth as a result of a breech home birth, and using drugs while pregnant, even with a healthy birth.<sup>92</sup>

After the *Dobbs* decision, pregnant people are being subjected to increased surveillance, monitoring, and potential criminalization. As the Department has recognized in the Proposed Rule, when providers ask questions of patients or make inquiries that “do not have a relationship to the care provided, or where they are made in a manner that is harassing, hostile, or evinces disregard for a patient’s privacy,” that might be evidence of discrimination.<sup>93</sup> This is particularly relevant in the post-*Dobbs* world for patients seeking pregnancy-related care or who could be pregnant. We urge the Department to ensure that the discussion in the Final Rule of this kind of discrimination clearly articulate examples related to pregnancy-related care or assumptions about patients’ reproductive health status.

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<sup>90</sup> See Brief for If/When/How: Lawyering for Reproductive Justice et al. as Amici Curiae Supporting Petitioners, *June Medical Services L.L.C v. Russo*, 140 S. Ct. 2103 (2020) (No. 18-1323), at 25–26, <https://www.ifwhenhow.org/resources/amicus-brief-june-v-gee/>.

<sup>91</sup> JEANNE FLAVIN, OUR BODIES, OUR CRIMES: THE POLICING OF WOMEN’S REPRODUCTION IN AMERICA 84 (N.Y. Univ. Press 2009).

<sup>92</sup> See Brief for If/When/How: Lawyering for Reproductive Justice et al. as Amici Curiae Supporting Petitioners, *June Medical Services L.L.C v. Russo*, 140 S. Ct. 2103 (2020) (No. 18-1323), at 25–26, <https://www.ifwhenhow.org/resources/amicus-brief-june-v-gee/>.

<sup>93</sup> Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, 47868.

The discriminatory targeting of people for their behavior while pregnant, for pregnancy outcomes, or based on a perception of the person's pregnancy status violate Section 1557. Given all the uncertainty facing patients who are, have been, or could be pregnant, it is particularly important for the Department to clarify that patients can seek redress if they have faced such targeting and harassment.

- v. The Final Rule should make clear that Section 1557 prohibits discrimination related to maternity care.

Although discrimination in maternity care and coverage is clearly prohibited by Section 1557, the Final Rule must nevertheless make this clear, since despite this prohibition, such discrimination continues to exist. This is especially critical for pregnant Black, Indigenous, Latina/x, Asian American and Pacific Islander, and all people of color, and others who live at the intersections of Section 1557's protected identities, who are often subjected to discrimination throughout pregnancy and the postpartum period, including mistreatment during labor and delivery.<sup>94</sup> For example, in a 2018 California survey, Black women and Asian language speakers who gave birth in hospitals reported slightly higher rates of harsh language and rough handling than white and Latina women.<sup>95</sup> And pregnancy and childbirth are more dangerous for Black women than for white women: as of 2020, the national maternal mortality rate for Black women is approximately three times the rate for white women.<sup>96</sup> People with disabilities seeking pregnancy-related care also face discrimination—among subspecialty provider offices, 44 percent of gynecology offices were inaccessible due to factors such as inaccessible equipment and lack of transfer assistance, leaving wheelchair users unable to access abortion or maternal care.<sup>97</sup>

The Final Rule must also make clear that insurance companies may not discriminate in maternity coverage. For example, within the past six months, the Center received five separate complaints from young people insured as dependents on their parents' health plans who were denied insurance coverage for any care related to their pregnancies. These coverage exclusions violate Section 1557.<sup>98</sup> Indeed, it is well established under Title IX and Title VII that a health insurance

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<sup>94</sup> Saraswathi Vedam et al., *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16 REPROD HEALTH 2019 at 1, <https://doi.org/10.1186/s12978-019-0729-2>.

<sup>95</sup> CAROL SAKALA ET AL., NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, LISTENING TO MOTHERS IN CALIFORNIA: A POPULATION-BASED SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES, 64-65 (Sept. 2018) <https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothersCAFullSurveyReport2018.pdf>.

<sup>96</sup> U.S. CTRS. FOR DISEASE CONTROL, MATERNAL MORTALITY RATES IN THE UNITED STATES (2020), <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm>.

<sup>97</sup> Tara Lagu et al., *Access to Subspecialty Care for Patients with Mobility Impairment: A Survey*, 158 ANNALS OF INTERNAL MED. 441 (2013), <https://www.acpjournals.org/doi/10.7326/0003-4819-158-6-201303190-00003>.

<sup>98</sup> 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-release/victory-in-sex-discrimination-complaints-brought-by-nwlc-after-investigation-by-hhs-employers-change-policies/>.

plan that provides comprehensive coverage to its beneficiaries but fails to provide comprehensive coverage for maternity care discriminates on the basis of sex.<sup>99</sup>

- vi. The Final Rule must make clear that Section 1557’s protections against discrimination on the basis of sex includes discrimination against people seeking or accessing fertility treatment.

Despite Section 1557’s clear prohibition of sex discrimination in health care, discrimination persists against those accessing infertility diagnoses, treatments, and services, including assisted reproductive technology. It is thus essential that the Final Rule explicitly name this as prohibited conduct under this provision.

Sex discrimination in the context of fertility care can take many forms. Some insurance companies outright refuse to cover any of the types of fertility care that are traditionally used by women (e.g., in vitro fertilization (IVF)).<sup>100</sup> Even in states that require insurance plans to cover IVF, some insurance plans require that patients use their “spouse’s sperm” to fertilize their eggs to be eligible for IVF insurance coverage, discriminating against patients based on their sex with respect to marital status, sexual orientation, and gender identity.<sup>101</sup> For example, OSF HealthCare, a self-insured Catholic hospital system with facilities in Illinois and Michigan, recently adopted an insurance policy for its employees limiting IVF coverage to “married couple[s] of opposite sex spouses.”<sup>102</sup>

Additionally, public and private insurers often discriminate against patients based on sex by requiring that they meet outdated and heteronormative definitions of infertility before providing IVF coverage. For example, relying on a 2013 definition of infertility that has since been rescinded by the American Society of

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<sup>99</sup> See, e.g., 34 C.F.R. §§ 106.39, 106.40 (2012) (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. (stating that Title VII, 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).

<sup>100</sup> GABRIELA WEIGEL ET AL., KAISER FAMILY FOUNDATION, COVERAGE AND USE OF FERTILITY SERVICES IN THE U.S. (2020), <https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s/>. These benefit exclusions disproportionately affect women of color due to racial disparities in the rate of certain diseases that may cause infertility. See Jennifer O’Hara, *Mayo Clinic Q&A Podcast: The Link Between Racial Disparities and Cervical Cancer*, MAYO CLINIC NEWS NETWORK (Jan. 10, 2022), <https://newsnetwork.mayoclinic.org/discussion/mayo-clinic-qa-podcast-the-link-between-racial-disparities-and-cervical-cancer/> (describing that Hispanic women have the highest incidence rate of cervical cancer, followed by non-Hispanic Black women).

<sup>101</sup> E.g., HAW. REV. STAT. § 431:10A-116.5 (1987); ARK. CODE R. 054.00.1–5(B) (1991). Furthermore, Texas, which only requires insurance providers to offer IVF insurance, also includes this same eligibility requirement. See TEX. INS. CODE ANN. § 1366.005.

<sup>102</sup> Shira Stein, *Hospital Chain Blocks Fertility Coverage for Its LGBTQ Employees*, BLOOMBERG L. (July 18, 2022), <https://news.bloomberglaw.com/health-law-and-business/hospital-chain-blocks-fertility-coverage-for-its-lgbt-employees>.

Reproductive Medicine,<sup>103</sup> several insurers require simply that patients in different-sex relationships attest that they have unsuccessfully tried to become pregnant by having unprotected sex for six months or a year, depending on their age, but require same-sex couples to undergo six to twelve unsuccessful cycles of intrauterine insemination (IUI) at their own expense before deeming them eligible for IVF coverage. These patients are thereby forced to absorb exorbitant costs out of pocket and are delayed or denied access to their IVF coverage benefits solely due to their sexual orientation.<sup>104</sup> Indeed, in the Center's recent lawsuit against Aetna on behalf of a class of plaintiffs denied equal coverage for fertility treatments because of their sexual orientation, one of the plaintiffs' total out-of-pocket costs reached nearly \$45,000 before she became pregnant.<sup>105</sup> And in the last year alone, the Center has received nearly 50 intakes from same-sex couples in 17 states under 5 different insurance companies who have been forced to pay tens of thousands of dollars out of pocket after they were denied coverage for fertility treatments that are otherwise provided for in their plan because they cannot attest to having engaged in six or twelve months of heterosexual sex.

Health care providers may also refuse to provide fertility care for discriminatory reasons. For example, Guadalupe Benitez underwent a year of invasive, costly, and medically unnecessary treatments by the sole in-network fertility care provider on her insurance plan only to then be denied the fertility treatment she needed based on the provider's religious objections to performing the procedure because Benitez identified as a lesbian. Benitez was forced to pay for her fertility care out-of-pocket at another clinic.<sup>106</sup> Further, studies have found that physicians may consciously or unconsciously block patients from accessing fertility treatments by making assumptions or possessing biases about who can or deserves to be a parent and who wants or deserves fertility treatment. For example, women of color "have reported that some physicians brush off their fertility concerns, assume they can get pregnant easily, emphasize birth control over procreation, and

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<sup>103</sup> *Compare* Practice Committee of the American Society for Reproductive Medicine, *Definitions of Infertility and Recurrent Pregnancy Loss: A Committee Opinion*, 99 FERTILITY & STERILITY 63, 63 (2013) (defining infertility as "a disease defined by failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination," with Practice Committee of the American Society for Reproductive Medicine, *Definitions of Infertility and Recurrent Pregnancy Loss: A Committee Opinion*, 113 FERTILITY & STERILITY 533, 533 (2020) (defining infertility as "a disease historically defined by the failure to achieve a successful pregnancy after 12 months or more of regular, unprotected sexual intercourse or due to an impairment of a person's capacity to reproduce either as an individual or with her/his partner.").

<sup>104</sup> See Amended Complaint at *Goidel v. Aetna Inc.*, No. 21-cv-07619 at ¶ 8 (S.D.N.Y. 2021), <https://nwl.org/wp-content/uploads/2021/09/19-2021.11.04-First-Amended-Complaint.pdf> (describing that a patient was forced to pay out of pocket \$45,000 to achieve a successful pregnancy after she was denied coverage for the benefits in her plan because, as a queer woman, she could not attest to engaging in heterosexual sex).

<sup>105</sup> Amended Complaint at *Goidel v. Aetna Inc.*, No. 21-cv-07619 (S.D.N.Y. 2021), <https://nwl.org/wp-content/uploads/2021/09/19-2021.11.04-First-Amended-Complaint.pdf>.

<sup>106</sup> *Benitez v. North Coast Women's Care Medical Group, Inc.*, 106 Cal. App. 4th 978, 983 (2003).

may dissuade them from having children.”<sup>107</sup>

- vii. The Final Rule must make clear that discrimination against those seeking contraception or contraceptive-related services is prohibited under Section 1557.

In the Final Rule, it is imperative that the Department make clear that Section 1557 prohibits discrimination against those seeking contraception or contraceptive-related services. This type of discrimination happens frequently and is becoming more widely reported in the wake of the *Dobbs* decision. For example, just weeks after the decision, a cashier at a chain pharmacy refused to sell condoms to a couple naming their personal objection to it.<sup>108</sup> Given that the landscape of reproductive rights remains unsettled after *Dobbs*, it is critical for the Department to clearly prohibit such forms of sex discrimination.

The Department has already taken initial action to clarify Section 1557’s prohibition on discrimination against those seeking contraception in retail pharmacies. On July 13, 2022, the Department issued important guidance to retail pharmacies about Section 1557 protections, responding to incidents occurring after *Dobbs*. The guidance identified certain scenarios impacting access to contraception in the retail pharmacy setting, such as an individual being refused access to hormonal contraception at a pharmacy that otherwise provides contraceptives, which could be discriminatory.<sup>109</sup> These examples should be reiterated in the Final Rule. The Department should also make clear that these same scenarios could be discriminatory if they occurred in a hospital pharmacy.

The Department should also clearly identify other examples of discrimination that relate to contraception. For example, if a state program that otherwise provides coverage of contraceptives decides to exclude a specific contraceptive because of an assertion that the contraceptive causes an abortion, that may constitute a 1557 violation.<sup>110</sup> An employer whose health plan only covers sterilization for people who

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<sup>107</sup> The Ethics Committee of the American Society for Reproductive Medicine, *Disparities in Access to Effective Treatment for Infertility in the United States: An Ethics Committee Opinion*, 116 FERTILITY & STERILITY 54, 57 (2021), [https://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/ethics-committee-opinions/disparities\\_in\\_access\\_to\\_effective\\_treatment\\_for\\_infertility\\_in\\_the\\_us-pdfmembers.pdf](https://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/ethics-committee-opinions/disparities_in_access_to_effective_treatment_for_infertility_in_the_us-pdfmembers.pdf) (discussing the various inequitable barriers to fertility care).

<sup>108</sup> Rob Wile, *A Walgreens Employee Refused to Sell Condoms to a Couple on Religious Grounds*, NBC NEWS (July 21, 2022), <https://www.nbcnews.com/business/news/walgreens-employee-refused-sell-condoms-couple-faith-rcna39165>.

<sup>109</sup> Off. of Civ. Rts., *Guidance to Nation’s Retail Pharmacies: Obligations under Fed. C.R. L. to Ensure Access to Comprehensive Reproductive Health Care Servs*, U.S. DEP’T OF HEALTH & HUMAN SERV., <https://www.hhs.gov/civil-rights/for-individuals/special-topics/reproductive-healthcare/pharmacies-guidance/index.html> (last updated July 14, 2022).

<sup>110</sup> In addition to violating section 1557, a state program in this instance may also be violating the ACA contraceptive coverage requirement. The Department has already made clear that the ACA contraceptive coverage requirement is a floor for coverage. Should a state restriction on contraceptives make compliance with the ACA’s contraceptive coverage requirement impossible, the federal government will step in to enforce the ACA. U.S. DEP’T OF LAB., HEALTH & HUM. SERV., & TREASURY, FAQs ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 54 at 7 (2022), <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-54.pdf>.

have already given birth would be unlawfully discriminating. Likewise, an entity that will provide information about male-controlled contraceptives for non-contraceptive purposes but not female-controlled contraceptives for non-contraceptive purposes would be violating Section 1557 protections. And a insurance issuer's provider network that only includes facilities that refuse to perform female sterilization procedures is engaging in discrimination.

The Department must also specify that items or services related to contraception are also protected.<sup>111</sup> Additional medications or services are often needed to facilitate use of contraception, such as anesthetics or medications to facilitate cervical dilation for insertion of long-acting reversible contraceptives. For example, a pharmacy refusal to provide misoprostol to a patient prescribed it in order to make intrauterine device (IUD) insertion easier—like an incident that happened in July 2022—could be a Section 1557 violation.<sup>112</sup>

When a patient is denied contraception, there can be lifelong consequences, and because of structural racism, these consequences can have a disproportionate impact on people of color and others who already face barriers to care.<sup>113</sup> Moreover, discrimination plays a key role in people's experience obtaining contraception. For example, a 2005 study of 326 African American women showed that of the 79% study participants who had sought birth control or family planning services, 67% reported experiencing race-based discrimination, especially participants with stronger Black identities, of younger ages, and lower incomes.<sup>114</sup> Another study found that women who reported any experiences of discrimination while seeking contraception were more likely to report use of less effective methods of contraception compared to women who did not experience discrimination.<sup>115</sup> Given the range of ways people, especially patients of color, can experience discrimination when seeking contraceptive-related care, the Final Rule must be clear about the protections Section 1557 offers.

viii. The Final Rule must make clear that Section 1557 prohibits discrimination where a patient is denied medication or treatment because of a covered entity's objections to the

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<sup>111</sup> In the context of insurance coverage requirements, the Department already recognizes that any item or service necessary to access contraception is part of contraception. U.S. DEPT'S OF LAB., HEALTH & HUM. SERV., & TREASURY, FAQs ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 54 at 10 (2022), <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-54.pdf>.

<sup>112</sup> Emily Woodruff, *As Abortion Ban is Reinstated, Doctors Describe 'Chilling Effect' on Women's Care*, NOLA (July 10, 2022), [https://www.nola.com/news/healthcare\\_hospitals/article\\_238af184-ff02-11ec-9bce-dfd660a21ce1.html](https://www.nola.com/news/healthcare_hospitals/article_238af184-ff02-11ec-9bce-dfd660a21ce1.html).

<sup>113</sup> *Reproductive Justice for Women of Color*, INTERSECTIONS OF OUR LIVES (Oct. 2017), <https://intersectionsofourlives.org/wp-content/uploads/2019/03/Reproductive-Justice-for-Women-of-Color.pdf>; Lisa L. Lindley & Katrina M. Walsemann, *Sexual Orientation and Risk of Pregnancy Among New York City High-School Students*, 105 AM. J. PUB. HEALTH 1379, 1383 (2015).

<sup>114</sup> Sheryl Thorburn & Laura M. Bogart, *African American Women and Family Planning Services: Perceptions of Discrimination*, 42 WOMEN & HEALTH 23, 23 (2005), <https://pubmed.ncbi.nlm.nih.gov/16418120/>.

<sup>115</sup> Karla Klosser, et al., *Perceived racial, socioeconomic and gender discrimination and its impact on contraceptive choice*, 84 CONTRACEPTION 273, 273 (2011), <https://www.sciencedirect.com/science/article/abs/pii/S0010782411000059?via%3Dihub>.

reproductive health care outcomes of such medication or treatment, whether actual or perceived.

In the wake of *Dobbs*, covered entities are denying medication and treatment for chronic health conditions and other disabilities that could prevent, complicate, or end pregnancies or fertility. For example, a patient in Tennessee was denied methotrexate, a drug that has relieved her disabling pain from rheumatoid arthritis for the last eight years but is also used in abortion care. She ultimately sought permanent sterilization in order to receive the medication she so desperately needed.<sup>116</sup> She faced discrimination as her provider engaged in sex stereotyping by making assumptions about her capacity for pregnancy given her sex and age. Furthermore, she was forced into a health care decision based on her sex that she did not want to take in order to continue treating her disability. The Final Rule must make clear that Section 1557 protects patients against such forms of sex- and disability-based discrimination

Similarly, the drugs mifepristone and misoprostol are used to treat a range of health conditions and disabilities, from ulcers to cancer to miscarriage management. Mifepristone is currently being tested for treating breast cancer, brain cancer, prostate cancer, alcoholism, post-traumatic stress disorder, and depression, among other conditions.<sup>117</sup> Mifepristone and misoprostol are also approved for termination of pregnancy. Following the *Dobbs* decision, patients who could be pregnant are at risk of discrimination when seeking this medication for purposes besides abortion.

As the Department has already recognized in its July 13, 2022 guidance, Section 1557 prohibits discrimination in the form of refusing to fill prescriptions for medications that are considered “abortifacients” but may be prescribed to treat other health conditions, such as cancer, arthritis, and ulcers.<sup>118</sup> The Final Rule must explicitly address this.

Finally, some individuals seeking sterilization care because of underlying health conditions have been denied that care because the provider is making assumptions or relying on stereotypes to disagree with the patient’s decision. For example, when seeking a hysterectomy or excisions to help remedy chronic pain caused by endometriosis, a patient was refused care by doctors who believe the patient is making the wrong choice because she will one day want to have

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<sup>116</sup> Katie Shepherd & Frances Stead Sellers, *Abortion Bans Complicate Access to Drugs for Cancer, Arthritis, Even Ulcers*, WASH POST (Aug. 8, 2022), <https://www.washingtonpost.com/health/2022/08/08/abortion-bans-methotrexate-mifepristone-rheumatoid-arthritis/>.

<sup>117</sup> Caroline Hopkins, *The ‘Abortion Pill’ May Treat Dozens of Diseases, but Roe Reversal Might Upend Research*, NBC NEWS (June 25, 2022), <https://www.nbcnews.com/health/health-news/abortion-pill-may-treat-dozens-diseases-roe-reversal-might-upend-resea-rcna34812>.

<sup>118</sup> Off. of Civ. Rts., *Guidance to Nation's Retail Pharmacies: Obligations under Fed. C.R. L. to Ensure Access to Comprehensive Reproductive Health Care Servs*, U.S. DEPT OF HEALTH & HUMAN SERV., <https://www.hhs.gov/civil-rights/for-individuals/special-topics/reproductive-healthcare/pharmacies-guidance/index.html> (last updated July 14, 2022).

children.<sup>119</sup> Section 1557 protects against such discrimination—which often involve the intersection of disability and sex-based biases. The Final Rule must specifically identify these kinds of discriminatory behaviors and make explicit that they are prohibited by Section 1557.

**f. The Department correctly declined to incorporate the religious and abortion provisions from Title IX.**

We support the Proposed Rule’s exclusion of the Title IX exceptions, including the religious exemption and “abortion neutrality provision,” commonly referred to as the Danforth Amendment. We urge the Department to further clarify why these exceptions cannot be included: Section 1557 does not, by its terms, import any exceptions from Title IX or from any other statute. The plain language of the statute bars any interpretation that would suggest that the Title IX exceptions or any other exceptions apply from the prohibition of sex discrimination. This approach is consistent with both the text and purpose of Section 1557.

The 2020 Rule wrongly interpreted the scope and breadth of the protections in the underlying statute and created confusion and harm, as the provisions exceeded the Department’s authority and contravened legislative intent. Moreover, incorporating the exemptions into the health care context could lead to the delay or denial of care and cause significant harm to patients, which is contrary to the purpose of Section 1557 and the ACA itself.

In the Final Rule, we urge the Department to finalize its proposal to *not* include either Title IX’s religious exemption or the Danforth Amendment. Further, we urge the Department to make clear in the Final Rule that inclusion of those provisions in the 2020 Rule not only exceeded the statutory authorization delegated to the Department but was contrary to the underlying law.

- i. The Department lacks statutory authority to incorporate the Danforth Amendment and religious exemption as doing so would be contrary to the statutory text.

We strongly support the Proposed Rule’s recognition that Section 1557 does not require the Department to incorporate Title IX’s Danforth Amendment and religious exemption. The Department’s proposed approach is consistent with both the underlying statute and the 2016 Rule. The Administrative Procedure Act (APA) only permits department regulations “to implement” the underlying statute of Section 1557. The Department may not limit the statute contrary to Congress’s intent. It is well settled that courts “begin with the text...[and] presume that a legislature says in a statute what it means and means in a statute what it says

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<sup>119</sup> Anne Branigin, *Choosing Between not Having Kids or Pain: An Endometriosis Case is Sparking Outrage*, THE LILY (Apr. 20, 2021), <https://www.thelily.com/choosing-between-children-and-a-lifetime-of-pain-a-endometriosis-case-in-the-uk-is-sparking-outrage/>.



there,” as Congress legislates with the background of the law.<sup>120</sup> Thus, any silence on incorporation of Title IX’s exemptions is not an oversight on the part of Congress, but rather an intentional decision, as “Congress legislates with knowledge of our basic rules of statutory construction.”<sup>121</sup>

The text of Section 1557 is clear. Subsection (a) refers to the “ground prohibited” by Title VI, Title IX, the Americans with Disabilities Act, and the Age Discrimination Act. We agree with the Department that, “as a textual matter, the more natural understanding of ‘ground prohibited’ is that it refers to the basis on which discrimination is prohibited.” Additionally, subsection (b) of Section 1557 repeats this same structure by referring to “discrimination on any basis described in subsection (a),” which suggests that “ground” in subsection (a) means the “basis” for discrimination, i.e., race, color, national origin, sex, age, and disability.”

Further, Congress specifically provided for the exceptions that would apply to Section 1557. The text of 1557 provides that its protections apply “except as otherwise provided for in this title.” This is clear text that shows Congress contemplated and provided for the limited, enumerated exemptions that apply to Section 1557. Canons of statutory interpretation provide that “[w]hen Congress provides exceptions in a statute, it does not follow that courts have authority to create others. The proper inference . . . is that Congress considered the issue of exceptions and, in the end, limited the statute to the ones set forth.”<sup>122</sup> If Congress had wanted to specifically incorporate Title IX’s exceptions, it could have expressly done so, as it did for the provisions in Title I of the ACA.<sup>123</sup>

Finally, the existence of other Title IX exceptions reflects the absurdity of including the religious and abortion exceptions in Section 1557. If Congress intended for Title IX’s exceptions to apply, then that would mean that exceptions relating to military training, admissions decisions, and membership practices of

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<sup>120</sup> *Conn. Nat’l Bank v. Germain*, 503 U.S. 249, 253-54 (1992) (citations omitted). *See also* *Rice v. Rehner*, 463 U.S. 713, 732 (1983) (referencing the Court’s consistent approach that a canon of construction should not be followed “when application would be tantamount to a formalistic disregard of congressional intent.”).

<sup>121</sup> *McNary v. Haitian Refugee Ctr.*, 498 U.S. 479, 496 (1991) (referring to presumption favoring judicial review of administrative action). *See also* *United States v. Fausto*, 484 U.S. 439, 463 n.9 (1988) (Stevens, J., dissenting) (Court presumes that “Congress is aware of this longstanding presumption [disfavoring repeals by implication] and that Congress relies on it in drafting legislation.”).

<sup>122</sup> *United States v. Johnson*, 529 U.S. 53, 58 (2000).

<sup>123</sup> By incorporating both exceptions in the 2020 Rule, the Department relied heavily upon the district court’s flawed decision in *Franciscan Alliance v. Burwell*. In *Franciscan Alliance*, following promulgation of the 2016 Rule, anti-abortion plaintiffs challenged the rule in district court and requested Danforth be incorporated. *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016). The district court wrongly sided with plaintiffs, reasoning that the Department was required to incorporate the full language of Title IX’s Danforth Amendment and religious exemption because the statute underlying Section 1557 referenced the ground prohibited under Title IX. The district court found that the text of Section 1557 bars discrimination “on the ground prohibited under Title IX...[and] Congress specifically included in the text of Section 1557... the signal ‘et seq.,’ which means ‘and the following,’ after the citation to Title IX...[this] can only mean Congress intended to incorporate the entire statutory structure, including the abortion and religious exemptions.” *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660, 690 (N.D. Tex. 2016). Judge O’Connor’s reasoning was flawed because Congress had the opportunity to expressly incorporate the Title IX exceptions into Section 1557 and chose not to when it made clear that the only exceptions that applied were those “otherwise provided for” in Section I of the ACA. Moreover, this decision is only a single district court case and another court has already held to the contrary.

certain tax-exempt organizations would apply as well. The fact that the Department is only focusing on a few exceptions to include merely confirms that any argument to include only those exceptions has no legal, textual, or even logical justification.

- ii. The Department lacks statutory authority to incorporate the Danforth Amendment and religious exemption as it would undermine patient access to health care and thereby contravene legislative intent.

Incorporation of the Danforth Amendment and the religious exemption would be contrary to congressional intent of the underlying legislation. In passing Section 1557, Congress intended “to expand access to care and coverage and eliminate barriers to access”<sup>124</sup> because the government has a “compelling interest in ensuring that individuals have nondiscriminatory access to healthcare.”<sup>125</sup> Both the Danforth Amendment and religious exemption would undermine this congressional intent by undermining patient access to health care.

The Department rightly names, when considering exemptions from Title IX, that education and health care are quite different contexts, particularly in the choice of, and access to, services. The decision to seek health care at a particular institution is often driven by geographic location, cost, insurance coverage, and the type of care being sought and the urgency of that care. Thus, not only would be nonsensical to apply these exemptions to Section 1557, but it would also result in denials of care, putting patients’ life and health at risk.

1. *Incorporation of the religious exemption would result in the delay or denial of patient care*

The harm in incorporating Title IX’s religious exemption cannot be overstated. Entities have invoked personal beliefs to deny access to health care and coverage and an increasingly broad range of health care services, including birth control, sterilization, certain fertility treatments, abortion, and gender-affirming care.<sup>126</sup> 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.<sup>127</sup> A transgender man was denied gender affirming surgery at a

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<sup>124</sup> Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31377 (May 18, 2016).

<sup>125</sup> Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31380 (May 18, 2016).

<sup>126</sup> See e.g. Nat’l Women’s Law Ctr., *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide* (February 2022), <https://nwlc.org/resource/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/>. See also 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>.

<sup>127</sup> ACLU, *Court Cases: Tamesha Means v. United States Conference of Catholic Bishops* (June 2015), <https://www.aclu.org/cases/tamesha-means-v-united-states-conference-catholic-bishops>.

religiously-affiliated hospital that refused to provide him a hysterectomy.<sup>128</sup> 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.<sup>129</sup> 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 religiously-affiliated medical institutions,<sup>130</sup> and more likely to experience pregnancy-related complications that require services or procedures prohibited in certain religiously-affiliated health care institutions.<sup>131</sup> Denials of care compound the harm to patients already facing barriers to care, particularly the very patients who will need Section 1557’s protections the most after *Dobbs*.

## 2. *The Danforth Amendment would cause confusion and harm patients.*

Incorporation of the Danforth Amendment into Section 1557 would cause confusion and undermine protections for nondiscrimination that are part of the underlying statute, putting patients in jeopardy. For example, as discussed above, patients seeking emergency abortion care are protected against discrimination and refusals of care.<sup>132</sup> Incorporating the Danforth Amendment would cause confusion as to covered entities’ responsibilities in emergency situations and would embolden refusals of care in emergency situations.

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<sup>128</sup> 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).

<sup>129</sup> Nat’l Women’s Law Ctr., *Put Patient Health First: Oppose the Attempts to Expand the Reach of Federal Refusal of Care Laws* (June 2018), <https://nwlc.org/resource/continued-efforts-to-undermine-womens-access-to-health-care/>.

<sup>130</sup> 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>.

<sup>131</sup> 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 (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 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 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>; 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.

<sup>132</sup> Several federal courts have found that the federal laws permitting refusals of care for abortion – namely the Weldon, Church, and Coats-Snowe Amendments – are consistent with EMTALA and do not allow refusal of care in these situations. See e.g., *New York v. United States Dep’t of Health & Hum. Servs.*, 414 F. Supp. 3d 475, 538 (S.D.N.Y. 2019).

Similarly, as the Department has already recognized in its July 13, 2022 guidance, Section 1557 prohibits discrimination when patients seek medication that may be considered an “abortifacient” (such as assisting treatment for an abortion or miscarriage) or that may also be used for abortion (such as when prescribed for health conditions such as cancer, arthritis, and ulcers).<sup>133</sup> But incorporating the Danforth Amendment would throw that guidance into doubt, undermine Section 1557’s protections, and embolden pharmacies to refuse care that Section 1557 otherwise requires.

Moreover, since the Danforth Amendment is approved for—and has only been used in—the educational context, its application to the broad health care field would result in confusion and potential problems for both providers and patients. And it could create a blanket exemption for refusing to provide care—going far beyond any other existing federal refusal law referenced in the ACA, which requires OCR to make a case-by-case determination. Incorporating the Danforth Amendment would undermine Section 1557’s protections and result in additional delays and denials of care.

## **Subpart C—Specific Application to Health Programs and Activities**

### **I. § 92.206 Equal Program Access on the Basis of Sex**

We support the Department’s proposal to restore the explicit prohibition on sex discrimination in access to health programs and activities, including discrimination based on sexual orientation, gender identity, sex characteristics, pregnancy, and pregnancy-related conditions. The removal of this provision in the 2020 Rule caused confusion regarding covered entities’ obligations in providing equal access to health programs and activities.

#### **a. Protections against anti-LGBTQI+ discrimination in health settings are crucial.**

Discrimination in health care settings based on sexual orientation, gender identity, and sex characteristics is well-documented. Transgender people, for example, face routine mistreatment, from hostile interactions to outright denial of care. According to a 2020 survey, 18% of transgender people—and 28% of transgender people of color—said that in the previous year a provider refused to see them at all because of their actual or perceived gender identity. In the same survey, 25% of transgender people overall and 34% of transgender people of color said that a provider denied them treatment related to gender transition in the previous year.

A 2022 survey similarly found evidence of discrimination based on gender identity. Nearly a third (32%) of transgender people, and 46% of transgender people

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<sup>133</sup> Off. of Civ. Rts., *Guidance to Nation's Retail Pharmacies: Obligations under Fed. C.R. L. to Ensure Access to Comprehensive Reproductive Health Care Servs.*, U.S. DEPT OF HEALTH & HUMAN SERV. <https://www.hhs.gov/civil-rights/for-individuals/special-topics/reproductive-healthcare/pharmacies-guidance/index.html> (last updated July 14, 2022).

of color, reported at least one kind of refusal by a health care provider this past year.<sup>134</sup> For example, in the past year:

- 21% of transgender and nonbinary people had a health care provider who refused to provide reproductive or sexual health services because of their gender identity.
- 20% said a health care provider refused to document evidence of gender dysphoria or readiness to receive gender-affirming care.
- 19% reported that a provider refused to help them form a family (such as by providing fertility care or assisted reproductive technology) because of their actual or perceived gender identity.

Similarly, intersex people experience substantial discrimination, mistreatment, and inadequate care in health settings.<sup>135</sup> For intersex people, discrimination often begins in infancy or early childhood, when many are subjected to nonconsensual, medically unnecessary surgeries because of their intersex traits. These procedures, which have high complication rates and lifelong consequences, seek to make intersex people's bodies conform to stereotypes about male and female bodies and are often based on prejudice against intersex people.<sup>136</sup>

Intersex people have reported encounters with providers who are hostile to intersex people or treat them as a curiosity. Some providers are uncomfortable interacting with intersex people or uninformed about how to do so respectfully. Intersex people have shared stories of providers violating their privacy, even inviting medical students to observe them because of their intersex traits. While there is a "significant gap" in data regarding intersex people and their health-related experiences,<sup>137</sup> available evidence indicates that these experiences are widespread. For example, a 2022 study found that a majority (55%) of intersex people said that just in the past year a health care provider refused to see them because of their intersex traits. A majority (53%) also reported that in the past year a health care provider refused to see them because of the provider's religious beliefs or the stated religious tenets of the hospital or health care facility. And 51%

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<sup>134</sup> Caroline Medina & Lindsay Mahowald, *Advancing Health Care Nondiscrimination Protections for LGBTQI+ Communities*, CTR. FOR AM. PROGRESS (Sep. 8, 2022), <https://www.americanprogress.org/article/advancing-health-care-nondiscrimination-protections-for-lgbtqi-communities>.

<sup>135</sup> Laetitia Zeeman & Kay Aranda, *A Systematic Review of the Health and Healthcare Inequalities for People with Intersex Variance*, 17 INT'L J. OF ENV'T RSCH. AND PUB. HEALTH 6533 (2020), <https://doi.org/10.3390/ijerph17186533>.

<sup>136</sup> OFFICE OF THE HIGH COMM'R FOR HUM. RTS., BACKGROUND NOTE ON HUMAN RIGHTS VIOLATIONS AGAINST INTERSEX PEOPLE 12 (2019), <https://www.ohchr.org/sites/default/files/Documents/Issues/Discrimination/LGBT/BackgroundNoteHumanRightsViolationsagainstIntersexPeople.pdf>.

<sup>137</sup> NAT'L ACAD. OF SCI., ENG'G, AND MED. ET. AL, UNDERSTANDING THE WELL-BEING OF LGBTQI+ POPULATIONS 67 (2020), <https://doi.org/10.17226/25877>.

reported that a health care provider refused to help them form a family because of their intersex characteristics.<sup>138</sup>

In the same study, many lesbian, gay, and bisexual respondents reported on discrimination they experienced based on their sexual orientation. Nearly one in six (15%) LGB respondents—and 22% of LGB people of color—reported at least one form of care refusal by a health care provider in the past year. For example, respondents reported that providers intentionally refused to recognize or treat their family members, refused to help them form a family, refused to provide care related to their sexual orientation, and in some cases refused to see them outright.<sup>139</sup>

Discrimination by providers deters many LGBTQI+ from seeking medical care. According to the 2022 survey, LGBTQI+ people (23%) were more than three times more likely than non-LGBTQI+ people (7%) to report that, in the past year, they postponed or avoided seeking needed medical care when sick or injured due to disrespect or discrimination from health care providers. This gap was even greater for intersex and transgender people, 50% and 37% of whom, respectively, reported avoiding seeking care when sick or injured. Similarly, LGBTQI+ people (21%) were three times more likely to have postponed or avoided getting preventive screenings in the past year—such as screenings for sexually transmitted infections, HIV, or high blood pressure or cholesterol—compared to non-LGBTQI+ people (7%). Transgender (41%) and intersex (42%) people were about six times as likely as non-LGBTQI+ people to have done so.<sup>140</sup>

**b. The Final Rule should prohibit sex-based distinctions that cause more than *de minimis* harm.**

We generally support the Department’s proposal to prohibit sex-based distinctions that cause more than *de minimis* harm to any individual. We encourage the Department to provide additional examples in the preamble of sex-based treatment or distinctions that may give rise to more than *de minimis* harm, including emotional or dignitary harm. For example, practices that may result in unwanted isolation, harassment, and misgendering for transgender and nonbinary people can constitute more than *de minimis* harm, even when they fall short of preventing them from participating in a health program or activity consistent with their gender.

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<sup>138</sup> Caroline Medina & Lindsay Mahowald, *Advancing Health Care Nondiscrimination Protections for LGBTQI+ Communities*, CTR. FOR AM. PROGRESS (Sep. 8, 2022), <https://www.americanprogress.org/article/advancing-health-care-nondiscrimination-protections-for-lgbtqi-communities>.

<sup>139</sup> Caroline Medina & Lindsay Mahowald, *Advancing Health Care Nondiscrimination Protections for LGBTQI+ Communities*, CTR. FOR AM. PROGRESS (Sep. 8, 2022), <https://www.americanprogress.org/article/advancing-health-care-nondiscrimination-protections-for-lgbtqi-communities>.

<sup>140</sup> Caroline Medina & Lindsay Mahowald, *Advancing Health Care Nondiscrimination Protections for LGBTQI+ Communities*, CTR. FOR AM. PROGRESS (Sep. 8, 2022), <https://www.americanprogress.org/article/advancing-health-care-nondiscrimination-protections-for-lgbtqi-communities>.

**c. The Department should ensure equal access to sex-specific programs and activities for transgender and nonbinary people.**

One form of harm that clearly rises above the *de minimis* level is being denied the chance to participate in health programs or activities in a manner consistent with one's gender. We welcome the Department's clarification that policies and practices that prevent people from doing so are prohibited. We encourage the Department to provide further guidance to ensure equal program access for nonbinary people. When programs or activities are conducted separately for men and women, many nonbinary people do not have a program or activity that is consistent with their gender identity, and covered entities may be unsure how to provide equal access in those circumstances.

The Department should clarify that when covered entities enforce sex distinctions in health programs and activities, nonbinary people can access those programs or activities *in the manner they feel most comfortable at any given time*. This standard ensures that nonbinary people themselves, rather than the covered entity, can determine what equal access means and that they have the flexibility to account for a range of relevant considerations and varying circumstances. To deny nonbinary people the opportunity to make this determination can give rise to harm beyond the *de minimis* level based on their gender identity, thus constituting unlawful sex discrimination.

The Department should further clarify in its preamble that entities that choose to enforce sex-based distinctions cannot do so in a manner that leaves nonbinary people without tenable, nondiscriminatory options. For example, sex-based distinctions that force nonbinary people to choose between unwanted isolation and participation in a manner that conflicts with their gender identity may cause more than *de minimis* harm and therefore be unlawful. Indeed, the needs of nonbinary people underscore why covered entities should only enforce sex-based distinctions when those distinctions are necessary and narrowly tailored.

**d. The Final Rule must enumerate specific forms of discrimination in reproductive health care in section § 92.206(b).**

While we appreciate the Department's enumeration of specific forms of sex discrimination prohibited in § 92.206(b), we urge the Department to strengthen these provisions by including discussion of sex discrimination based on pregnancy or related conditions as discussed above and provide examples of such discrimination in the Preamble.

In § 92.206, the Department addresses requirements for covered entities to provide individuals equal access to health programs and activities without discriminating on the basis of sex. To that end, the Department outlines specific ways covered entities are prohibited from discriminating based on gender identity. We strongly support the Department's efforts to clarify Section 1557's application to the forms of discrimination identified in proposed § 92.206(b). We also appreciate

the examples of such discrimination that the Department provides in the preamble section explaining § 92.206 protections.

We ask the Department to expand further on forms of sex discrimination by including additional sections to § 92.206 that focus on specific forms of discrimination based on pregnancy or related conditions prohibited by Section 1557, including intersectional discrimination. Accordingly, we propose the following additions and amendments to § 92.206(b):

(3) Adopt or apply any policy or practice of treating individuals differently or separating them on the basis of sex in a manner that subjects any individual to more than *de minimis* harm, including by adopting a policy or engaging in a practice that prevents. **Prohibited practices include, but are not limited to, policies and practices that:**

**(a) prevent** an individual from participating in a health program or activity consistent with the individual's gender identity;

**(b) prevent an individual from participating in a manner they feel most comfortable at any given time, if none of the available health programs or activities are consistent with their gender identity;**

**or**

**(c) subject pregnant people to discriminatory treatment during childbirth, including but not limited to rough handling, harsh language, or undertreatment of pain;**

...

**(5) Deny or limit services, or a health care professional's ability to provide services, on the basis of pregnancy or related conditions, including termination of pregnancy, contraception, miscarriage management, fertility care, maternity care, or any health services;**

**(6) Deny or limit services based on an individual's reproductive or sexual health care decisions or history, including termination of pregnancy, miscarriage, or adverse pregnancy outcome; or**

**7) Deny or limit services, or a health care professional's ability to provide services, that may prevent, cause complications to, or end fertility or pregnancies, including medications or treatments for disabilities or emergency medical conditions under 42 U.S.C. § 1395dd.**



**e. The Department should clarify covered entities' obligations to provide nondiscriminatory access to gender-affirming care.**

We welcome the Department's clarification regarding practices that discriminate against people seeking gender-affirming care, and we recommend several modifications to strengthen it beyond what has already been named above.

We recommend that the Department shorten (b)(2) by deleting the phrase "if such denial or limitation has the effect of excluding individuals from participation in, denying them the benefits of, or otherwise subjecting them to discrimination on the basis of sex under a covered health program or activity." This superfluous language may unintentionally limit the scope of prohibited discriminatory actions under this section.

Additionally, we recommend that the Department amend (b)(4) to remove the phrase "that the covered entity would provide to an individual for other purposes." Currently, the language of the proposed regulation can be read to imply that a denial of gender-affirming care is only discriminatory when "the covered entity would provide [the care] to an individual for other purposes." This implication adds an additional and unnecessary barrier to establishing that a denial of care is discriminatory. If the denial of care is based on a protected characteristic—in this case, the patient's "sex assigned at birth, gender identity, or gender otherwise recorded"—that is sufficient to constitute unlawful discrimination under Section 1557. While the fact that a provider offers a similar service for other purposes can be used as *evidence* of discrimination, that is not the only circumstance in which unlawful discrimination can arise. For example, if a pharmacist refuses to fill a hormone prescription because the treatment's purpose is related to the patient's transgender status, that is a discriminatory denial. If the Department learns that the pharmacist happens to have filled hormone prescriptions for other purposes, that information can provide further evidence of discrimination, but the discriminatory denial may be unlawful even if that fact is not established.

We recognize the Department likely included this language with the intention of clarifying that providers do not need to offer care outside their scope of practice. However, § 92.206(c) adequately ensures that providers are not required to do so: If a treatment is outside a providers' area of practice, that would typically be a legitimate, nondiscriminatory reason to deny care. In sum, we recommend that § 92.206(b)(1), (b)(2), and (b)(4) be amended as follows:

In providing access to health programs and activities, a covered entity must not:

- (1) Deny or limit health services, including those that are offered exclusively to individuals of one sex, to an individual based upon the individual's sex assigned at birth, gender identity, **transgender or nonbinary status**, or gender otherwise recorded;
- (2) Deny or limit a health care professional's ability to provide health services on the basis of an individual's sex assigned at birth, gender identity,

- ~~transgender or nonbinary status, or gender otherwise recorded if such denial or limitation has the effect of excluding individuals from participation in, denying them the benefits of, or otherwise subjecting them to discrimination on the basis of sex under a covered health program or activity;~~
- (3) ...
- (4) Deny or limit health services sought for **the** purpose of gender transition or other gender-affirming care ~~that the covered entity would provide to an individual for other purposes~~ if the denial or limitation is based on a patient's sex assigned at birth, gender identity, **transgender or nonbinary status**, or gender otherwise recorded.”

Additionally, we recommend that the preamble of the Final Rule clarifies that “gender-affirming care” does not include practices involving discriminatory harm, including nonconsensual surgeries on children with variations in their sex characteristics and “conversion” efforts to change an individual’s gender identity or sexual orientation. Some have sought to recast these practices as “gender-affirming” in response to clinical criticism and regulation. In fact, such practices are starkly inconsistent with the patient-centered, evidence-based principles that define gender affirming care. The Department should clarify that nondiscrimination protections related to gender-affirming care do not reach such practices. Accordingly, nothing in Section 1557 would, for example, bar a hospital from prohibiting its staff from performing non-emergent genital surgeries on intersex patients too young to provide informed consent or assent.

**f. The Department should amend §§ 92.206(c) and 92.207(c) regarding nondiscriminatory refusals of care.**

We understand the Department’s intention in proposing §§ 92.206(c) and 92.207(c) was to clarify that Section 1557 protects against *discriminatory* denials of care, but that not all denials of care are necessarily discriminatory. We agree. However, we urge the Department to revise the sections in several ways to avoid creating confusion over what a “legitimate, nondiscriminatory” reason is versus a discriminatory one. For example, the Department should make clear that when there is direct evidence of discriminatory intent, Section 1557 protects against refusals of care even where a health care entity also claims a legitimate reason for refusing care.

We appreciate the Department recognizing that a provider’s disapproval of gender transition or gender affirming care does not constitute a legitimate, nondiscriminatory reason for refusing care. Like anti-transgender bias driving denials of gender-affirming care, deep bias or stereotypes relating to abortion or other forms of reproductive health care often form the basis of why patients are denied care, rather than any scientific or medical evidence that the care is unnecessary, clinically inappropriate, or contraindicated. Alongside the discussion

of gender-affirming care in 92.206(c), the Department must similarly explicitly name that a provider’s belief that reproductive health care—including termination of a pregnancy—is never beneficial to patients is not a legitimate reason to deny or limit that care.

Moreover, we urge the Department to amend the language around medical necessity. We are concerned that the current language in §§ 92.206(c) and 92.207(c) may be misconstrued to allow the application of medical necessity, eligibility, and clinical appropriateness standards that in themselves are discriminatory. For example, a recent study has shown that several current clinical algorithms and practice guidelines use race as a factor without providing a rationale.<sup>141</sup> To avoid confusion, we recommend that the Department clarify in §§ 92.206(c) and 92.207(c) that care standards cannot facially discriminate or otherwise result in discrimination based on a protected characteristic.

Finally, the Center has concerns that the use of the specific language “legitimate, nondiscriminatory reason” in the proposed §§ 92.206(c) and 92.207(c) may incorrectly be interpreted to mean that the burden shifting framework for certain Title VII disparate treatment claims set forth in *McDonnell Douglas Corp. v. Green*<sup>142</sup> is the standard of proof applicable to all Section 1557 claims. Where there is direct evidence of discrimination, such as a facially discriminatory policy, a plaintiff need not show that they were treated less favorably than a similarly situated comparator, or that any “legitimate, nondiscriminatory reason” advanced by the defendant is pretextual.<sup>143</sup> We urge the Department to expand on the discussion at 87 Fed. Reg. 47,867 to clarify that no such implication is meant to arise from use of this language here.

For these reasons, the Center proposes the following changes to the proposed text of § 92.206(c):

Nothing in this section requires the provision of any health service where the covered entity has a legitimate, nondiscriminatory reason for denying or limiting that service **to an individual**, including where the covered entity typically declines to provide ~~the~~ **any comparable** health care services ~~to any individual or where the covered entity reasonably determines that such health service is not clinically appropriate for a particular individual,~~ **provided that the clinical standards are not discriminatory themselves or applied in a discriminatory manner.** **For example** ~~However,~~ a provider’s belief that gender transition, ~~or~~ other gender-affirming care, **or reproductive health care (including, but**

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<sup>141</sup> See Darshali A. Vyas et al., *Hidden in Plain Sight—Reconsidering the Use of Race Correction in Clinical Algorithms*, 383 NEW ENGLAND J. OF MED. 874, 876–78 (2020) (discussing, for example, that the Vaginal Birth after Cesarean (VBAC) algorithm predicts a lower likelihood of success for anyone identified as African American or Hispanic, but does not include other variables, such as marital status and insurance type, that the study which produced the algorithm also correlated with VBAC failure, without explanation or justification).

<sup>142</sup> 411 U.S. 792, 802 (1973).

<sup>143</sup> See, e.g., *United Automobile Workers v. Johnson Controls, Inc.*, 499 U.S. 187, 200 (1991).

**not limited to, termination of pregnancy)** can never be beneficial for such individuals (or its compliance with a state or local law that reflects a similar judgment) is not a ~~sufficient basis for a judgment that a health service is not clinically appropriate~~ **legitimate, nondiscriminatory reason for denying or limiting the health service.**

And for § 92.207(c):

(c) Nothing in this section requires coverage of any health service where the covered entity has a legitimate, nondiscriminatory reason for determining that such health service fails to meet applicable coverage requirements, ~~such as medical necessity requirements,~~ in an individual case, **provided that the coverage requirements or medical necessity standards are not discriminatory themselves or applied in a discriminatory manner.**

## **II. § 92.207 Nondiscrimination in Health Insurance Coverage and Other Health-Related Coverage**

### **a. The Proposed Rule properly restores the application of Section 1557 to health insurance companies.**

The Center strongly supports the Proposed Rule’s restoration of the application of Section 1557’s prohibition on discrimination to “all covered entities that provide or administer health insurance coverage or other health-related coverage.”<sup>144</sup> The 2020 Rule improperly attempted to cabin the application of Section 1557 by treating health insurance issuers as not “principally engaged in the business of providing health care” and by limiting the application of Section 1557 to the issuer’s specific “operations” that are directly supported by federal financial assistance.<sup>145</sup> Those limitations were contrary to the text of Section 1557, to the Civil Rights Restoration Act of 1987 (CRRRA), and to the broad remedial intent of Congress. Because eliminating discrimination in the provision of health insurance is key to achieving the legislative intent and goals of the ACA, the Center also commends the Proposed Rule’s clarification that Section 1557 applies to health insurance companies’ actions with regard to both designing and administering self-funded health benefit plans.

#### **i. The Proposed Rule correctly deems health insurance issuers within the scope of covered entities.**

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<sup>144</sup> Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47,824, 47,868.

<sup>145</sup> Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160, 37,201 (June 19, 2020).

The Proposed Rule corresponds with the text of Section 1557, as well as Congress’s intent in passing the law, by affirming that health insurance issuers are covered entities.

Section 1557 clearly states that it covers “*any* health program or activity,”<sup>146</sup> and the provision of health insurance is a health program or activity. Indeed, other parts of the ACA define the term “health care entity” to include “a health insurance plan.”<sup>147</sup> Even if it were debatable whether the provision of health insurance is a “health program or activity,” Section 1557’s text indicates that it must be read broadly. First, this phrase refers to “*any* health program or activity,” and the Supreme Court has explained that “[r]ead naturally, the word ‘any’ has an expansive meaning, that is, ‘one or some indiscriminately of whatever kind.’”<sup>148</sup> Second, Congress’s use of the word “or” between broad terms like “program” and “activity” indicates that Congress wanted the statute to sweep in a broad array of conduct.

The 2020 Rule attempted to limit the definition of “health program or activity” to only those entities involved in providing health care directly to patients, but there is no justification for this limitation. As discussed above, Section 1557 does not, by its terms, apply only to “health care.” But even if it did, the 2020 Rule’s contention that “health care” does not encompass “health insurance” is nonsensical. The 2020 Rule cited to 5 U.S.C. § 5371 in support of this proposition, but 5 U.S.C. § 5371 concerns pay rates and personnel practices for federal employees<sup>149</sup> and the statute uses the term “health care” simply to describe a category of federal employees who work in that sector.<sup>150</sup> Further, other parts of the ACA specify that “[t]he term ‘health insurance coverage’ means benefits consisting of *medical care* (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care).”<sup>151</sup> And as several courts have recognized, an entity need not be directly involved in *patient* care to be considered principally engaged in providing *health* care.<sup>152</sup>

Further, “a fair reading of legislation demands a fair understanding of the legislative plan,”<sup>153</sup> and the ACA is, after all, a law about health insurance.<sup>154</sup>

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<sup>146</sup> 42 U.S.C. § 18116(a) (emphasis added).

<sup>147</sup> 42 U.S.C. § 18113.

<sup>148</sup> *United States v. Gonzales*, 520 U.S. 1, 5 (1997) (quoting Webster’s Third New International Dictionary 97 (1976)).

<sup>149</sup> Treasury, Postal Service and General Government Appropriations Act, Pub. L. No. 101-509 (1991).

<sup>150</sup> 5 U.S.C. § 5371 (“For the purposes of this section, ‘health care’ means direct patient-care services or services incident to direct patient-care services.”).

<sup>151</sup> 42 U.S.C. § 18111 (citing 42 U.S.C. § 300gg-91(b)(1)).

<sup>152</sup> *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, 440 (W.D. Tex. 1998) (finding that a health maintenance organization (HMO) that provides medical benefits to enrollees is “principally engaged in the business of providing...health care”).

<sup>153</sup> *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015); *see also id.*, at 2493 (“We cannot interpret federal statutes to negate their own stated purposes.”).

<sup>154</sup> *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012) (explaining that Congress enacted ACA in an effort to “increase the number of Americans covered by health insurance and decrease the cost of health care”).

Further, as discussed in greater detail above, Section 1557 was enacted to “ensure that all Americans are able to reap the benefits of health insurance reform equally without discrimination,”<sup>155</sup> and the rampant sex discrimination women faced in the insurance market was a particular area of concern for Congress.<sup>156</sup> Several important ACA provisions were enacted specifically to correct these insurer practices that discriminated against women either on their face or in their effect,<sup>157</sup> 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 intent or effect—resulted in gender-based discrimination, specifically including those perpetrated by health insurance issuers. To achieve this goal, the Final Rule must include health insurance issuers as covered entities.

- ii. The Proposed Rule properly applies Section 1557 to all operations of health insurance issuers that receive Federal financial assistance.

The Proposed Rule further corresponds with the text of Section 1557 by affirming the application of the law to *all* parts of a health insurer’s business if any part receives Federal financial assistance. Congress wrote that Section 1557 applies to “*any* health program or activity, *any part of which* is receiving Federal financial assistance.”<sup>158</sup> There is only one reasonable interpretation of that language: *the entire* health program or activity must comply with Section 1557’s prohibition on discrimination, *even if only part* of the health program or activity receives Federal financial assistance. Congress’s use of the phrase “*any part of which* is receiving Federal financial assistance,” makes clear that Section 1557 applies to the *entire* health program or activity, *not just part* of that program or activity, even if Federal financial assistance touches only “part” of the covered “health program or activity.”

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<sup>155</sup> 156 CONG. REC. S1842 (daily ed. Mar. 23, 2010).

<sup>156</sup> *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.”).

<sup>157</sup> *See, e.g.*, 42 U.S.C. 300gg(a) (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 (prohibiting preexisting condition exclusions which were often used to discriminate against women in part because several of conditions excluded by insurers primarily affect women and because women are more likely than men to suffer from chronic conditions).

<sup>158</sup> 42 U.S.C. § 18116(a) (emphasis added).

This language is consistent with the Civil Rights Restoration Act of 1987 (CRRA), which supports an expansive interpretation of Section 1557’s scope of coverage. Congress enacted the CRRA to overrule the Supreme Court’s decision in *Grove City College v. Bell*, 465 U.S. 555, 570-74 (1984), which interpreted Title IX as extending statutory coverage only to the particular “program or activity” within a private college that was the recipient of federal funding, and not to the entire educational institution.<sup>159</sup> Through the CRRA, Congress clarified that the nondiscrimination provisions of Title IX, Title VI, the Rehabilitation Act, and the Age Discrimination Act generally extend broadly to entire entities that receive federal funding, not just to the particular programs within those entities that receive federal funding.<sup>160</sup> Section 1557’s use of the CRRA language “program or activity” and “any part of which,” coupled with the statute’s reference to Title IX, Title VI, the Rehabilitation Act, and the Age Discrimination Act, demonstrate Congress’s intent to adopt the same broad application for Section 1557.<sup>161</sup>

- iii. The Proposed Rule rightly makes explicit that health insurance entities must comply with Section 1557 when designing and administering self-funded plans.

The Center also commends the Department for specifying that Section 1557’s protections apply to actions taken by covered entities in their role as third-party administrators (TPAs)—including in marketing and designing self-funded health benefit plans as well as administering said plans. Without TPA liability for discriminatory plan design and administration, the full aims of Section 1557 cannot be achieved. Self-funded plans are a large—and growing—portion of the private health insurance landscape; the majority (64%) of workers in the United States with employer-sponsored health insurance are enrolled in self-insured plans.<sup>162</sup> Yet studies have shown that self-funded plans persist in discriminating on bases prohibited under Section 1557.<sup>163</sup>

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<sup>159</sup> See *Nat’l Collegiate Athletic Ass’n v. Smith*, 525 U.S. 459, 466 n. 4 (1999).

<sup>160</sup> See, e.g., S. Rep. No. 100–64, 100th Cong., 2d Sess. 4, at 6 (1988); *id.* at 7 (“The inescapable conclusion is that Congress intended that title VI as well as its progeny—Title IX, Section 504, and the ADA—be given the broadest interpretation.”).

<sup>161</sup> The 2020 Rule eschewed this plain reading, instead improperly invoking the CRRA in an attempt to narrow Section 1557’s reach. Specifically, the 2020 Rule asserted that the CRRA “defined ‘program or activity’ under Title VI, the Rehabilitation Act, the Age Act, and Title IX to cover all the operations of entities only when they are ‘principally engaged in the business of providing . . . health care . . . .’” 85 Fed. Reg. at 37,171 (quoting Public Law 100-259, 102 Stat. 28 (Mar. 22, 1988)). As a threshold matter, this is incorrect—this limitation applies only to one subsection of the CRRA’s definition of “program Federal financial assistance or activity.” 20 U.S.C. § 1687(3). For a wide variety of entities, all operations are covered if any part of the entity receives. *Id.* § 1687(1), (2), (4). In any event, as already discussed, health insurance companies are “in the business of providing health care.” See, *supra*, Subpart C, Section II(a).

<sup>162</sup> *Emp. Health Benefits 2021 Ann. Surv.*, KAISER FAM. FOUND. 9 (2021), <https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf> (“Sixty-four percent of covered workers, including 21% of covered workers in small firms and 82% in large firms, are enrolled in plans that are self-funded.”).

<sup>163</sup> Anna Kirkland, et al., *Transition Coverage and Clarity in Self-Insured Corp. Health Insurance Benefit Plans*, 6 TRANSGENDER HEALTH 207, 214 (Jul. 30, 2021), <https://www.liebertpub.com/doi/full/10.1089/trgh.2020.0067>

Some TPAs have argued that they are not responsible for discriminatory plan terms. Often, these TPAs argue that because ERISA requires TPAs to “administer a self-insured health plan according to its terms,” TPAs are insulated from liability for discriminatory benefit design and any remedy must be sought against the plan sponsor—often, the participant’s employer.<sup>164</sup> But ERISA specifically requires TPAs to comply with other federal laws, like Section 1557.<sup>165</sup> Accordingly, TPAs may be held liable under Section 1557 for discriminatory plan administration, for agreeing to administer a plan with discriminatory benefit design, and when discriminatory plan terms “originate[] with” the TPA.<sup>166</sup> This is so even if the plan sponsor “subsequently adopted the plan and maintained control over its terms.”<sup>167</sup>

This concern is not hypothetical. As the Proposed Rule correctly recognizes, many large insurance issuers design and market self-funded plans to sponsors and contract to serve as a TPA.<sup>168</sup> Often, these issuers will administer these self-funded plans using the same coverage policies they apply to the fully insured plans they underwrite. Thus, the injuries from discriminatory terms in self-funded plans are often directly traceable to and redressable by TPAs. Failure to hold TPAs liable for their own discriminatory conduct would thus foreclose a critical avenue of relief for the vast and expanding percentage of the U.S. population covered by self-funded plans. This concern would be particularly acute if the Department were also to keep the employment discrimination carve out in the proposed § 92.2(b), or otherwise fail to clarify that Section 1557 prohibits discrimination in employment, as self-funded plan participants would then be foreclosed entirely from obtaining relief.<sup>169</sup> The Center thus applauds the Department’s critical clarification that TPAs are liable under Section 1557 for both unlawful plan administration and benefit design.

#### **b. The Final Rule should robustly prohibit discrimination in coverage of gender-affirming care.**

People seeking gender-affirming care face pervasive discriminatory insurance practices, including the blanket denial of all gender affirming care, exclusions of specific treatments, and unwarranted eligibility restrictions or medical necessity

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(showing that self-funded plans had three times as many categorical exclusions for gender affirming health care).

<sup>164</sup> See, e.g., *Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 954 (D. Minn. 2018); Mot. to Dismiss Pl.’s Amended Compl. 1, ECF No. 50, *Kulwicki v. Aetna Life Insurance Co.*, No. 3:22-cv-00229 (RNC) (D. Conn. June 3, 2022) [hereinafter *Kulwicki* Motion to Dismiss].

<sup>165</sup> See 29 U.S.C. § 1144(d) (“Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States ....”).

<sup>166</sup> *Tovar v. Essentia Health*, 857 F.3d 771, 778 (8th Cir. 2017).

<sup>167</sup> *Tovar v. Essentia Health*, 857 F.3d 771, 778 (8th Cir. 2017).

<sup>168</sup> See, e.g., *A Self-Funded Plan Can Be Part of Your Strategy to Lower Health Care Costs*, AETNA, <https://www.aetna.com/employers-organizations/self-insurance-plans.html>; *UMR*, UNITED HEALTHCARE, <https://www.uhc.com/employer/employer-resources/umr>; *Self-Funded Options*, BLUE CROSS BLUE SHIELD OF N.D., <https://www.bcbsnd.com/employers/shop-employer-plans/self-funded-options>.

<sup>169</sup> See, *supra*, Subpart A, Section II(c). As set forth above in discussing the proposed § 92.2(b), it is not sufficient to force individuals to rely on other employment discrimination statutes to vindicate rights that Section 1557 protects, as these statutes are not coextensive.



standards. The restoration of § 92.207(b)(4) and (5) is therefore critical for ending discrimination against individuals who rely on gender-affirming care.<sup>170</sup>

As in previous sections, we recommend that “transgender or nonbinary status” be listed in addition to “gender identity.” Additionally, we recommend that the Department amend § 92.207(b)(4) to explicitly clarify that coverage exclusions and limitations can be discriminatory even when they fall short of categorically excluding all gender-affirming care. Many insurers single out transgender people by maintaining automatic exclusions of specific types of gender-affirming treatments or relying on medically unsupported utilization management practices. In fact, while the vast majority of Marketplace insurers have removed their categorical exclusions of *all* gender-affirming care, a substantial portion continue to exclude a range of specific treatments.<sup>171</sup> These treatments often include those that are disproportionately used by transgender women, such as facial surgeries and breast augmentation.

When treatment-specific exclusions are based on gender identity or transgender status, they constitute unlawful discrimination. This practice is implicitly prohibited by the general language of § 92.207(b)(5), but it is important to make the prohibition explicit, particularly as some covered entities believe that treatment-specific exclusions are permissible. Accordingly, we recommend revising § 92.207(b)(4) to remove the word “all,” such that the provision reads as follows:

(4) Have or implement a categorical coverage exclusion or limitation for ~~all~~ health services related to gender transition or other gender-affirming care.

We further encourage the Department to clarify, either through regulatory or preambulatory language, that exclusions of specific treatments for gender transition may be discriminatory regardless of whether those same treatments are covered for other purposes. Like under § 92.206, the fact that an insurer covers the same or similar treatments for other purposes can be used as evidence of discrimination, but this showing should not be a prerequisite for establishing discrimination in all circumstances. An insurer that denies coverage for a gender-affirming facial surgery, for example, may be unlawfully discriminating if its denial is based on the fact that the treatment is related to gender transition or if it is based on stigmatizing or prejudicial views towards transgender people, such as the assumption that such surgeries are purely cosmetic. This denial can constitute a violation of Section 1557 even if it is not shown that facial surgeries are covered for conditions other than gender dysphoria.

Further, the Department should clarify that when an insurer’s coverage of comparable treatments for other purposes *is* used as evidence for discrimination,

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<sup>170</sup> Sharita Gruberg et al., *The State of the LGBTQ Community in 2020*, CTR. FOR AM. PROGRESS (Oct. 6, 2020), <https://www.americanprogress.org/article/state-lgbtq-community-2020>.

<sup>171</sup> *Summary of Findings: 2021 Marketplace Plan Compliance with Section 1557*, OUT2ENROLL (2020), <https://out2enroll.org/wp-content/uploads/2020/11/Report-on-Trans-Exclusions-in-2021-Marketplace-Plans.pdf>.

that comparison can be construed broadly. Some insurers have argued, for example, that because there are differences in technique between genital surgery for cisgender people who have experienced injuries and genital surgery to treat gender dysphoria, these procedures are not comparable, and it is therefore not discriminatory to cover the former but exclude the latter. But nondiscrimination principles do not require a comparator to be alike in all respects. Indeed, it should be sufficient evidence of discrimination if, for example, an insurer generally covers surgical care but not surgeries related to gender transition, or generally covers prescription drugs but excludes gender-affirming hormone therapy.

**c. The Final Rule should address sex discrimination related to pregnancy or related conditions**

As with proposed § 92.206, the Department must strengthen the text of proposed § 92.207 to address sex discrimination related to pregnancy or related conditions, including discrimination related to abortion, fertility care, and contraception. Additionally, we urge the Department to eliminate the phrase “if such denial, limitation, or restriction results in discrimination on the basis of sex” in § 92.207(b)(5) as it undermines the point of outlining these forms of discrimination, as the restrictions referenced are inherently discriminatory. If the Department keeps this phrase in the Final Rule, we would caution the Department against limiting this phrase to reference of discrimination based on sex, as these discriminatory circumstances could also occur on the basis of disability, age, race, or intersectional discrimination from denying coverage of such care. Accordingly, we urge the Department to amend proposed § 92.207(b) as follows:

(4) Have or implement a categorical coverage exclusion or limitation for ~~all~~<sup>172</sup> services related to gender transition or other gender-affirming care, **termination of pregnancy, contraception, fertility care, miscarriage management, pregnancy loss, maternity care, other reproductive and sexual health services, or any health services;**

(5) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost-sharing or other limitations or restrictions on coverage, for specific health services related to gender transition or other gender-affirming care, **termination of pregnancy, contraception, fertility care, miscarriage management, pregnancy loss, maternity care, other reproductive and sexual health services, or any health services;** ~~if such denial, limitation, or restriction results in discrimination on the basis of sex; or~~

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<sup>172</sup> See the previous subsection for a discussion of this recommendation.

**(7) Deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations on coverage for health services that may prevent, cause complications to, or end fertility or pregnancies.**

In addition, we urge the Department to specify in the preamble that the health services addressed in our proposed § 92.207(b)(7) include both the full spectrum of reproductive and sexual health services, treatments, and medications for people with disabilities that may prevent, complicate, or end fertility or pregnancies.

**d. The Final Rule should support integrated settings for disabled people.**

We support the newly added requirement in § 92.207(b)(6) that insurers must cover services in the most integrated setting appropriate to the needs of disabled beneficiaries. This addition reflects a fundamental tenet of disability rights law, recognized in the watershed Supreme Court decision *Olmsted v. Zimring*.<sup>173</sup> Discriminatory insurance practices, such as making certain services available to people in institutional care but not to those who reside in the community, contribute to isolation and unmet health needs, disproportionately impacting disabled women and disabled people of color. While insurers may assume that administering such treatments in institutional settings is more convenient or cost-saving, the rule must make clear that those are not legitimate, nondiscriminatory reasons for the discrepancy in coverage.

**e. The Final Rule should prohibit discriminatory benefit designs.**

We welcome the Department’s clarification that while covered entities may employ “reasonable” medical management techniques and other benefit designs, those designs cannot be discriminatory. Insurers persist in relying on benefit designs that result in discrimination based on protected characteristics, burying discriminatory measures in mechanisms that are less transparent to consumers but often no less harmful.

Many of the conditions that are most often singled out for especially restrictive utilization management techniques—including mental health conditions, HIV, diabetes, and gender-affirming care—disproportionately impact women of color, disabled women, and LGBTQI+ people.<sup>174</sup> For example:

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<sup>173</sup> 527 U.S. 581 (1999).

<sup>174</sup> See, e.g., *Minority Population Profiles*, HHS OFF. OF MINORITY HEALTH (2018), <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=26>.

- Nearly two-thirds of Native and Black transgender women have been diagnosed with HIV,<sup>175</sup> an astronomical rate compared to the HIV prevalence in the general population of less than half of one percent.<sup>176</sup> Black women overall, who account for 15% of women in the U.S., make up 60% of all new HIV infections among women.<sup>177</sup>
- Native women are nearly three times more likely than white women to be diagnosed with diabetes, and Black and Latina women are nearly twice as likely.<sup>178</sup>
- LGBTQ people, particularly transgender people, are far more likely to experience depression and anxiety than non-LGBTQ people.<sup>179</sup>

We encourage the Department to explicitly clarify that unjustifiably restrictive benefit designs are prohibited when they result in discrimination based on a protected characteristic. Such practices may include offering no or limited specialists in a field in provider networks, imposing mandatory step therapy and prior authorization, adverse tiering of drugs, and clinically inappropriate age limits.

### III. § 92.209 Nondiscrimination on the Basis of Association

We support restoring the prohibition on associational discrimination. For decades, courts have uniformly held that nondiscrimination laws reach discrimination on the basis of the protected characteristic of a person with whom one has a relationship or association.<sup>180</sup> The Department failed to engage with this well-established case law when it rescinded the associational discrimination provision in the 2020 Rule. Indeed, the Department failed to provide any reasoning whatsoever for removing this provision. This *sub silentio* rescission suggested that associational discrimination was permissible, threatening to cause confusion and unlawful mistreatment. This outcome has been particularly concerning given the documentation of associational discrimination in health care—such as that faced by

<sup>175</sup> *HIV Infection, Risk, Prevention, and Testing Behav. Among Transgender Women—Nat'l HIV Behav. Surveillance*, 7 U.S. Cities 2019–2020, CTRS. FOR DISEASE CONTROL AND PREVENTION 5 (Apr. 2021), <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-27.pdf>.

<sup>176</sup> *HIV Surveillance Rep: Stat. Overview*, CTRS. FOR DISEASE CONTROL PREVENTION (April 28, 2022), <https://www.cdc.gov/hiv/statistics/overview/index.html>.

<sup>177</sup> Bisola O. Ojikutu & Kenneth Mayer, *HIV Prevention Among Black Women in the US—Time for Multimodal Integrated Strategies*, 4 JAMA NETWORK OPEN e215356 (April 9, 2021), <https://doi.org/10.1001/jamanetworkopen.2021.5356>.

<sup>178</sup> *Diabetes Mellitus*, OFF. OF RSCH. ON WOMEN'S HEALTH 8 (April 2011), <https://orwh.od.nih.gov/sites/orwh/files/docs/ORWH-HIC-Diabetes-Mellitus.pdf>.

<sup>179</sup> *Mental Health Disparities: LGBTQ*, AM. PSYCHIATRIC ASS'N 2 (2017), <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-LGBTQ.pdf>

<sup>180</sup> See, e.g., *Hively v. Ivy Tech Cmty. Coll. of Ind.*, 853 F.3d 339, 345 (7th Cir. 2017) (en banc); *Barrett v. Whirlpool Corp.*, 556 F.3d 502, 512 (6th Cir. 2009); *Holcomb v. Iona Coll.*, 521 F.3d 130, 139 (2d Cir. 2008); *Tetro v. Elliot Popham Pontiac, Oldsmobile, Buick, & GMC Trucks, Inc.*, 173 F.3d 988, 994–95 (6th Cir. 1999); *Deffenbaugh-Williams v. Wal-Mart Stores, Inc.*, 156 F.3d 581, 589 (5th Cir. 1998), *vacated in part on other grounds by Williams v. Wal-Mart Stores, Inc.*, 182 F.3d 333 (5th Cir. 1999) (en banc); *Parr v. Woodmen of the World Life Ins. Co.*, 791 F.2d 888, 892 (11th Cir. 1986).

the daughter of Jami and Krista Contreras in 2015, who at six days old was turned away by a pediatrician because her parents were both women.<sup>181</sup> Thus, we welcome the return of this provision and encourage the Department to enforce it robustly.

#### **IV. CMS Regulatory Provisions**

We support restoring references to sexual orientation and gender identity in the CMS regulations listed in the Proposed Rule and generally refer back to our comment on the 2023 Notice of Benefit and Payment Parameters.<sup>182</sup> We write to add our recommendation that the Department also enumerate sex stereotyping, sex characteristics (including intersex traits), and pregnancy and pregnancy-related conditions, relying on the same authorities applicable to the enumeration of sexual orientation and gender identity. Doing so would improve consistency across Department regulations, further the health and safety of program beneficiaries, and protect them from the pervasive discrimination documented in this comment.

#### **V. Accessible Medical and Diagnostic Equipment**

We appreciate the opportunity to comment on whether the Final Rule should incorporate the Access Board's 2017 Medical Diagnostic Equipment Accessibility Standards. We believe these standards must be made enforceable as part of the Final Rule. As the National Council on Disability has noted, "[f]ederal regulations requiring availability of accessible medical and diagnostic equipment in health care facilities are necessary to the provision of nondiscriminatory health care" for disabled people.<sup>183</sup>

Even though the comprehensive 2017 guidelines were published nearly six years ago, health providers, insurers, and agencies have done little to incorporate them voluntarily. People with mobility, developmental, and strength and balance disabilities have therefore continued to be denied access to the most basic medical procedures, like physical exams and weight measurements.<sup>184</sup> For example, one study of women with chronic mobility disabilities who had developed breast cancer found that the lack of accessible mammography machines, weight scales, and examination tables was a significant barrier to diagnosis and treatment; providers

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<sup>181</sup> Abby Phillip, *Pediatrician Refuses to Treat a Baby with Lesbian Parents and There's Nothing Illegal About It*, WASHINGTON POST (Feb. 19, 2015, 4:36pm), <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>.

<sup>182</sup> See Nat'l Women's Law Ctr., Comment Letter on Proposed 2023 Notice of Benefits and Payment Parameters (Jan. 28, 2022), <https://www.regulations.gov/comment/CMS-2021-0196-0149>.

<sup>183</sup> NAT'L COUNCIL ON DISABILITY, *Enforceable Accessible Med. Equip. Standards: A Necessary Means to Address the Health Care Needs of People with Mobility Disabilities 2* (May 20, 2021), [https://ncd.gov/sites/default/files/Documents/NCD\\_Medical\\_Equipment\\_Report\\_508.pdf](https://ncd.gov/sites/default/files/Documents/NCD_Medical_Equipment_Report_508.pdf).

<sup>184</sup> See, e.g., Emily DiMatteo et al., *Reprod. Just. for Disabled Women: Ending Systemic Discrimination*, CTR. FOR AM. PROGRESS (Apr. 13, 2022), <https://www.americanprogress.org/article/reproductive-justice-for-disabled-women-ending-systemic-discrimination>. See also *Enforceable Accessible Med. Equip. Standards: A Necessary Means to Address the Health Care Needs of People with Mobility Disabilities*, NAT'L COUNCIL OF DISABILITY (May 20, 2021), [https://ncd.gov/sites/default/files/Documents/NCD\\_Medical\\_Equipment\\_Report\\_508.pdf](https://ncd.gov/sites/default/files/Documents/NCD_Medical_Equipment_Report_508.pdf).

were reluctant to use accessible equipment even when it was available.<sup>185</sup> Studies have reported similar findings for disabled patients who sought prenatal care<sup>186</sup> and gynecological and reproductive health care.<sup>187</sup>

These practices contribute to disparities in health care. For example, disabled people are less likely to receive breast and cervical cancer screening.<sup>188</sup> They face heightened barriers to accessing abortion,<sup>189</sup> birth control,<sup>190</sup> and assistive reproductive technology.<sup>191</sup> When they are pregnant, they often receive inferior prenatal and postpartum care.<sup>192</sup>

The ability to receive effective health care in one's own community, with one's freely chosen provider, in a manner that is as timely and appropriate as the care received by nondisabled people, should not depend on whether one uses a wheelchair or has chronic conditions. But without enforceable medical diagnostic equipment standards, this is the reality for many disabled people. To significantly address this clear form of disability discrimination, the Department must codify an enforceable requirement for accessible medical diagnostic equipment.

## Subpart D—Procedures

### I. § 92.301 Enforcement Mechanisms

Section 1557 provides the full range of enforcement mechanisms and remedies available under the referenced statutes, to any person pursuing a discrimination claim under Section 1557, regardless of their protected class. For example, a person may state a claim under Section 1557 on a disparate impact theory for discrimination based on race, despite the fact that a disparate impact theory is not recognized under Title VI. Similarly, a person may recover

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<sup>185</sup> Lisa I. Iezzoni et al., *Physical Access Barriers to Care for Diagnosis and Treatment of Breast Cancer Among Women with Mobility Impairments*, 37 ONCOLOGY NURSING FORUM 711 (2010), <https://doi.org/10.1188/10.ONF.711-717>.

<sup>186</sup> Lisa I. Iezzoni et al., *Physical Accessibility of Routine Prenatal Care for Women with Mobility Disability*, 24 J. OF WOMEN'S HEALTH 1006 (Dec. 14, 2015), <https://doi.org/10.1089/jwh.2015.5385>.

<sup>187</sup> Claire Kalpakjian et al., *Persps. on Gynecological and Reprod. Health from Women with Physical Disabilities*, 97 PHYSICAL MED. AND REHAB. e127, <https://doi.org/10.1016/j.apmr.2016.08.396>

<sup>188</sup> See *Breast and Cervical Cancer Screening Among Women with Physical Disabilities*, 78 PHYSICAL MED. AND REHAB. 12 (Dec. 1, 1997), [https://www.archives-pmr.org/article/S0003-9993\(97\)90220-3/fulltext](https://www.archives-pmr.org/article/S0003-9993(97)90220-3/fulltext); Brian S. Armour et al., *State-Level Differences in Breast and Cervical Cancer Screening by Disability Status*, 19 WOMEN'S HEALTH ISSUES 406 (Nov. 1, 2009), <https://doi.org/10.1016/j.whi.2009.08.006>.

<sup>189</sup> *Access, Autonomy, and Dignity: Abortion Care for People with Disabilities*, NAT'L P'SHIP FOR WOMEN & FAMILIES & AUTISTIC SELF ADVOC. NETWORK (Sep. 2021), <https://www.nationalpartnership.org/our-work/resources/health-care/repro/repro-disability-abortion.pdf>.

<sup>190</sup> Willi Horner-Johnson et al., *Experiences of Women with Disabilities in Accessing and Receiving Contraceptive Care*, 50 J. OF OBSTETRIC, GYNECOLOGICAL & NEONATAL NURSING 732 (Aug. 10, 2021), <https://doi.org/10.1016/j.jogn.2021.07.005>.

<sup>191</sup> *Rocking the Cradle: Ensuring the Rts. of Parents with Disabilities and Their Child.*, NAT'L COUNCIL ON DISABILITY, 167 (2012), [https://ncd.gov/sites/default/files/Documents/NCD\\_Parenting\\_508\\_0.pdf](https://ncd.gov/sites/default/files/Documents/NCD_Parenting_508_0.pdf).

<sup>192</sup> See, e.g., Mariëlle Heideveld-Gerritsen et al., *Maternity Care Experiences of Women with Physical Disabilities: A Systematic Rev.*, 96 MIDWIFERY 102938 (May 2021), <https://doi.org/10.1016/j.midw.2021.102938>; Monika Mitra, *Postpartum Health of Women with Intell. and Developmental Disabilities: A Call to Action*, 26 J. OF WOMEN'S HEALTH 303 (Apr. 2017), <https://doi.org/10.1089/jwh.2017.6382>.

compensatory damages on a showing that a covered entity illegally discriminated against them based on their age, even though such damages may not be available under the Age Discrimination Act. For the millions of individuals living at the intersection of multiple identities, parsing of exhaustion requirements and remedies would inhibit enforcement. For example, an elderly, Black woman who wanted to complain of intersecting forms of discrimination in health care or health insurance would have to navigate potentially different legal standards, procedures, and remedies. Section 1557 therefore does not distinguish the administrative and judicial remedies available if the discrimination is based on age, race, color, national origin, disability, or sex. We support the Department’s approach.

## **II. § 92.302 Notifications of views regarding application of federal conscience and religious federal laws**

The Proposed Rule includes a new provision clarifying the procedure for determining when covered entities may be granted an exception or modification to 1557’s requirements under either the federal refusal statutes incorporated by reference into Section 1557 or RFRA. While we continue to oppose these harmful laws which have been used to deny people critical care and coverage and are being used to drive loopholes into otherwise applicable law, we agree that OCR must make these determinations on a case-by-case basis, evaluating the application of the refusal statutes or RFRA to the individual entity. And we strongly support the Proposed Rule’s recognition that this approach allows OCR to consider any harm that such an exemption could have on third parties. OCR should recognize that the federal refusal laws—particularly the Weldon, Church, and Coats-Snowe Amendments—have emboldened health care providers, including hospitals, insurance companies, and individual health care providers, to delay and deny patients care. Any additional barriers to care must factor significantly into OCR’s consideration of any request for an exemption to Section 1557’s requirements under these statutes. Finally, we urge the Department to make public any exemptions granted by OCR. This information is critical to ensuring patients know the scope of their rights when seeking health care from a covered entity.

### **Conclusion**

We appreciate the opportunity to comment on this Proposed Rule. We request that the supporting documentation that we have made available through direct links in our citations be considered part of the formal administrative record for purposes of the Administrative Procedure Act. For further information, please contact Dorianne Mason, Director of Health Equity at the National Women’s Law Center at [dmason@nwlc.org](mailto:dmason@nwlc.org).