UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

BAGLY, *et al.*,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*

Defendants.

Civil Action No. 20-cv-11297-PBS

MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT

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INTRODUCTION

Section 1557 of the Patient Protection and Affordable Care Act ("ACA") prohibits discrimination in health care on the basis of a person's sex, race, color, national origin, age, and disability. In 2020, the U.S. Department of Health and Human Services ("HHS") promulgated a regulation that undermines Section 1557's nondiscrimination provision. *See* Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (codified at 42 C.F.R. pts 438, 440, 460) (the "Rollback Rule" or the "Rule"). Because HHS rolled back earlier interpretations of Section 1557 that had protected the Plaintiffs, Plaintiffs brought this suit. However, the early stages of this litigation straddled the 2020 presidential election and the resulting change in administration. Consequently, not long after this Court partially denied HHS's motion to dismiss, HHS assured the Plaintiffs, this Court, and the greater public that it would fix the problems in the Rollback Rule by promulgating a new regulation. That was three years ago. Although HHS claims to be on the verge of promulgating a new rule, it has been making that claim for months, and Plaintiffs cannot wait forever. While HHS works on a new rule, the Rollback Rule remains in effect and continues to harm Plaintiffs. What is more, the calendar inches closer to another election, and another potential change in administration. This Court should resolve Plaintiffs' claims now and set guardrails to govern Section 1557 rulemaking that will apply to future interpretations of the statute.

Plaintiffs are entitled to partial summary judgment on their Administrative Procedure Act ("APA") claims. Three sets of the Rollback Rule's individual provisions cannot withstand scrutiny, because they conflict with the statute that they purport to implement, because the agency's decision to adopt those provisions was arbitrary and capricious, or both. Two additional errors in the Rollback Rule are similarly unlawful and require vacatur of the entire rule.

First, the Rollback Rule eliminated HHS's earlier definition of discrimination "on the basis of sex," which had included, among other things, discrimination based on sexual orientation, gender identity, and pregnancy, including termination of pregnancy, and express prohibitions on discrimination based on gender identity, claiming that this definition was not "consistent" with purportedly authoritative interpretations of Title IX. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,467 (former 45 C.F.R. § 92.4), 31,471-72 (former 45 C.F.R. §§ 92.206, 92.207), 27,854 (May 18, 2016) (the "2016 Rule"). However, it is the Rollback Rule that defies longstanding authority and is therefore statutorily foreclosed at *Chevron* Step One. *See Chevron U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 866 (1984). HHS's interpretation is also arbitrary and capricious, *see* 5 U.S.C. § 706, in that HHS failed to adequately explain its change in position. Although HHS acknowledged it was reversing course from the 2016 Rule, its explanation falls short of the required standard of a *reasoned* explanation for the change, *see FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009), especially in light of the Supreme Court's rejection of HHS's narrow understanding of discrimination on the basis of sex in *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020). This Court should vacate these provisions constraining the definition of sex discrimination.

Second, the Rollback Rule unlawfully imports two cherry-picked exemptions from Title IX—the "religious exemption" and "abortion-provision-and-coverage exemption"—into the health care context. 45 C.F.R. § 92.6(b). Title IX has numerous exemptions; selectively adopting these two cannot be reconciled with Section 1557's text or with the APA's requirement of reasoned decision making. Among other problems, there is no way to incorporate these exemptions without also incorporating their focus on the educational context. And importing the abortion-provision-and-coverage exemption is foreclosed given the existence of abortion-specific provisions

elsewhere in the ACA. These provisions thus fail at *Chevron* Step One. HHS's decision to insert these exemptions was also arbitrary and capricious because HHS failed to consider the harm they would cause, and it failed to adequately explain why its views on these harms had changed since the 2016 Rule. This Court should vacate the exemption provisions.

Third, the Rollback Rule adopted a definition of "health program or entity" that improperly excludes health coverage issuers and administrators, improperly exempts certain programs that HHS itself administers, and improperly narrows the reach of the regulation's nondiscrimination provisions within a covered entity. 45 C.F.R. § 92.3(a)(2), (b), (c). No matter how HHS slices and dices the text of the statute, its attempts to exempt regulated entities are not persuasive. HHS cannot reasonably contend that a nondiscrimination provision in a health coverage statute does not apply to health coverage. *See King v. Burwell*, 576 U.S. 473, 478-80 (2015) (explaining that the ACA is "a series of interlocking reforms designed to expand coverage in the individual health insurance market"). Nor is it reasonable for HHS to largely exempt itself from a nondiscrimination provision that it has been charged with administering. And HHS cannot reasonably wall off Section 1557's application to only specific subparts of certain covered entities. These provisions also fail at *Chevron* Step One and violate the APA's requirement of reasoned decision making.

Fourth, the Rollback Rule violates the APA by betraying the drafters' biases. The Rule itself evinces animus toward, and negative stereotypes about, transgender people and their health care. And the decisionmakers that developed the Rule spoke openly about their prejudice in the leadup to its promulgation. This type of "subjective bad faith" by agency decision-makers "constitutes arbitrary and capricious action." *Tummino v. Torti*, 603 F. Supp. 2d 519, 542 (E.D.N.Y. 2009) (citations omitted) (collecting cases). At a minimum, HHS failed to consider an important aspect of the problem: the likely risk of discrimination—motivated by bias—against

LGBTQI+ persons, women, and pregnant people in accessing health care. Because these errors permeate the Rollback Rule, it should be vacated in its entirety.

Fifth, HHS failed to conduct an adequate regulatory impact analysis. Instead, HHS leaned on purported savings associated with repealing notice-and-tagline requirements and discounted the costs of discrimination because they could not be easily quantified. But HHS is not entitled simply to disregard costs that are uncertain or difficult to quantify. The "mere fact" that the effect of a rule "is uncertain is no justification for disregarding the effect entirely." *Pub. Citizen v. Fed. Motor Carrier Safety Admin.*, 374 F.3d 1209, 1219 (D.C. Cir. 2004). HHS's analysis does not add up to a "reasoned determination that [a regulation's] benefits justify its costs." Exec. Order No. 13,563 § 1(b). HHS's arbitrary cost-benefit analysis also counsels in favor of full vacatur.

This Court should grant Plaintiffs' Motion for Partial Summary Judgment, "hold unlawful and set aside" the Rollback Rule as "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," 5 U.S.C. § 706(2), (2)(A), and vacate both the challenged provisions and the Rule as a whole.

BACKGROUND

A. Regulatory History & Legal Background.

Passed in 2010, the ACA, Pub. L. No. 111-148, 124 Stat. 119, is "a comprehensive national plan" to "increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538-39, 583 (2012). As the cornerstone of Congress's efforts to "remedy the shameful history of invidious discrimination and the stark disparities in outcomes in our health care system" and "ensure that all Americans are able to reap the benefits of health insurance reform equally, without discrimination," Congress included Section 1557, which prohibits discrimination on the basis of race, color, national origin, sex, disability, and age in health programs or activities receiving federal financial assistance. Health

Care and Education Reconciliation Act of 2010, 156 Cong. Rec. S. 1,821, 1,842 (daily ed. Mar. 23, 2010) (statement of Sen. Patrick Leahy); 42 U.S.C. § 18116.

Plaintiffs incorporate by reference the regulatory history of Section 1557, including the promulgation of the 2016 Rule and the Rollback Rule, as described in the Amended Complaint. *See* Amended Complaint ("Am. Compl.") ¶¶ 86-188, ECF No. 18.

In the wake of HHS's promulgation of the Rollback Rule, several different parties filed suit to prevent the Rule's enforcement and to revive certain aspects of the 2016 Rule. *See Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Human Servs.*, No. 1:20-cv-01630, 2020 WL 3444030 (D.D.C. June 22, 2020); Compl., *Walker v. Azar*, No. 1:20-cv-02834 (E.D.N.Y. June 26, 2020), ECF No. 1; *Washington v. U.S. Dep't of Health & Human Servs.*, No. 2:20-cv-01105, 2020 WL 4050303 (W.D. Wash. July 16, 2020); *New York v. U.S. Dep't of Health & Human Servs.*, No. 1:20-cv-05583, 2020 WL 4059929 (S.D.N.Y. July 20, 2020). Courts issued partially overlapping injunctions in two of those suits. *See Walker v. Azar*, 480 F. Supp. 3d 417, 430 (E.D.N.Y. 2020); *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Human Servs.*, 485 F. Supp. 3d 1, 64-65 (D.D.C. 2020). Both courts determined that the 2020 Rule likely violated the APA, yet the chosen remedies slightly differed. *See Walker*, 480 F. Supp. 3d at 429-30; *Whitman-Walker*, 485 F. Supp. 3d at 41-42. In *Walker*, the preliminary injunction reinstates the 2016 Rule's definitions of "on the basis of sex," "gender identity," and "sex stereotyping," and stays the repeal of 45 C.F.R. Section 92.206. *See* 480 F. Supp. 3d at 430; *Walker v. Azar*, No. 1:20-cv-02834, 2020 WL 6363970, at *4 (E.D.N.Y. Oct. 29, 2020).[1] By contrast, the preliminary injunction in *Whitman-Walker* revives the 2016 Rule's definition of "on the basis of sex" only insofar as it includes "discrimination on the

[1] It is unclear whether the *Walker* injunction reinstates the definition of "on the basis of sex" with respect to pregnancy and termination of pregnancy, making further clarification from this Court critical.

basis of sex [stereotyping]," and enjoins HHS "from enforcing [the 2020 Rule's] incorporation of the religious exemption contained in Title IX." 485 F. Supp. 3d at 64. Further, the court concluded that HHS had failed to adequately weigh the impact incorporation of the religious exemption might have on access to health care. *Id.*

All ongoing challenges the Rollback Rule are currently stayed.[2] *See Chinatown Serv. Ctr. v. U.S. Dep't of Health & Human Servs, et al.*, No. 21-cv-00331 (D.D.C. May 27, 2021); Joint Mot. for Stay of Proceedings at 3, *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Human Servs.*, No. 1:20-cv-01630-JEB (D.D.C. Feb. 16, 2021), ECF No. 70; Minute Order (D.D.C. Feb. 16, 2021); Unopposed Mot. For A Stay of Proceedings at 2, *New York v. U.S. Dep't of Health & Human Servs*, No. 1:20-cv-05583-AKH (S.D.N.Y. Feb. 10, 2021), ECF No. 139, Order at 1, No. 20-3827 (2d Cir. May. 18, 2021)); Order at 8, *Asapansa-Johnson Walker v. Azar II*, No. 1:20-cv-02834-FB (E.D.N.Y. Oct. 29, 2020), ECF No. 34.[3]

On July 25, 2022, Defendants issued a notice of proposed rulemaking regarding Section 1557 of the ACA. HHS submitted a draft of the new final rule to OIRA on December 21, 2023. ECF No. 132. The final rule has not yet been promulgated. All aspects of the 2020 Rollback Rule—other than those enjoined in *Walker* and *Whitman-Walker*—remain in effect today.

B. Factual Background.

The Defendants' promulgation of the Rollback Rule has had substantial negative effects on the health care landscape, including, *inter alia*¸ the provision of health coverage and health care

[2] The State of Washington's case was dismissed for lack of standing. *See Washington v. U.S. Dep't of Health & Human Servs.*, 482 F. Supp. 3d 1104, 1122 (W.D. Wash. 2020).

[3] HHS appealed both adverse preliminary injunction decisions. *See Walker v. Azar*, USCA No. 20-3827 (D.C. Cir. Nov. 10, 2020); *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Human Servs.*, USCA No. 20-5331 (2d Cir. Nov. 9, 2020). Both appeals have been held in abeyance. *See* Joint Mot. To Stay Appeal at 3, No. 20-5331, *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Human Servs.* (D.C. Cir. Feb. 16, 2021); Order at 1, No. 20-5331 (D.C. Cir. May 14, 2021); Joint Mot. To Stay Appeal at 3, No. 20-3827, *Asapansa-Johnson Walker v. Azar II* (2d Cir. Mar. 15, 2021); Order at 1, No. 20-3827 (2d Cir. May 18, 2021).

for people protected by Section 1557.

1. The Rollback Rule Has Led To Changes In The Provision Of Health Care For LGBTQI+ Individuals.

The Rollback Rule emboldens discriminatory practices by insurance companies and creates barriers to care for LGBTQI+ individuals, as health care providers and insurers received a greenlight to deny coverage or treatment based on gender identity, sexual orientation, and sex stereotyping. This has resulted in LGBTQI+ individuals being denied access to essential health services, such as gender affirming care. For example, since the Rollback Rule, the insurer of Ebony Eva Harper, a transgender woman, has denied her certain types of gender affirming care. Ex. A, Declaration of Tony Hoang ("Hoang Decl.") ¶ 22; *see also* Ex. B, Declaration of Patrick McGovern ("McGovern Decl.") ¶¶ 15, 19; *see generally* Ex. C, Declaration of Alice Reiner ("Reiner 2024 Decl.). Similarly, CrescentCare recently performed a pap smear on a transgender man, but when the claim was submitted to the patient's plan, it was denied, citing changes to the patient's gender designation for the reason for denial. *Id.* ¶ 18. These denials support the statistics that commenters raised: that "[t]wenty-five percent of respondents experienced a problem with their insurance . . . related to their being transgender, including being denied coverage for care related to gender transition." Ex. D, Sagar Decl. ¶ 3(d) at 5 (citation omitted). The increase of insurance denials under the Rule has a direct correlation to an increase in un-and under-treated conditions in patients which, in turn, creates a greater burden of time and resources on health care providers. McGovern Decl. ¶¶ 30-31.

The Rollback Rule has also created a discriminatory landscape affecting members of Equality California in Texas, Nebraska, Kentucky, Kansas, Louisiana, Arizona, Mississippi, and other states that are hostile to protecting LGBTQI+ health care. Hoang Decl. ¶ 12. Without robust anti-discrimination protections, its members are at a substantial risk of experiencing discrimination

or denials of care, including potentially in emergency situations. *Id.* ¶ 13; *see also* McGovern Decl. ¶¶ 13-15. If one of Equality California's members has a medical emergency in any of those states, a hospital could refuse to treat them because they are transgender, could misgender them, or, as discussed below, could deny them life-saving emergency abortion care. *Id.* ¶ 13.

Simply put, as predicted by commenters, the Rollback Rule has "only serve[d] to amplify [LGBTQI+ peoples' health] disparities." Sagar Decl. ¶ 3(b).

2. The Rollback Rule Has Led To Changes In The Provision Of Health Care For People Who Are, Have Been, Or May Become Pregnant.

The Rollback Rule emboldens covered health entities to deny critical reproductive and pregnancy-related health care and information and foments increased fear of such discrimination, leading to adverse health outcomes. *See* Ex. E, Declaration of Rachael Lorenzo ("Lorenzo Decl.") ¶ 25. For many who have had an abortion or suffered a miscarriage, the Rule has increased fear of discrimination based on those reproductive health decisions or prior pregnancy outcomes, which in turn has caused people to delay or forgo all types of health care. *See id.* ¶ 13, 15. For those seeking care to support their pregnancy, the Rule has reduced perceived protections against substandard or culturally insensitive maternity care, again causing pregnant patients to forgo care and exacerbating the maternal mortality crisis, particularly for pregnant Indigenous and Black people. *See id.* ¶ 19. For those seeking to terminate their pregnancy, the Rule has greenlit refusals to provide complete and accurate information about pregnancy options, leading to delays in care and adverse outcomes. *See id.* ¶ 8.

The Rollback Rule has particularly harmed those facing pregnancy-related emergencies. *Id.* ¶¶ 8, 9. For example, Plaintiff Indigenous Women Rising ("IWR") has received a substantial uptick in calls from clients suffering pregnancy complications for which emergency abortion care is the necessary treatment but who have been denied that care by the hospitals in their communities.

Id. ¶ 11. These individuals have been forced to seek assistance from abortion funds like IWR to travel away from their home communities to access life- and health-saving emergency abortion care. *Id.* The Rule's deletion of express regulatory protections for pregnant individuals in these circumstances and incorporation of exemptions greenlights these denials of care, jeopardizing patient health and increasing costs on support organizations like IWR. *Id*. ¶¶ 13-14.

When health care, including pregnancy and abortion care, is delayed or denied, costs rise. For example, due to the lack of clear guidance on federal protections against discrimination in the Rollback Rule, the average amount of grant funding IWR provides to each of its clients has increased significantly since its last declaration, and overall funding outlays have skyrocketed.[4] *Id.* ¶¶ 6, 8, 14. Likewise, IWR has been forced to expand operations to meet increased demand for nondiscriminatory, stigma-free pregnancy-related doula and midwifery care. *Id.* ¶ 17–20.

Commenters predicted these outcomes, explaining that without robust nondiscrimination protections health care "providers have invoked personal beliefs to deny access to health insurance and an increasingly broad range of health care services, including, birth control, sterilization, certain fertility treatments, abortion, transition-related care for transgender individuals, and end of life care." Sagar Decl. ¶ 3(f). Commenters presented evidence that these denials would particularly impact Black women, who are more likely to need to seek reproductive health care at religiously-affiliated health care institutions and are also more likely to experience pregnancy complications that require services and procedures prohibited at religiously-affiliated institutions. *Id*. ¶ 3(f). Commenters raised that one in every six patients is treated at a Catholic health care institution, and religious hospitals are increasingly the *only* available option in many regions. *Id*. ¶ 3(g).

[4] While multiple factors have contributed to this strain, including the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022), HHS's decision to target abortion in the Rollback Rule rather than clarify federal nondiscrimination requirements has only compounded the harm. Lorenzo Decl. ¶¶ 12, 16.

Commenters further explained that refusals of maternity care and coverage would have devastating consequences for Black and Indigenous people in particular, who are already suffering extreme rates of death from pregnancy. *Id.* ¶ 3(ff). Indeed, pregnancy-related complications are one of the ten leading causes of death for Black people capable of pregnancy between the ages of 15-34 years. *Id.* ¶ 3(pp) at 61 (citation omitted). Commenters also explained that denial of family planning services result in increased unintended pregnancies, which in turn lead to poor birth outcomes, maternal health complications, and economic hardship and insecurity. *Id.* ¶ 3(ddd). A study cited by one commenter found that carrying an unwanted pregnancy to term quadrupled the odds that the parent and child would live below the federal poverty lines. *Id.*

The Rollback Rule sows confusion and signals to health care entities that they can refuse to provide complete and accurate information about pregnancy and abortion care, deny emergency abortion care and miscarriage management, and refuse or force treatment based on a patient's past reproductive health decisions or pregnancy outcomes—all without consequence. This confusion is particularly harmful for people who live in or travel to states that have challenged federal protections for access to reproductive health care. Lorenzo Decl. ¶ 10 (discussing the harms arising from both the Rollback Rule and post-*Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022)). Simply put, the Rollback Rule's deletion of explicit protections against discrimination based on pregnancy and termination of pregnancy and incorporation of exemptions only exacerbates the fear of discrimination and the resultant harm to patient health. *Id.* ¶¶ 9, 15-16.

C. Procedural History.

1. Plaintiffs File Suit.

Shortly after the Rollback Rule was finalized, Plaintiffs filed this action. *See* ECF No. 1. Plaintiffs are a diverse group of persons and entities that are being harmed by the Rule, including a transgender man who uses health insurance and regularly needs to access medical treatment,

Hoang Decl. ¶ 19; a membership organization that advances the health and equality of LGBTQI+ people, *Id.* ¶¶ 2, 15; three private health care facilities that serve LGBTQI+ people, one of which also provides some pregnancy-related services, McGovern Decl. ¶¶ 3-4; *see also* ECF No. 27-12 (Twilbeck Decl.) ¶¶ 5, 7-8; ECF No. 27-7 (Riener Decl., Nov. 18, 2020) ¶ 3; and four health care advocacy organizations that provide a wide range of services, such as facilitating access to health care to LGBTQI+ people and reproductive and pregnancy-related health care to people who can become pregnant. Am. Compl. ¶¶ 45-71. Each health care facility has sued on behalf of itself, its patients, and others that use its services. *Id.* ¶¶ 30, 36, 44-71. Each health care advocacy organization has sued on behalf of itself and those that use their services. *Id.* ¶¶ 51, 60, 67, 71.

Plaintiffs challenge both the legality of specific provisions of the Rollback Rule and the legality of the Rule as a whole under the APA. Chiefly, Plaintiffs ask the Court to declare the Rollback Rule to be illegal, to set aside, vacate it, and to enjoin its implementation permanently.

2. This Court Denies Defendants' Motion To Dismiss.

Defendants filed a motion to dismiss, ECF No. 21, which this Court largely denied, ECF No. 63. The Court found that Plaintiffs had standing to assert APA challenges as to three provisions of the Rollback Rule.[5] *First*, it found that Plaintiffs IWR and CrescentCare have organizational standing to challenge the Rule's incorporation of Title IX's abortion-provision-and-coverage exemption. ECF No. 63 at 21. *Second*, the Court found that Plaintiffs have standing to challenge the Rule's narrowed scope of covered entities. *Id.* at 24-25. *Third*, the Court found that Plaintiffs have standing to challenge the Rollback Rule's elimination of the 2016 Rule's prohibition on

5 The Court also held that Plaintiffs stated a claim that the Rollback Rule discriminates on the basis of sex and was motivated by animus against transgender people, in violation of the Due Process Clause of the U.S. Constitution, ECF No. 63 at 44, and concluded that intermediate scrutiny would apply to this claim, *id.* at 38-39. Plaintiffs now move for partial summary judgment. *See infra* pp.13-14.

categorical coverage exclusions for gender transition care. *Id.* at 27-28.[6]

The Court also held that Plaintiffs' claims are ripe. *See id.* at 35-36. The Court acknowledged Defendants' "stated . . . *intention*" to promulgate a new rule, but also recognized that "Plaintiffs have shown changes in coverage by several insurers and face a risk of economic injury from reduced reimbursements *now*." *Id*. at 36 (emphasis added). Because "[n]o court has enjoined the incorporation of Title IX's abortion exemption, the narrowing of the scope of covered entities, or the elimination of the prohibition on categorical coverage exclusions for care related to gender transition," and Defendants had not yet finalized a new rule on these topics, the Court held that "prudential ripeness concerns" did not counsel in favor of dismissal. *Id*. at 35-36.

The Court also held that Plaintiffs stated a claim that the Rollback Rule discriminates on the basis of sex and was motivated by animus against transgender people, in violation of the Due Process Clause of the U.S. Constitution, *id.* at 44, and concluded that intermediate scrutiny would apply to this claim, *id*. at 38-39.

3. The Parties Agreed To Stay The Litigation.

Shortly after this Court resolved the motion to dismiss, Defendants moved for voluntary remand without vacatur, and for a dismissal of Plaintiffs' Amended Complaint without prejudice. ECF No. 66. In the alternative, Defendants renewed their request for a stay, ECF No. 67 at 17, asserting that HHS would propose a new rule "no later than April 2022." *Id*. at 1.

After a hearing, this Court denied the motion for voluntary remand but granted a time-limited stay. ECF No. 83. As this Court explained, although "Defendants declare that their reconsideration of the 2020 Rule 'is based on a substantial and legitimate need to ensure the 2020

[6] The Court declined to address Plaintiffs' standing to challenge the repeal of the definition of "on the basis of sex," the repeal of 45 C.F.R. Section 92.206, and the incorporation of Title IX's religious exemption based on "the nationwide injunctions issued by sister courts." ECF No. 63 at 10.

Rule's provisions adequately advance the Administration's policy,'" the Defendants "cannot guarantee anything other than that the new final rule '*may* resolve or moot *some* or all of the claims that remain subject to review in this litigation.'" *Id*. at 2 (quoting ECF No. 68 ¶ 13 and ECF No. 67 at 3). At the same time, because "federal courts possess the inherent power to stay proceedings for prudential reasons," the Court granted Defendants' request for a stay "until the end of April 2022 to save both judicial and administrative resources." *Id*. at 2-3. Defendants did not propose a new rule before April 2022. The Court therefore ordered production of the administrative record (ECF No. 97), which was filed on July 18, 2022 (ECF No. 102-2).

After Defendants issued a notice of proposed rulemaking in July 2022, *see* ECF No. 104-1, the Parties filed a joint motion to stay all proceedings until thirty (30) days after Defendants publish a new final rule implementing Section 1557. ECF No. 111. Plaintiffs agreed to this stay with the expectation that Defendants would issue a final rule by "no[] later than this winter" of 2023. ECF No. 124. Defendants have not done so.

The Court issued an order that Plaintiffs' motion for summary judgment "should be filed no earlier than December 21, 2023." ECF No. 123. Because the Defendants have failed to meet their own deadline, Plaintiffs now move for summary judgment on three of the four counts in their Amended Complaint: Count I for violation of the APA, 5 U.S.C. § 706(2)(A), for agency action not in accordance with law, Count II for violation of the APA, 5 U.S.C. § 706(2)(A), for agency action that is arbitrary, capricious, and an abuse of discretion, and Count IV for violation of the APA, 5 U.S.C. § 706(2)(A), for adopting an enforcement policy narrowing the scope of covered entities that is contrary to law.[7]

[7] Plaintiffs agreed not to press Count IV to the extent that it alleged that "HHS adopted a general enforcement policy based on its reading of Section 1557 in the Rollback Rule and will 'return[] to' enforcing Section 1557 using 'the biological binary meaning of sex,' without regard for discrimination on the basis of, *inter alia*, sexual orientation or

STANDARD OF REVIEW

A motion for summary judgment must be granted if the moving party proves "that there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c); *see also Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23 (1986). However, "the summary judgment rubric has a 'special twist in the administrative law context.'" *Bos. Redevelopment Auth. v. Nat'l Park Serv.*, 838 F.3d 42, 47 (1st Cir. 2016) (citation omitted). Here, "a motion for summary judgment is simply a vehicle to tee up a case for judicial review and, thus, an inquiring court must review an agency action not to determine whether a dispute of fact remains but, rather, to determine whether the agency action was arbitrary and capricious." *Id*.

The APA requires courts to "hold unlawful and set aside agency action" that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). An agency's "policy choices" are "[s]ubject, of course, to statutory constraints," that courts must enforce. *Associated Fisheries of Maine, Inc. v. Daley*, 127 F.3d 104, 109 (1st Cir. 1997). The First Circuit recently reiterated "the familiar *Chevron* two-step analysis" in considering an agency's interpretation of a statute. *Relentless, Inc. v. U.S. Dep't of Com.*, 62 F.4th 621, 628 (1st Cir. 2023); *cert. granted*, 144 S. Ct. 325 (2023).[8] At step one, the court asks "whether Congress has directly spoken to the precise question at issue." *Id*. To determine this question, courts "apply the 'ordinary

transgender status." ECF No. 18 ¶ 425(a) (citation omitted). HHS's "Notification of Interpretation and Enforcement of Section 1557 of the Affordable Care Act and Title IX of the Education Amendments of 1972," reversed that policy. ECF No. 50 at 1. Plaintiffs therefore agree to dismiss this part of Count IV. ECF No. 51 at 6. The remaining part of Count IV addresses HHS's enforcement policy with respect to the scope of covered entities encompassed by the statutory term "any health program or activity, any part of which is receiving Federal financial assistance" and "any program or activity . . . administered by an Executive Agency or any entity established under [Title I of ACA]," 42 U.S.C. § 18116(a)." ECF No. 18 ¶ 425(b) (citation omitted). This part of Count IV remains an active controversy as discussed *infra* Section A.3.

[8] The Supreme Court granted certiorari in *Relentless* to consider whether to continue deferring to agency interpretations of statutes. Plaintiffs will advise this Court if the Supreme Court ultimately decides to alter the applicable analysis.

tools of statutory construction.'" *Id.* (citation omitted). Here, "the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." *Id.* "If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect." *Chevron*, 467 U.S. at 843 n.9. This Court can and should stop at *Chevron* Step One as the statute at issue is clear and unambiguous. And even if a court reaches step two, where "the statute is silent or ambiguous with respect to the specific issue," courts should not blindly defer to the agency. *Relentless*, 62 F.4th at 628. Instead, "the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Id.* (citation omitted). In either case, courts must "reject administrative constructions of a statute that frustrate the policy that Congress sought to implement." *Shays v. Fed. Election Comm'n*, 528 F.3d 914, 925 (D.C. Cir. 2008) (alterations omitted).

A rule that is consistent with the law still may be set aside if it is arbitrary and capricious. An agency rule is arbitrary and capricious if the agency has "entirely failed to consider an important aspect of the problem," or "offered an explanation for its decision that runs counter to the evidence before the agency." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). An agency is required to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Id.* (citation omitted).

APA review further requires courts to consider an agency's prior positions. Where an agency departs from a prior policy, it must "display awareness that it is changing position," show that "there are good reasons" for the reversal, and demonstrate that its new policy is "permissible under the statute." *Fox Television Stations*, 556 U.S. at 515. The agency must also "be cognizant that longstanding policies may have 'engendered serious reliance interests that must be taken into

account.'" *Dep't of Homeland Sec. v. Regents of the Univ. of California*, 140 S. Ct. 1891, 1913 (2020) (quoting *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 222 (2016)). It is "arbitrary and capricious to ignore such matters." *Id.*

Where the Court finds that the challenged agency action is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," the court must "hold unlawful and set aside" that action. 5 U.S.C. § 706(2), (2)(A). "[T]he normal practice is to set it aside pending further proceedings," and "a remand for further explanation while leaving the regulation in force" is a disfavored remedy. *Daley*, 170 F.3d at 32.

ARGUMENT

A. This Court Should Vacate The Rollback Rule's Discrete Provisions.

The Rollback Rule is contrary to Section 1557. HHS failed to supply a reasoned explanation for its policy change from the 2016 Rule, it adopted a regulation not supported by and contrary to the evidence in the administrative record, and it failed to address important issues raised during the notice-and-comment process. This Court should therefore vacate and hold unlawful several of the Rollback Rule's individual provisions, including: (1) the deletion of the 2016 Rule's definition of discrimination "on the basis of sex" and the express prohibition on discrimination based on gender identity; (2) the selective importation of exemptions from Title IX; and (3) the narrowing of the scope of health programs and activities subject to Section 1557 by excluding many private health insurers and many of HHS' own programs.

1. This Court Should Vacate The Rollback Rule's Repeal Of The Definition Of Discrimination "On The Basis Of Sex."

In its 2016 Rule, HHS defined "on the basis of sex" to include "discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity." 81 Fed. Reg. at 31,387. This

clarification was necessary to "reflect the current state of nondiscrimination law." *Id.* at 31,388. As such, "the definition of 'on the basis of sex' established by this rule is based upon existing regulation and previous Federal agencies' and courts' interpretations." *Id.* at 31,388.

The Rollback Rule repeals this definition of "on the basis of sex" and adopts an interpretation that is contrary to Section 1557, purportedly to make HHS's understanding of that term "more consistent" with HHS's own interpretations. 84 Fed. Reg. at 27,854-27,857; 85 Fed. Reg. at 37,162. Meanwhile, HHS "decline[d]" to insert a different definition of "sex." 84 Fed. Reg. at 27,857; 85 Fed. Reg. at 37,178.

For two reasons, this Court should vacate the Rollback Rule's elimination of the 2016 Rule's definition of "on the basis of sex," 81 Fed. Reg. at 31,467 (former 45 C.F.R. § 92.4), and express prohibitions on discrimination based on gender identity, *id.* at 31,471-72 (former §§ 92.206, 92.207), at *Chevron* Step One as impermissible interpretations of Section 1557, and also hold Defendants' actions were arbitrary and capricious. *First*, Defendants' decision to remove the 2016 Rule's protections against discrimination based on gender identity, sexual orientation, sex stereotyping, and pregnancy and related medical conditions, including termination of pregnancy, was based on their mistaken interpretation of federal civil rights law, *see* 85 Fed. Reg. at 37,168, 37,177-80; *id.* at 37,183-97, and purported desire "to restore[] the rule of law by confining regulation within the scope of the Department's legal authority." *id.* at 37,163. These positions are both contrary to the plain text of Section 1557 and flatly irreconcilable with *Bostock* and longstanding Title IX precedent. *Second*, HHS failed to fulfill its responsibility to offer sufficient explanation for this change. *See Fox Television Stations*, 556 U.S. at 515.

a. The Rollback Rule's Interpretation Of Discrimination "On The Basis Of Sex" Is Contrary To Law Because It Is Foreclosed By The Text Of Section 1557.

Section 1557 bars sex discrimination "on the ground prohibited under . . . title IX." 42

U.S.C. § 18116(a). Title IX is "broadly written" with "a broad reach." *Jackson v. Birmingham Bd. of Educ.*, 554 U.S. 167, 175 (2005). The Supreme Court has repeatedly emphasized that Title IX must be given "a sweep as broad as its language." *Id.* at 173 (quoting *N. Haven Bd. of Educ. v. Bell*, 456 U.S. 512, 521 (1982)). Section 1557's statutory prohibition on discrimination "on the basis of sex" therefore includes discrimination on the basis of sexual orientation, gender identity, sex stereotyping, pregnancy, and related medical conditions, including termination of pregnancy.

The Supreme Court has clarified "it is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex," because "homosexuality and transgender status are inextricably bound up with sex." *Bostock*, 590 U.S. at 660-61. *Bostock* applied a straightforward, textual reading of Title VII's prohibition on discrimination "because of . . . sex." *Id.* After *Bostock*, the overwhelming majority of federal courts to consider the question have determined that the Supreme Court's Title VII analysis in *Bostock* applies with equal force to Title IX,[9] and in turn to Section 1557.[10] Even before *Bostock*, courts consistently held that Section 1557's prohibition on sex discrimination reaches discrimination against transgender people.[11] These courts invoked various theories, including that discrimination

[9] *See, e.g.*, *A.C. by M.C. v. Metro. Sch. Dist.*, 75 F.4th 760, 769 (7th Cir. 2023); *Grabowski v. Ariz. Bd. of Regents*, 69 F.4th 1110, 1116 (9th Cir. 2023); *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 593, 619 (4th Cir. 2020), *reh'g en banc denied*, 976 F.3d 399 (4th Cir. 2020); *but see Adams v. Sch. Bd.*, 57 F.4th 791, 808 (11th Cir. 2022).

[10] *See, e.g.*, *Doe v. Snyder*, 28 F.4th 103, 114 (9th Cir. 2022); *Hammons v. Univ. of Md. Med. Sys. Corp.*, 649 F. Supp. 3d 104, 115-16 (D. Md. 2023); *C.P. by and through Pritchard v. Blue Cross Blue Shield of Ill.*, No. 3:20-cv-06145, 2022 WL 17788148, at *6 (W.D. Wash. Dec. 19, 2022); *Fain v. Crouch*, 618 F. Supp. 3d 313, 335 (S.D.W. Va. 2022); *Kadel v. Folwell*, No. 1:19-CV-272, 2022 WL 17415050, at *2 (M.D.N.C. Dec. 5, 2022); *Scott v. St. Louis Univ. Hosp.*, 600 F. Supp. 3d 956, 965 (E.D. Mo. 2022); *Murphy v. Health Care Serv. Corp.*, No. 22-CV-2656, 2023 WL 6847105, at *2 (N.D. Ill. Oct. 17, 2023); *Walker*, 480 F. Supp. 3d at 429; *Joganik v. E. Texas Med. Ctr.*, No. 6:19-CV-517-JCB-KNM, 2021 WL 6694455, at *10 (E.D. Tex. Dec. 14, 2021); *but see Neese v. Becerra*, 640 F. Supp. 3d 668, 676-84 (N.D. Tex. 2022) (single outlier court holding that Title IX's, and thus Section 1557's, prohibition on sex discrimination does not extend to sexual orientation or gender identity discrimination).

[11] *See, e.g.*, *Boyden v. Conlin*, 341 F. Supp. 3d 979, 995-97 (W.D. Wis. 2018); *Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 952 (D. Minn. 2018); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1099-1100 (S.D. Cal. 2017).

based on gender identity or sexual orientation is a form of sex stereotyping prohibited under federal laws protecting against sex discrimination. *See, e.g.*, *Rosa v. Park W. Bank & Tr. Co.*, 214 F.3d 213, 215-16 (1st Cir. 2000) (citing *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989)).[12]

Section 1557's prohibition against sex discrimination also includes discrimination on the basis of pregnancy and related medical conditions, including termination of pregnancy. This statutory interpretation has been long and widely understood, as the 2016 Rule correctly explained. *See* 81 Fed. Reg. at 31,434 & n.259. Indeed, for nearly five decades, the regulations implementing Title IX have explicitly prohibited sex discrimination on the basis of "pregnancy, childbirth, false pregnancy, termination of pregnancy, or recovery therefrom." Department of Health, Education, and Welfare, General Administration, 40 Fed. Reg. 24,128, 24,135, 24,140, 24,142 (June 4, 1975), codified at C.F.R. pt. 86[13]; *see also Conley v. Nw. Fla. State Coll.*, 145 F. Supp. 3d 1073, 1076-79 (N.D. Fla. 2015) (upholding the Title IX regulations because, "[i]n light of the legislative history of Title IX, the broad sweep of its language, and the fact that the term 'sex' is understood in common usage to encompass pregnancy, . . . Congress's prohibition of discrimination 'on the basis of sex' unambiguously includes pregnancy-based discrimination within its purview").[14] No court

[12] Sex-stereotyping doctrine also protects against discrimination based on pregnancy and related medical conditions, including abortion. *See Nevada Dep't of Human Res. v. Hibbs*, 538 U.S. 721, 736 (2003) (upholding the Family Medical Leave Act as countering stereotypes about "mothers or mothers-to-be . . . that forced women to continue to assume the role of primary family caregiver, and fostered employers' stereotypical views about women's commitment to work and their value as employees.") (citation omitted).

[13] Upon its creation in 1979, the Department of Education adopted the Title IX regulations originally promulgated by the Department of Health, Education, and Welfare unchanged in relevant part. *See* 45 Fed. Reg. 30,955 (May 9, 1980), codified at 34 C.F.R. § 106.40.

[14] *See also Pfeiffer v. Marion Ctr. Area Sch. Dist.*, 917 F.2d 779, 784 (3d Cir. 1990), *abrogated by Fitzgerald v. Barnstable Sch. Comm.*, 555 U.S. 246 (2009) (Title IX regulations "specifically apply its prohibition against gender discrimination to discrimination on the basis of pregnancy"); *Hogan v. Ogden*, No. 06-CV-5078, 2008 WL 2954245, at *9 & n.11, 13 (E.D. Wash. July 30, 2008) (same); *Chipman v. Grant Cnty. Sch. Dist.*, 30 F. Supp. 2d 975, 977-78 (E.D. Ky. 1998) (same); *Hall v. Lee Coll.*, 932 F. Supp. 1027, 1033 n.1 (E.D. Tenn. 1996) (same); *see also Cazares v. Barber*, No. 90-CV-0128, slip op. (D. Ariz. May 31, 1990); *Wort v. Vierling*, No. 82-3169, slip op. (C.D. Ill. Sept. 4, 1984), *aff'd*, 778 F.2d 1233 (7th Cir. 1985).

has ever held to the contrary.[15] And Congress tacitly approved this definition when the original Title IX regulations were presented to Congress for review in 1975.[16] *See United States v. Rutherford*, 442 U.S. 544, 554 n.10 (1979) ("[O]nce an agency's statutory construction has been 'fully brought to the attention of the public and the Congress,' and the latter has not sought to alter that interpretation although it has amended the statute in other respects, then presumably the legislative intent has been correctly discerned.").[17]

Discrimination on the basis of termination of pregnancy broadly encompasses both adverse action against individuals because they have obtained or sought abortion care, and also policies or practices that restrict the provision or coverage of abortion care. Because only pregnant people need abortion care, denying such medical treatment when a covered entity is competent to provide it, or denying abortion coverage from an otherwise comprehensive health plan, is a discriminatory sex-based denial of health services. *See, e.g.*, *Allegheny Reprod. Health Ctr. v. Pa. Dep't of Hum. Servs*., No. 26 MAP 2021, 2024 WL 318389, at *62 (Pa. Jan. 29, 2024) (excluding abortion coverage from Medicaid is sex discrimination); *N.M. Right to Choose/NARAL v. Johnson*, 975

[15] Further, it has long been understood that Title VII—which courts routinely turn to when interpreting Title IX, *see, e.g.*, *Davis v. Monroe Cnty. Bd. Of Educ.*, 526 U.S. 629, 651 (1999), and, in turn, Section 1557—prohibits discrimination based on pregnancy, including termination of pregnancy. *See Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am., UAW v. Johnson Controls, Inc.*, 499 U.S. 187, 197-99 (1991) (discrimination based on capacity for pregnancy is sex discrimination); *see also, e.g.*, *Doe v. C.A.R.S. Prot. Plus, Inc*., 527 F.3d 358, 364 (3d Cir2008), *order clarified*, 543 F.3d 178 (3d Cir. 2008) (discrimination based on abortion is sex discrimination); *Turic v. Holland Hosp., Inc*., 85 F.3d 1211, 1213-14 (6th Cir. 1996) (same).

[16] At the time, federal law required that the Department of Health, Education, and Welfare submit regulations to Congress for review and comment; Congress then had 45 days to pass a joint resolution rejecting the regulations in whole or in part. 20 U.S.C. § 1232(d)(1). Congress held extensive hearings on the Title IX regulations and considered and rejected a number of resolutions calling for disapproval of the regulations in whole or in part. *See* Jocelyn Samuels & Kristen Galles, *In Defense of Title IX: Why Current Policies Are Required to Ensure Equality of Opportunity*, 14 Marquette Sports L. Rev.11, 21 n.50 (2003). In the end, the regulatory definition of discrimination on the basis of sex as including "pregnancy" and "termination of pregnancy" (originally listed in the notice of proposed rulemaking as "abortion" and "miscarriage," 39 Fed. Reg. 22,228, 22,234–37 (June 20, 1974)) remained.

[17] Further, Congress has twice amended Title IX without ever casting doubt upon the statutory interpretation embodied in the regulations. *See* Education Amendment of 1976, Pub. L. No. 94-482, Title IV, § 412(a), 90 Stat. 2234; Civil Rights Restoration Act of 1987, Pub. L. No. 100-259, § 3(a), 102 Stat. 28.

P.2d 841, 856 (N.M. 1998) (same); *Doe v. Maher*, 515 A.2d 134, 159 (Conn. Super. Ct. 1986) (same); *cf. Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1270-71 (W.D. Wash. 2001) (excluding contraceptive coverage from a comprehensive prescription plan is sex discrimination). Indeed, the existence of Title IX's abortion-provision-and-coverage exemption confirms that Congress understood Title IX to otherwise require abortion care and coverage. Congress's addition of this language makes clear not only that Title IX prohibits discrimination based on pregnancy and termination of pregnancy, but also that absent an explicit exception, laws prohibiting sex discrimination require the provision and coverage of abortion care when denying that care would single out pregnant people for less comprehensive treatment or coverage.

Furthermore, HHS removed the 2016 Rule's express protections against discrimination related to sexual orientation, gender identity, sex stereotyping, and pregnancy, including termination of pregnancy, based on the federal government's position in *Bostock*, and a single case granting first a preliminary injunction and then summary judgment against the 2016 Rule. *See* 85 Fed. Reg. at 37,163-64 (citing *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660, 669, 689 (N.D. Tex. 2016) (concluding that "HHS's expanded definition of sex discrimination [in the 2016 Rule] exceeds the grounds incorporated by Section 1557")); *Franciscan All., Inc. v. Azar*, 414 F. Supp. 3d 928, 945 (N.D. Tex. 2019) (vacating and remanding that portion of the 2016 Rule based on the faulty reasoning in the preliminary injunction opinion)).[18] But *Franciscan Alliance* creates no ambiguity about whether the Rollback Rule's erasure of the definition of "on the basis of sex" is contrary to law, and in no way brings that rule in line with the plain text of Section 1557.

[18] The Rollback Rule also references an order in *Religious Sisters of Mercy. v. Burwell*, which found the *Franciscan Alliance* preliminary injunction decision to be "thorough and well-reasoned," but did not engage in any additional analysis. *See Religious Sisters of Mercy v. Burwell*, Nos. 3:16-cv-386 & 3:16-cv-432 (D.N.D. Jan. 23, 2017) (temporarily staying enforcement of Section 1557's prohibitions against discrimination based on gender identity and termination of pregnancy against named plaintiffs in cases raising claims under the Religious Freedom Restoration Act and the First Amendment).

No court decision—including *Franciscan Alliance*—has questioned Section 1557's well-established prohibitions on pregnancy discrimination, and so erasing the term "pregnancy" from the Rollback Rule's definition of sex was clearly contrary to law. Defendants' reliance on *Franciscan Alliance* to roll back protections against discrimination based on gender identity and termination of pregnancy was no less misplaced. As to gender identity, *Franciscan Alliance*'s reasoning is contrary to the overwhelming weight of authority. *See infra* n.19. As to termination of pregnancy, the decision contravenes the plain text and intent of Section 1557's incorporation of Title IX's sex discrimination prohibition and longstanding case law and regulatory guidance. *See supra* pp. 19-21. Thus, *Franciscan Alliance* is an outlier decision that eschews precedent and lacks even persuasive authority. Further, while the preliminary injunction in *Franciscan Alliance* vacated a portion of the 2016 Rule's definition of sex discrimination, "it did not order the agency to do anything in particular when promulgating a future rule implementing Section 1557." *Whitman-Walker Clinic, Inc.*, 485 F. Supp. 3d at 41. Defendants cannot rely on this single, erroneous, and unpersuasive case to justify a regulation inconsistent with the statute it purports to implement.

b. HHS Failed To Adequately Explain Its Change In Position Regarding The Definition Of Discrimination "On The Basis Of Sex."

There is a second, separate reason for this Court to vacate the Rollback Rule: HHS's failure to adequately explain why the agency changed positions regarding the definition of discrimination on the basis of sex. Although HHS acknowledged it was reversing course from the 2016 Final Rule, its explanation falls short of the required standard of a *reasoned* explanation for the change. *See Fox Television Stations*, 556 U.S. at 515.

HHS has not sufficiently explained its decision to remove the additional clarification offered in the 2016 Rule. In 2016, HHS found that although the ACA already prohibited

discrimination based on sex, "many women and transgender individuals continue[d] to experience discrimination in the health care context," which "demonstrate[d] the need for further clarification regarding the prohibition of discrimination on the basis of sex." 81 Fed. Reg. at 31,460. Indeed, commenters presented evidence of discrimination against those groups, which Plaintiffs' own experiences further validated, indicating that the discrimination that the 2016 Rule identified remains prevalent. *See* Sagar. Decl. ¶ 3(e), (s); *see also* Hoang Decl. ¶¶ 15, 17, 19-20. If the agency were correct that the definition needed to be adjusted to better align with other interpretations, that is no reason to choose to not include a definition at all. That is precisely the kind of "disconnect between the decision made and the explanation [] given" that this Court "cannot ignore." *New York v. U.S. Dep't of Health & Human Servs.*, 414 F. Supp. 3d 475, 541 (S.D.N.Y. 2019) (citation omitted).

HHS also asserts that the 2016 Rule's interpretation of civil rights law was "erroneous," 84 Fed. Reg. at 27,849; 85 Fed. Reg. at 37,166, and that after *Bostock*, there remained widespread "confusion" regarding whether discrimination based on transgender status counts as sex discrimination. 85 Fed. Reg. at 37,180; *see also* 84 Fed. Reg. at 27,848. But HHS's legal analysis does not actually explain *how* that interpretation was incorrect. *See* 84 Fed. Reg. at 27,849; 85 Fed. Reg. at 37,166. To the contrary, the 2016 Rule grounded its interpretation of "sex" on a detailed survey of the extensive existing case law. *See* 81 Fed. Reg. at 31,388-92. And the 2016 Rule's analysis of the case law *was* correct. Am. Compl. ¶¶ 119-152. Indeed, nearly all federal appellate courts that have addressed the question, even before *Bostock*, concluded that Title IX's statutory prohibitions on sex discrimination encompass discrimination against transgender individuals for having a gender identity different from their sex assigned at birth. *See supra* p. 5. The Rollback Rule addressed this authority in a handful of dismissive paragraphs that did not acknowledge—let

alone respond to—this substantial body of contrary authority. *See, e.g.*, 84 Fed. Reg. at 27,849; 85 Fed. Reg. at 37,164 & n.15. Instead, the Rule heavily relied on *Franciscan Alliance*, which cannot bear the weight HHS placed on it. *Supra* pp. 21-22.[19] HHS's terse explanation, which says "almost nothing," is wholly inadequate to justify a policy reversal. *Encino Motorcars*, 579 U.S. at 223.

Indeed, the timing of HHS's promulgation of the Rollback Rule suggests that HHS hoped to avoid having to explain its decision making. The 2019 Proposed Rule conceded that the *Bostock* opinion "will likely have ramifications for the definition of 'on the basis of sex' under Title IX." 85 Fed. Reg. at 37,168. Multiple advocates asked HHS to wait to issue the Rollback Rule until it could incorporate the Court's ruling. *See id.*; *see also* Sagar. Decl. ¶ 3(s). Yet HHS designated the Rollback Rule for publication on June 19, 2020, even though the Supreme Court typically issues all decisions by late June or early July for each Term. And the Rollback Rule itself repeatedly relied on the Department of Justice's imperiled—and ultimately defeated—litigating position in *Bostock*. 85 Fed. Reg. at 37,168. By rushing the Rollback Rule's publication, HHS failed to consider the concerns raised by commenters, the prevailing textual arguments in *Bostock*, and the risks, costs, and benefits of immediately implementing a regulation which they knew to contradict Supreme Court precedent.

But rushing to print does not excuse HHS's failures to distinguish or explain its departures from its own earlier interpretations. HHS claimed in the Rollback Rule that by eliminating the 2016 Rule's definition of discrimination "on the basis of sex," it was reverting to "longstanding

[19] HHS's reliance on *Franciscan Alliance* to support deleting the definition of "on the basis of sex" was additionally arbitrary and capricious because the only issue presented by the plaintiffs in that case was whether the 2016 Rule required them to "perform and provide insurance coverage for gender transitions and abortions." *Franciscan All., Inc.*, 227 F. Supp. 3d at 670. By vacating protections for gender identity and termination of pregnancy wholesale from the 2016 Rule, the relief granted was overbroad and injected confusion about Section 1557's prohibitions on other forms of discrimination related to gender identity and termination of pregnancy—such as harassment for being transgender, refusal of miscarriage management, or mistreatment against a patient because they sought or had an abortion in the past. Defendants' decision to perpetuate that error cannot pass muster as reasoned decision making.

statutory interpretations" of the civil rights statutes underlying Section 1557 that conformed with the government's "official position concerning those statutes." 85 Fed. Reg. at 37,161. But in 2012, the HHS Office for Civil Rights ("OCR") specifically stated, "Section 1557's sex discrimination prohibition extends to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity," and it took the position that Section 1557 prohibited discrimination on the basis of sexual orientation.[20] In addition, in 2015, OCR entered into a voluntary agreement with The Brooklyn Hospital Center resolving allegations of gender identity discrimination under Section 1557. *See* 85 Fed. Reg. at 37,191. Likewise, in response to complaints filed in 2013 alleging that several health plan sponsors violated Section 1557's prohibition against pregnancy discrimination by excluding maternity coverage for dependent children, OCR initiated investigations that culminated in several of those plan sponsors voluntarily amending their plans to add that coverage effective January 1, 2016, prior to the 2016 Rule's effective date.[21] Each of the letters closing out those investigations clarified the agency's understanding that Section 1557 prohibits discrimination on the basis of, *inter alia*, "sex (including pregnancy)." *Id.*[22]

In sum, an agency's flexibility to depart from prior policies "has limits." *United Steel v. Mine Safety & Health Admin.*, 925 F.3d 1279, 1284 (D.C. Cir. 2019). HHS's actions here

[20] *See* Letter from Leon Rodriguez, Dir., U.S. Dep't of Health & Human Servs., Off. for Civil Rights, to Maya Rupert, Federal Policy Director, Nat'l Ctr. for Lesbian Rts. (July 12, 2012), https://perma.cc/RB8V-ACZU.

[21] *See, e.g.*, Letter from Sunu Chandy, Deputy Dir. for Civil Rts., Dep't of Health & Hum. Servs., to Marcia D. Greenberger, NWLC, & Dr. Jay Gogue, President, Auburn Univ. (Jan. 19, 2017), https://perma.cc/5QX2-329M.

[22] *See also* Letter from Sunu Chandy, Deputy Dir. for Civil Rts., Dep't of Health & Hum. Servs., to Marcia D. Greenberger, NWLC, & Jeffrey Wadsworth, President & CEO, Batelle Mem'l Inst. (Jan. 19, 2017), https://perma.cc/U8YT-H7ZF; Letter from Sunu Chandy, Deputy Dir. for Civil Rts., Dep't of Health & Hum. Servs., to Marcia D. Greenberger, NWLC, & Thayne M. McCulloh, President, Gonzaga Univ. (Jan. 19, 2017), https://perma.cc/BJX4-A6N5; Letter from Sunu Chandy, Deputy Dir. for Civil Rts., Dep't of Health & Hum. Servs., to Marcia D. Greenberger, NWLC, & Frank T. Brogan, Chancellor, Pa. State Sys. of Higher Educ. (Jan. 19, 2017), https://perma.cc/ZRG3-GSFG.

transgress those limits.

2. This Court Should Vacate The Rollback Rule's Incorporation of Title IX's Religious-Institution and Abortion-Provision-and-Coverage Exemptions.

Defendants cherry-picked Title IX's exemptions for educational institutions "controlled by a religious organization if the application of this subsection would not be consistent with the religious tenets of such organization," 20 U.S.C. § 1681(a)(3), and for the provision and coverage of abortion, 20 U.S.C. § 1688, for incorporation into the Rollback Rule. But as explained below, there is no way to incorporate Title IX's exemptions without also incorporating their focus on the educational context, which is incompatible with the text and purpose of the ACA. Likewise, the other abortion- and religion-specific provisions in the ACA foreclose incorporation of Title IX's exemptions. This Court should vacate these provisions of the Rollback Rule at *Chevron* Step One as impermissible interpretations of Section 1557 and also hold that HHS promulgated them in a manner inconsistent with the APA's protection against arbitrary and capricious agency action.

a. HHS's Adoption Of The Religious Exemption Is Contrary To Law Because It Is Foreclosed By The Text Of Section 1557.

The plain language of Section 1557 makes clear that HHS may not incorporate any of Title IX's exemptions. Section 1557 states that "[*e*]*xcept as otherwise provided for in this title* (or an amendment made by this title), an individual shall not, *on the ground prohibited* under. . . title IX of the Education Amendments of 1972 . . . be subjected to discrimination. . . ." 42 U.S.C. § 18116(a) (emphasis added). This text forecloses HHS's reading of the statute. Section 1557 refers to the cross-referenced non-discrimination statutes for the grounds on which they prohibit discrimination, and the "ground prohibited" under Title IX is "sex." *Id.*; 20 U.S.C. § 1681(a).

Further, the presence of explicit exceptions in Section 1557 rules out the possibility that further unstated exceptions were intended. Where an exception is already expressly stated in a law,

no other exceptions may be implied—"expressio unius est exclusio alterius." *Leatherman v. Tarrant Cnty. Narcotics Intel. & Coordination Unit*, 507 U.S. 163, 168 (1993); *see also United States v. Smith*, 499 U.S. 160, 167 (1991) ("Where Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of evidence of a contrary legislative intent." (citation omitted)). Section 1557 states that its prohibition on discrimination applies "[e]xcept as otherwise provided for in this title (or an amendment made by this title)." 42 U.S.C. § 18116(a). Elsewhere in Title I of the ACA, Congress provided various exemptions, including those of a religious nature. *See, e.g.*, 42 U.S.C. § 18113 (an exemption for those who have a religious objection to participating in aid-in-dying procedures); *id.* § 18023(c)(2)(A)(i) (stating that nothing in the Act "shall be construed to have any effect on Federal laws regarding . . . conscience protection"). "When Congress provides exceptions in a statute," "[t]he proper inference . . . is that Congress considered the issue of exceptions and, in the end, limited the statute to the ones set forth." *United States v. Johnson*, 529 U.S. 53, 58 (2000). That inference applies here; Congress' decision to incorporate in Section 1557 the other exceptions in Title I of the ACA suggests that Congress did not intend any other exceptions—such as Title IX's exemption for certain religious educational institutions—to apply.

Defendants purport to justify the incorporation of the exemption by citing the *Franciscan Alliance* decision and arguing that incorporating this exemption followed "Congress's specific direction to prohibit only the ground [for discrimination] proscribed by Title IX." *See* 85 Fed. Reg. at 37,180 n.190 (citation omitted). The *Franciscan Alliance* court, in turn, reasoned that because "Congress included the signal '*et seq.*,' which means 'and the following,' after the citation to Title IX . . . Congress intended to incorporate [Title IX's] entire statutory structure, including . . . [its] religious exemptions." *Franciscan Alliance*, 227 F. Supp. 3d at 690. These arguments read far too

much into the structure of a citation and misconstrue the meaning of the term "ground."

Title IX's exemptions do not form part of "the ground," 42 U.S.C. § 18116(a), on which Title IX "prohibit[s] … discrimination"—the exemptions do not "prohibit" discrimination at all—they permit discrimination in certain circumstances. That is, the word "ground" means "the reason or point that something (as a legal claim or argument) relies on for validity." Black's Law Dictionary (10th ed. 2014); *see also, e.g.*, *Sanders v. United States*, 373 U.S. 1, 16 (1963) (defining "ground" to mean "a sufficient legal basis for granting the relief sought"). For that reason, the "ground" on which something is prohibited cannot include instances in which that same thing is permitted. And the format of the statutory citation within the text of Section 1557—including "*et seq.*" at the end of the statute—cannot reasonably be read to change the plain meaning of the word "ground." Thus, at least one court has already determined that "[b]y referencing the 'ground' of discrimination prohibited by Title IX, Section 1557 plainly barred discrimination on the basis of sex . . . It did not, however, explicitly incorporate Title IX's exemption of certain educational operations of entities controlled by religious organizations from its nondiscrimination mandate." *Whitman-Walker Clinic*, 485 F. Supp. 3d at 43.

Moreover, Title IX includes an abundance of other exemptions that would be clearly absurd to incorporate in the health care context. In the very same subsection of the United States Code where Title IX's religious exemption is codified, *see* 20 U.S.C. § 1681(a)(3), a host of other organizations are granted permission to discriminate on the basis of sex for uniquely educational purposes, *see id.* § 1681(a)(3)-(a)(9). These include: military academies; sororities and fraternities; the Boy Scouts, Girl Scouts, YWCA, and YMCA; Boys State and Girls State conferences; certain mother-daughter and father-son activities; and scholarships or financial assistance awarded as a prize in beauty pageants. *See id.* Exempting such organizations that sex segregate for educational

purposes from Section 1557's non-discrimination provision—which applies when an organization conducts a health program or activity—would be at best futile, and at worst would yield absurd and potentially harmful results. Further, incorporating these exemptions would do nothing to serve the original purpose for Congress's grant of these exemptions in Title IX—to serve educational purposes. No reasonable reading of Section 1557 would require incorporating these exemptions, and there is no legal or textual basis to include some but not all of Title IX's exemptions.

Nor is there anything special about the religious exemption that makes HHS's cherry-picking make sense. As the 2016 Rule explained, *see* 81 Fed. Reg. at 31,379-80, Title IX's religious exemption—which is limited to the educational context—is incompatible with Section 1557's broad statutory scheme that regulates the conduct of "health programs or activities," including health care providers, researchers, and insurers. First, in attempting to shoehorn it in, the agency appears to suggest that the exemption can simply be re-written so that it applies to "**any** ~~educational~~ institution which is controlled by a religious organization." 20 U.S.C. § 1681(a)(3). But that is not what Title IX says, and agencies do not have the authority to read words out of statutes. *Cf. Barber v. Thomas*, 560 U.S. 474, 490 (2010) (noting that courts should avoid interpretations that "read words out of the statute"). And because Title IX explicitly limits its religious exemption to *educational* institutions, Title IX's religious exemption has no place in a law prohibiting discrimination in a wide variety of *health* programs and activities.

b. HHS's Adoption Of The Abortion Exemption Is Contrary To Law Because It Is Foreclosed By The Text Of Section 1557.

For many of the same reasons that HHS cannot reasonably interpret Section 1557 to include Title IX's religious exemption, HHS cannot reasonably interpret Section 1557 to include Title IX's abortion-provision-and-coverage exemption either.

The same textual analysis discussed *supra* regarding Title IX's religious exemption

precludes incorporation of the abortion-provision-and-coverage-exemption. Indeed, the textual argument for not incorporating the abortion exemption applies with even greater force because courts presume Congress has acted "intentionally and purposely" when it "includes particular language in one section of a statute but omits it in another section of the same Act," *Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 452 (2002), and abortion is directly addressed elsewhere in Title I of the ACA. *See* 42 U.S.C. § 18023(a)(1) (clarifying that Title I of the ACA allows states to prohibit abortion coverage in the state exchanges); *id.* § 18023(c)(1) (indicating that the ACA shall not "preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor"); *id.* § 18023(c)(2)(A)(ii) (clarifying that Title I of the ACA incorporates existing "Federal laws regarding . . . willingness or refusal to provide abortion"). These abortion-specific provisions in Title I, coupled with Section 1557's statement that its prohibition of discrimination applies "[e]xcept as otherwise provided for" in Title I, further confirm that the abortion-provision-and-coverage exemption cannot reasonably be read into Section 1557. *See Leatherman*, 507 U.S. at 168; *Smith*, 499 U.S. at 167.[23]

c. HHS's Adoption Of Title IX's Exemptions Is Arbitrary And Capricious Because HHS Failed To Consider Important Aspects Of The Problem And Did Not Adequately Explain Its Change In Position.

HHS previously understood the gravity of harm that would result from importing Title IX's

[23] Defendants again cite *Franciscan Alliance* in support of their decision to read Title IX's abortion-provision-and-coverage-exemption into Section 1557, but that court's rationale makes no more sense here than it did with respect to the religious exemption. The inclusion of the phrase '*et seq.*,' cannot logically be read to mean that some, unspecified additional provisions should be imported into a health care statute. And there is no way to incorporate the entirety of Title IX without also incorporating its focus on education, and that focus is incompatible with the ACA. Thus, for reasons similar to those discussed above, importing the Title IX abortion-provision-and-coverage-exemption is incompatible with the text and purpose of Section 1557.

exemptions into the health care context. In 2016, the Department declined to deviate from the plain language of Section 1557 and thus did not incorporate Title IX's religious-or abortion- exemption in the 2016 Rule. *See* 81 Fed. Reg. at 31,380, 31,388. HHS reasoned that the exemptions "do not readily apply" in the health care context because "there are significant differences between the educational and health care contexts that warrant different approaches." *Id.* at 31,378, 31,380. HHS explained that, unlike students choosing between educational institutions, patients often cannot choose between providers—especially in rural areas. *See id.* at 31,380. HHS further recognized that a person in an ambulance does not have the option of comparison-shopping hospitals, particularly in the emergency context. *See id.* Thus, HHS concluded that incorporating Title IX's exemptions "could result in a denial or delay in the provision of health care to individuals and in discouraging individuals from seeking necessary care, with serious and, in some cases, life threatening results." *Id.*

With the Rollback Rule, Defendants reverse course. Despite overwhelming concerns raised by commenters, Defendants refused to acknowledge the danger to patients from incorporation of Title IX's exemptions into the health context. Multiple commenters discussed the acute harm that would arise in the context of pregnancy-related emergencies, where abortion care is often the clinically appropriate treatment.[24] Laws prohibiting sex discrimination generally require covered entities to provide abortion care where denying it would single out pregnant patients for less comprehensive treatment, absent an explicit exception. *See infra* p. 34. In the emergency context, this means that when a hospital otherwise offers comprehensive emergency care and has the competency to provide gynecologic or obstetric care, refusing to provide emergency abortion care

[24] *See* Sagar Decl. ¶ 3(f), (bb), (cc), (ccc); *see also Reinforcement of EMTALA Obligations Specific to Patients Who Are Pregnant or Are Experiencing Pregnancy Loss*, Ctrs. for Medicare & Medicaid Servs. 4 (Sept. 17, 2022), https://www.cms.gov/files/document/qso-21-22-hospital-revised.pdf.

violates Section 1557.[25] Commenters explained that incorporating Title IX's abortion-provision-and-coverage and religious-institutional exemptions from the limited education context to apply to *all* health providers receiving federal financial assistance could expand the pool of those at risk of being denied critical and often life-saving abortion care.[26] And while the harm is particularly acute now given the widespread confusion and fear wrought by state abortion bans since *Dobbs*, *see* Lorenzo Decl. ¶¶ 9-12, HHS was well aware of these potential effects and the need for clear federal standards on what care hospitals must provide notwithstanding state law[27] at the time the Rollback Rule was finalized.[28]

Multiple commenters also emphasized that the incorporation of Title IX's religious exemption could increase the number of health care facilities that refuse to provide a wide variety of health care services, including birth control, fertility services, sterilization, abortion, gender

[25] Because Section 1557 applies "except as otherwise provided for" under Title I of the ACA, Section 1303 of the ACA incorporates into Section 1557 harmful federal laws that allow certain entities to refuse to provide abortion care or coverage in limited situations—the Weldon, Church, and Coats-Snowe Amendments. 42 U.S.C. § 18023(c)(2). However, Section 1303 clarifies that its application of refusal laws excludes emergency care. *See id.* 18023(d) ("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 1557, the Emergency Medical Treatment and Active Labor Act (EMTALA), and other laws prohibiting discrimination in health care, denials of emergency care, and medical malpractice, among others).

[26] *See* Sagar Decl. ¶ 3(bb), (f), (cc)

[27] Section 1557 expressly preempts any state law—whether criminal or civil—that bans abortion care that Section 1557 requires. 42 U.S.C. § 18116(b) ("Nothing in [Title I of the ACA] . . . shall be construed to . . . supersede State laws that provide additional protections against discrimination . . . ."); *id.* § 18041(d) ("Nothing in [Title I of the ACA] shall be construed to preempt any State law that does not prevent the application of the provisions of this title."); *id.* § 18023 (exempting from preemption only laws regarding the "coverage, funding, or procedural requirements on abortions"). Moreover, because refusing this care is facially discriminatory, even good faith reliance on state law is no defense. *See Johnson Controls, Inc.*, 499 U.S. at 199 (where there is explicit facial discrimination, the reason for discriminating is irrelevant); *accord Kadel v. Folwell*, 620 F. Supp. 3d 339, 376 (M.D.N.C. 2022). The need for clarity around Section 1557's federal obligations is even more dire given that the U.S. Supreme Court will consider this term the extent to which EMTALA separately requires emergency abortion care notwithstanding state abortion bans. *See Moyle v. United States* and *Idaho v. United States*, U.S. Sup. Ct. Docket Nos. 23-276 and 23-277.

[28] Although the U.S. Supreme Court overturned the federal constitutional right to abortion care in 2022, in 2019—when the Rollback Rule was first proposed—multiple states signed 25 new bans on all, most, or some abortion care into law, with the expectation that the federal constitutional protection would be overturned. *See* Elizabeth Nash et al., Guttmacher Inst., *State Policy Trends 2019: A Wave of Abortion Bans, But Some States Are Fighting Back* (Dec. 10, 2019), https://www.guttmacher.org/article/2019/12/state-policy-trends-2019-wave-abortion-bans-some-states-are-fighting-back. Thus, Defendants were aware of these potential effects.

affirming care, and end-of-life care.[29] Other commenters noted that the exemption could be interpreted by some medical institutions to permit them to deny any and all health services to individuals on the basis of sex, including refusing to treat LGBTQI+ people or people who had previously had an abortion, even when the care was health-or life-saving.[30] These denials of care would be especially harmful for those who live in rural areas, the Association of American Medical Colleges highlighted, because alternate care could be too far or too expensive.[31]

Nonetheless, Defendants determined that the Title IX exemptions ought to be incorporated in the Rollback Rule, *see* 85 Fed. Reg. at 37,162, without acknowledging the likely impact on access to care, or explaining why it reversed course from the 2016 Rule. Indeed, Defendants persisted in this approach despite emphasizing the significant differences between health care and education elsewhere in the rule. *See id.* at 37,183-84.

HHS's failure to consider an important aspect of the problem and provide a reasoned explanation for reversing its prior position renders the Rule's incorporation of the Title IX exemptions arbitrary and capricious. *See Spirit Airlines, Inc. v. U.S. Dep't of Transp.*, 997 F.3d 1247, 1255 (D.C. Cir. 2021) (finding agency action arbitrary and capricious where agency "gave no indication it even considered" an important aspect of the problem before it beyond a "single sentence"); *Allied Local & Reg'l Mfrs. Caucus v. EPA*, 215 F.3d 61, 80 (D.C. Cir. 2000) (explaining that an agency "must respond to significant points raised during the public comment period"); *Encino*, 579 U.S. at 222 (explaining that when an agency reverses course, a "reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered

[29] *See* Sagar Decl. ¶ 3(a), (f), (ff).

[30] *See id.* ¶ 3(d), (gg).

[31] *See id.* ¶ 3(hh), (ii).

by the prior policy" (citing *Fox*, 556 U.S. at 515-16)). One court has thus already held that the Rollback Rule was likely arbitrary and capricious given HHS's failure to "'adequately consider the effect of' a blanket religious exemption on the ability for individuals to access care on a prompt and nondiscriminatory basis." *Whitman-Walker Clinic, Inc.*, 485 F. Supp. 3d at 43-47.

3. This Court Should Vacate The Rollback Rule's Interpretation Of "Health Program Or Entity" And Enjoin Defendants From Enforcing Section 1557 Pursuant To This Interpretation.

The Rollback Rule's interpretation of the phrase "health program or activity" is impermissibly restrictive and should be enjoined for at least three reasons. First, the Rule expressly excludes health coverage issuers and administrators as not "principally engaged in the business of providing healthcare." *See* 45 C.F.R. § 92.3(c). Second, the Rule narrows the category of covered entities to a "program or activity administered by" HHS under Title I of the ACA, not to other health programs and activities that HHS administers. *See id.* § 92.3(a)(2)). Third, the Rule walls off Section 1557's application to only specific subparts of certain covered entities. *See id.* § 92.3(b). The Rule thus severely limits the scope of Section 1557's application, departing from the statutory text and Section 1557's broad remedial intent. This Court should vacate these provisions of the Rollback Rule at *Chevron* Step One as impermissible interpretations of Section 1557, and also hold that HHS promulgated them in a manner inconsistent with the APA's protection against arbitrary and capricious agency action.

a. The Rollback Rule Improperly Exempts Health Coverage Issuers and Administrators.

The Rollback Rule interprets Section 1557 to exempt activities of health coverage issuers and administrators (other than operations that directly receive funding from HHS) from its requirements). *See* 45 C.F.R. § 92.3(c). The Rule provides that "an entity principally or otherwise engaged in the business of providing health insurance shall not, by virtue of such provision, be

considered to be principally engaged in the business of providing healthcare." *Id.* But the text of Section 1557 states the law applies to "*any* health program or activity." 42 U.S.C. § 18116 (emphasis added). The provision of health coverage is unambiguously a health program or activity, rendering this portion of the Rollback Rule contrary to the statute's plain language. *See Pritchard*, 2022 WL 17788148, at *7 (holding that "the plain language of [Section 1557] includes insurance contracts and their administration as 'health program[s] or activit[ies],'" and thus "[c]learly, application of the [Rollback] Rule is contrary to the statutory law").

Start with the text. Congress deliberately chose broad language in this provision. "Read naturally, the word 'any' has an expansive meaning, that is, 'one or some indiscriminately of whatever kind.'" *United States v. Gonzales*, 520 U.S. 1, 5 (1997) (quoting Webster's Third New Int'l Dictionary 97 (1976)). Consequently, in the absence of "any language limiting the breadth of that word," it must be read as referring to *all* of the subject that it is describing. *Id.* The statutory term "program or activity" is also generally given broad application, especially when interpreting the underlying civil rights laws that are constituent parts of Section 1557. *See, e.g.*, *Consol. Rail Corp. v. Darrone*, 465 U.S. 624, 632-34 (1984); *Bell*, 456 U.S. at 520-35. The provision of health coverage fits comfortably within those broad statutory terms. Health coverage issuers and administrators define what care plan members receive; by designing plan benefits, administering utilization management policies, creating drug formularies, and contracting with a network of providers, these entities are inextricably intertwined with medical care. The provision of health coverage is therefore a "health program or activity" encompassed by the plain text of Section 1557.

Other provisions of the ACA support this reading of the statute. Indeed, in the phrase directly following "any health program or activity," Congress specifically identified "contracts of insurance" as one of the types of federal financial assistance that might bring an entity within the

scope of the statute. 42 U.S.C. § 18116(a). The hallmark provisions of the ACA reset longstanding health insurance practices that, until the passage of the ACA, amounted to permissible discrimination. *See, e.g.*, 42 U.S.C. §§ 300gg-3 ("Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status"); 300gg(a) ("Prohibiting Discriminatory Premium Rates"); 300gg-4 ("Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status"); 18116 ("Nondiscrimination"). Against this clear legislative purpose, Congress did not silently exclude health coverage issuers and administrators from the statute's general nondiscrimination provision.

For these reasons, HHS's declaration that health insurers are not a "program or activity" under Section 1557 and not subject to Section 1557's nondiscrimination prohibitions because they are not "principally engaged in the business of providing healthcare" is untenable. To support its new interpretation, HHS contends that providing "health insurance" is different than providing "healthcare" and points to the definitions of "healthcare" and "health insurance" in unrelated statutes to support its distinction. *See* 85 Fed. Reg. at 37,172-73. But Section 1557 does not, by its terms, apply only to "health care." Rather, Section 1557 plainly covers all "health programs and activities," in addition to direct health care. *Cf. Doe v. Mercy Catholic Med. Ctr.*, 850 F.3d 545, 553-54 (3d Cir. 2017) (rejecting argument that "education programs or activities" should be read to apply to "educational institutions" only). And health coverage clearly is a health-related program or activity. It is what enables the vast majority of Americans to access health care.

Moreover, the statutory support used in the Rollback Rule to distinguish health coverage does not move the needle. Take, for example, 5 U.S.C. § 5371, which concerns pay rates and personnel practices for federal employees. That statute uses the term "health care" simply to describe a category of federal employees who work in that sector. *See id.* ("For the purposes of

this section, 'health care' means direct patient-care services or services incident to direct patient-care services."). The second example is drawn from a subchapter of the Social Security Act that deals with administrative data standards. *See* 45 C.F.R., Subchapter C. Transposing these definitions into a health coverage statute with a broad remedial purpose makes no sense. *See Singh*, 386 F.3d at 1233 n.8 ("The same or similar words may have different meanings when used in different statutes motivated by different legislative purposes.").

Even if Section 1557's reference to "any health program or activity" could somehow be limited to "health care," that limitation would not exclude health insurance. To the contrary, other parts of the ACA define "health care" to include "health insurance," and vice versa. *See, e.g.*, 42 U.S.C. § 18113(b) (defining "the *term 'health care entity'* [to] *include[ ] . . . a health insurance plan*") (emphasis added); 42 U.S.C. § 300gg-91(b)(1) ("[t]he term '*health insurance coverage' means benefits consisting of medical care*") (emphasis added). 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. *See, e.g.*, *Dorer v. Quest Diagnostics Inc.*, 20 F. Supp. 2d 898, 900 (D. Md. 1998) (holding a laboratory which provided clinical diagnostic testing and received Medicare and Medicaid was principally engaged in providing health care); *Zamora-Quezada v. HealthTexas Med. Grp. of San Antonio*, 34 F. Supp. 2d 433, 444 (W.D. Tex. 1998) (explaining that a health care delivery system was fueled by the financial arrangements of an insurance company, and thus the insurance company controlled the delivery of health care and caused the discrimination patients experienced).

b. The Rollback Rule Improperly Exempts Certain Programs And Activities That HHS Administers, Including The Indian Health Service.

HHS also attempts to limit Section 1557's nondiscrimination protections to only those health programs or activities of HHS that are administered under Title I of the ACA, not to other

health programs and activities that HHS administers. *See* 85 Fed. Reg. at 37,244 (codified at 45 C.F.R. § 92.3(a)(2)). In the Rollback Rule, HHS asserts that the text of the statute compelled this interpretation because Congress had included a limitation in the text—"under this title"—meaning Title I programs and activities. *See* 85 Fed. Reg. at 37,170. The consequence of HHS's interpretation is that many HHS health programs and activities are purportedly no longer subject to Section 1557's anti-discrimination requirements.

HHS's interpretation, however, is inconsistent with the plain language of the statute, which states Section 1557 applies to "any program or activity that is administered by an Executive Agency *or* any entity established under this title." 42 U.S.C. § 18116(a) (emphasis added). HHS reads the word "or" out of the statute, and it reads "under this title" into the preceding phrase "any program or activity that is administered by an Executive Agency." 87 Fed. Reg. 47,829; *id.* at 47,838. But this Court must apply "traditional tools of statutory construction" in determining Congress's intent, *Chevron*, 467 U.S. at 843 n.9, and it is a "settled rule that [courts] must, if possible, construe a statute to give every word some operative effect," *Cooper Indus., Inc. v. Aviall Servs., Inc.*, 543 U.S. 157, 167 (2004); *see also United States v. Ven–Fuel, Inc.*, 758 F.2d 741, 751-52 (1st Cir. 1985) ("All words and provisions of statutes are intended to have meaning and are to be given effect, and no construction should be adopted which would render statutory words or phrases meaningless, redundant or superfluous."). The word "or" is clearly doing some work here. "[I]ts ordinary use is almost always disjunctive, that is, the words it connects are to 'be given separate meanings.'" *United States v. Woods*, 571 U.S. 31, 45 (2013) (quoting *Reiter v. Sonotone Corp.*, 442 U.S. 330, 339 (1979)). Moreover, if "under this title" applied to "Executive Agency," there would have been no need for the statute to reference programs administered by Executive agencies; the two phrases would be redundant. The only reading of the statute that gives effect to

each of the words in the statute is a reading that acknowledges HHS's health programs and activities are covered.

HHS's reading is also inconsistent with the purpose of the statute and other ordinary canons of statutory construction. Again, the purpose of the ACA is to increase health access and coverage, not narrow it. *See, e.g.*, *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 538-39. Two canons of statutory construction buttress this view. First, civil rights laws like Section 1557 enjoy liberal construction so that the beneficiaries protected by those laws realize the fullest benefit possible. *See, e.g.*, *Hogar Agua y Vida en el Desierto, Inc. v. Suarez-Medina*, 36 F.3d 177, 182 (1st Cir. 1994). Second, Section 1557 is a civil rights law embedded in a broader remedial statute—the Affordable Care Act. Courts should give language in remedial statutes "a generous construction consistent with its reformative mission" so long as the results are not unreasonable. *See Johnson v. Koplovsky Foods, Inc.*, 5 F. Supp. 2d 48, 54 (D. Mass. 1998) (citation omitted). According to this liberal construction, and viewing Section 1557 in context of the larger ACA statutory scheme as this Court must do, *King*, 576 U.S. at 486, it is clear that Section 1557 should be read broadly. Yet HHS's unreasonable interpretation would do the opposite and result in numerous HHS health programs and activities being excluded from Section 1557's scope.

c. The Rollback Rule Improperly Excludes From Section 1557's Scope Any Part Of A Health Program Or Activity Not Principally Engaged In Providing Health Care, Unless That Particular Part Receives Federal Financial Assistance.

The Rollback Rule defines the term "health program or activity" to mean different things depending on whether the entity in question is deemed to be principally engaged in the business of providing health care. *See* 45 C.F.R. § 92.3(b). Where an entity is deemed "principally engaged in the business of providing healthcare," and any part of that entity "receive[s] Federal financial assistance," HHS concedes that the term "'health program or activity' encompasses all of the

operations of [that] entit[y]." *Id.* However, "[f]or any entity *not* principally engaged in the business of providing healthcare," HHS has interpreted Section 1557 so that "the requirements applicable to a 'health program or activity' under this part shall apply to such entity's operations *only to the extent* any such operation receives Federal financial assistance." *Id*. (emphases added).

The statute prohibits this reading. Section 1557 applies to "any health program or activity, *any part of which* is receiving Federal financial assistance." 42 U.S.C. § 18116(a) (emphasis added). 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 it, and that Federal financial assistance need touch only a "part" of the covered entity for Section 1557's duties to attach to the whole. *Id.* (emphasis added). Under the only reading of the statute that is consistent with the text, universities, school districts, and state and local governments need not be principally engaged in health care for the health programs and activities that they operate (for example, the health plans they sponsor) to be subject to Section 1557, even if those particular health programs don't receive federal funding. Similarly, even if health coverage were not a health program or activity, *but see supra* pp. 34-37, health insurers who sponsor non-insurance-related health programs that receive federal funding would still be bound by Section 1557.

Unable to rely on the text of Section 1557 itself, HHS attempts to justify the provision by pointing to the Civil Rights Restoration Act of 1987 ("CRRA"). According to HHS, the CRRA defined "program or activity" under Title IX and other laws 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 Pub. L. 100-259, 102 Stat. 28 (Mar. 22, 1988)). HHS therefore claims that limiting the application of Section 1557 to the particular operations that receive Federal financial assistance of health programs or activities not engaged in providing health care "more clearly and

consistently applies the CRRA's limitations." 85 Fed. Reg. at 37,172. HHS is wrong.

As an initial matter, HHS's reading subverts the entire point of the CRRA. Congress enacted the CRRA to supersede *Grove City College v. Bell*, 465 U.S. 555, 570-74 (1984), where the Supreme Court limited Title IX's coverage only to the particular "program or activity" within a private college that received federal funding, not to the entire educational institution. *See Cohen v. Brown Univ.*, 991 F.2d 888, 894 (1st Cir. 1993). HHS's distorted application of the CRRA to Section 1557 in effect resurrects *Grove City*, as if it were never abrogated by statute. Setting *Grove City* aside, HHS's reading of the CRRA doesn't make sense on its own terms because HHS overlooks key portions of the CRRA's definition. The CRRA defines "program or activity," to "mean all of the operations of" several types of entities—*regardless* of whether those entities are "principally engaged in the business of providing education, health care, housing, social services, or parks and recreation"—if "any part of" the entity "is extended Federal financial assistance." 20 U.S.C. § 1687(1)-(4). Yet in promulgating regulations to define "program or activity" in Section 1557, HHS imported only the part of the CRRA's definition that describes a "corporation, partnership, or other private organization, or an entire sole proprietorship," *see id.* § 1687(3), without the remaining parts of the CRRA's definition of "program or activity," *id.* § 1687(1)-(2), (4). Given that the rest of the CRRA requires an entire entity to comply with anti-discrimination laws if *any part* receives Federal financial assistance, HHS is wrong to suggest that its narrow reading represents a "return to the CRRA's statutory text." 84 Fed. Reg. at 27,862.

Finally, HHS argues it can limit application of Section 1557 to particular operations of a health program or activity that receive Federal financial assistance because that limitation "advances its goal of reducing regulatory burdens" in furtherance of Executive Order 13765. 85 Fed. Reg. at 37,172. The Executive Order that HHS references provides that "to the maximum

extent permitted by law", the Secretary of HHS and others with responsibilities under the ACA shall take actions to minimize the economic regulatory burdens imposed by the Act. *See* Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal, Exec. Order No. 13,765, 82 Fed. Reg. 8,351 (Jan. 20, 2017). But, for all the reasons cited above, HHS's interpretation of the statute is not permitted by law. HHS thus cannot rely on Executive Order 13765 to support its unduly limited reading of Section 1557.

B. In The Alternative, This Court Should Vacate The Rollback Rule In Its Entirety.

Three other errors "permeated the entire rulemaking process" such that this Court should vacate the Rollback Rule in its entirety. *Pub. Citizen*, 374 F.3d at 1217. First, bad-faith anti-LGBTQ+ bias motivated the Rollback Rule, making it ultimately arbitrary and capricious in violation of the APA .[32] Second, in promulgating the Rollback Rule, HHS failed to consider an important aspect of the problem: the likely risk of discrimination against LGBTQ+ persons, women, and pregnant people in accessing health care and resulting harm to patient health. Third, the Rollback Rule fails to comply with the requirements of reasoned decision making in weighing costs and benefits. These errors supply an independent basis for vacatur of the provisions outlined above, as well as all other provisions of the Rollback Rule.

1. This Court Should Vacate The Rollback Rule Because It Was Motivated By Impermissible Bias.

a. HHS's Bad Faith In Promulgating The Rule Violates The APA.

Under the APA, "[p]roof of subjective bad faith by [decision-makers], depriving a [petitioner] of fair and honest consideration of its proposal, generally constitutes arbitrary and capricious action." *Tummino*, 603 F. Supp. 2d at 542 (collecting cases).

[32] HHS's bad faith in promulgating the rule also violates the Equal Protection Clause. Plaintiffs reserve the right to later engage in discovery and move on summary judgment with respect to the constitutional claims.

Tummino is instructive. There, the court cited improper political influence as the basis for invalidating as arbitrary and capricious the Food and Drug Administration's (FDA) decision to impose a minimum age requirement for obtaining an emergency contraceptive over the counter. *See id.* at 544-47. The court found that FDA lacked good faith in its decision based on "repeated and unreasonable delays," "pressure emanating from the White House," and "significant departures from the FDA's normal procedures and policies." *Id.* at 544. The White House had pressured the FDA, citing concerns over "unhappy constituents," and the FDA rejected its own internal scientific recommendation that no such age restriction was needed, instead invoking "fanciful and wholly unsubstantiated 'enforcement concerns.'" *Id.* at 546-47.

For three reasons, the same result should obtain here. *First*, like *Tummino*, there was "improper political influence" on HHS's decision-making such that it was "influenced by factors not relevant under the controlling statute." 603 F. Supp. 2d at 544; *see also, e.g.*, *Latecoere Int'l, Inc. v. U.S. Dep't. of Navy*, 19 F.3d 1342,1354-58 (11th Cir. 1994) (finding agency action arbitrary when motivated by bias against a foreign company); *D.C. Fed. of Civic Assocs. v. Volpe*, 459 F.2d 1231, 1245-46 (D.C. Cir. 1972) (finding agency action arbitrary when political pressures motivated the agency to disregard statutory factors).

The Rollback Rule itself evinces animus toward, and reliance on negative stereotypes about, transgender people and their health care. *E.g.*, 85 Fed. Reg. at 37,187 (claiming, counter to fact, that "the medical community is divided on many issues related to gender identity, including the value of various 'gender affirming' treatments for gender dysphoria (especially for minors), the relative importance of care based on the patient's sex, and the compatibility of gynecological practice with a requirement of nondiscrimination on the basis of gender identity"). Throughout the Preamble, HHS makes clear its reason for removing "gender identity" from the definition of sex

was to enforce a "biological binary of male and female," thereby excluding transgender, nonbinary, and intersex people from protection. *See, e.g.*, *id.* at 37,178.

This animus echoes statements that were made by the political officials who crafted the rule. Former OCR Director Roger Severino also made numerous public statements expressing animus toward LGBTQI+ people before and after he took office. *See Dep't of Com.*, 139 S. Ct. at 2573-74 (holding that courts considering whether agency action is arbitrary and capricious may inquire into "the mental processes of administrative decisionmakers" upon a "strong showing of bad faith or improper behavior" (citation omitted)). Severino argued that transgender people "us[e] government power to coerce everyone, including children, into pledging allegiance to a radical new gender ideology,"[33] that a transgender boy wanting to use the boys' restrooms at school was "a gender-dysphoric teen girl . . . [who] sued her school district to get full access to the boys' bathrooms,"[34] and that transgender military personnel serving openly "dishonors the[ ] sacrifice[ ]" of veterans.[35] He published several articles expressing opposition to same-sex marriage and denying the existence of sexual orientation discrimination.[36] While serving as Director, Severino labeled claims of discrimination against transgender people as "hypothetical" and "not yet seen out in the world."[37] Under his leadership, HHS ceased gathering information about transgender

[33] Roger Severino, *DOJ's Lawsuit Against North Carolina Is Abuse of Power*, The Daily Signal (May 9, 2016) https://perma.cc/3FFM-KFMB.

[34] Jim DeMint & Roger Severino, *Commentary: Court Should Reject Obama's Radical Social Experiment* (Nov. 7, 2016), https://www.inquirer.com/philly/opinion/20161107_Commentary__Court_should_reject_Obama_s_radical_social_experiment.html.

[35] Roger Severino, *Pentagon's Radical New Transgender Policy Defies Common Sense*, CNSNews (July 1, 2016), https://perma.cc/VK37-5FP7.

[36] *E.g.*, Roger Severino, *Filibusted: Missouri Democrats Fail to Block Religious Liberty Bill Concerning Same-Sex Marriage*, The Daily Signal (Mar. 9, 2016), https://perma.cc/KA2U-NPHS.

[37] Sandhya Raman, *Trump Administration Swayed by Conservative Think Tank on Abortion, LGBT Decisions, Group Says*, Roll Call (Apr. 25, 2019), https://bit.ly/31R9YLJ.

people in its surveys[38] and removed references to LGBTQI+ issues in its strategic plans.[39]

Severino's animus clearly infected the agency's rulemaking process because the evidence before the agency does not support the rule it promulgated. *Tummino*, 603 F. Supp. 2d at 542; *Latecoere Int'l, Inc.*, 19 F.3d at 1365. HHS issued the Rollback Rule despite ample record evidence from major medical organizations and health care professionals describing the standard of care for transgender people, *see* Sagar Decl. ¶ 3(a), (aa), (cc), (mm), (ll), (nn), (hh), (oo), (qq), (rr), (ss), (tt), (uu), (bbb), (eee); numerous accounts from transgender people about their experiences of discrimination in health care settings, and data demonstrating the high rates of such discrimination.[40] The Preamble's insistence on enforcing a "biological binary of male and female" ignored medical consensus that sex is made up of numerous traits, including gender identity, and that physical sex characteristics often do not fall on a binary scale.[41] Instead, the Preamble relied on debunked ideas about the negative effects of hormones, prevalence of regret, and efficacy of "less drastic" interventions to conclude that there is "a lack of scientific and medical consensus" about the efficacy of gender affirming care. Fed. Reg. 85 at 37,187; 37,197. This deeply flawed reasoning suggests that HHS's stated reasons are not, in fact, those that actually motivated the agency's decision. *See, e.g.*, *Dep't of Com.*, 139 S. Ct. at 2575 (affirming remand of rule where

[38] Sejal Singh et al., *The Trump Administration Is Rolling Back Data Collection on LGBT Older Adults*, Ctr. for Am. Progress (Mar. 20, 2017), https://ampr.gs/3iA7reN.

[39]Dan Diamond, *Trump Policy Shop Filters Facts to Fit His Message*, Politico (July 28, 2018), https://politi.co/3fcJokc. The Rollback Rule was part of a larger campaign by the previous presidential administration against the LGBTQI+ community. These changes were both large and small: Among the first actions of the Trump presidency were to target LGBTQI+ people through withdrawals of administrative protections in education, employment, housing, the census, the military, in custody, and seeking asylum. *See*, *e.g.*, Am. Compl. ¶¶ 367-76. The administration also scrubbed all mentions of LGBTQI+ people from the websites of the White House, Department of State, and Department of Labor on its fifth day in office. Emily O'Hara, *Trump Administration Removes LGBTQ Content From Federal Websites*, NBC News (Jan. 24, 2017), https://nbcnews.to/31SgD8g.

[40]Sagar Decl. ¶ 3(c), (f), (h), (i), (j), (k), (l), (m), (n), (p), (q), (r), (t), (u), (v), (w), (x), (y), (z), (aa), (dd), (ee), (jj), (vv), (ww), (xx), (yy), (zz), (aaa).

[41]Sagar Decl. ¶ 3(o), (vv).

the "the evidence tells a story that does not match the explanation the Secretary gave for his decision"); *Latecoere Int'l, Inc.*, 19 F.3d at 1364 (agency's action was arbitrary where there was "strong evidence" that its decision was "irrational and resulted from prejudicial violations").

Second, HHS's decisional process represents a "significant departure[] from the [agency's] normal procedures and policies." *Tummino*, 603 F. Supp. 2d at 544; *see also id*. at 547. HHS posted the final Rollback Rule on June 12, 2020, three days before the Supreme Court issued its decision in *Bostock*. The Rollback Rule was then published in the federal register on June 19, 2020, only with "minor and primarily technical corrections," 85 Fed. Reg. 37,160, failing to amend Preamble language inconsistent with *Bostock*. These "procedural irregularities," *Tummino*, 603 F. Supp. 2d at 544, and the "timing of the decision," *id.* at 547, suggest that HHS acted in bad faith.

Third, HHS invoked only "fanciful and wholly unsubstantiated . . . 'concerns,'" in support of its adoption of the new positions in the Rollback Rule. *Id.* at 546; s*ee also, e.g.*, *New York*, 414 F. Supp. 3d at 541 (holding another OCR rule arbitrary and capricious where the central factual claim of a "significant increase" of complaints of violations of federal refusal of care statutes was "flatly untrue"). HHS largely relied on *Franciscan Alliance* to support its reversals but ignored the substantial body of caselaw holding that categorical gender-affirming care exclusions amount to unlawful sex discrimination,[42] asserting without support that those cases have "caused confusion." 85 Fed. Reg. at 37,180.[43]

This case is on all fours with *Tummino* and the decisions on which it relies. There can be

[42] *See, e.g.*, *Kadel v. Folwell*, 446 F. Supp. 3d 1, 17 (M.D.N.C. 2020), *aff'd sub nom. Kadel v. N.C. State Health Plan for Tchrs. & State Emps.*, 12 F.4th 422 (4th Cir. 2021), *as amended* (Dec. 2, 2021); *Lange v. Houston Cnty.*, 608 F. Supp. 3d 1340, 1358-60 (M.D. Ga. 2022); *C.P. v. Blue Cross Blue Shield of Ill.*, 3:20-CV-06145-RJB, 2022 WL 17788148, at *6 (W.D. Wash. Dec. 19, 2022).

[43] The Rollback Rule also takes the position that misgendering transgender people is not sex discrimination. 85 Fed. Reg. at 37,185. It does so in the face of numerous accounts of harassment related to misgendering, data that misgendering leads to negative health consequences, and consensus by medical professionals that gendering people

no question that animus was at least a motivating factor behind Defendants' actions. HHS promulgated the rule as part of the Trump administration's anti-transgender political agenda, lacked scientific justification, and failed to provide a substantive response to commenters who raised these issues. The promulgation of the Rollback Rule was a product of "bad faith by [agency decision-makers]"—driven by impermissible animus. *Tummino*, 603 F. Supp. 2d at 542. As in *Tummino*, HHS's Rollback Rule is arbitrary and capricious under the APA.

b. At A Minimum, HHS Failed To Consider An Important Aspect Of The Problem: The Risk Of Discrimination Against LGBTQI+ Persons, Women, and Pregnant People In Accessing Health Care.

In the 2016 Rule, HHS explicitly acknowledged the seriousness of continuing discrimination against LGBTQI+ individuals and women in accessing health care, including pregnancy-related care, and the disparities that such discrimination causes. 81 Fed. Reg. at 31,460 ("[D]espite the ACA improving access to health services and health insurance, many women and transgender individuals continue to experience discrimination in the health care context . . . ."). HHS pointed to research finding that a quarter of the transgender individuals studied reported "being harassed in health care settings and postponing medical care because of discrimination by providers" and another finding that 26.7% of the transgender people surveyed reported that a health care provider had refused to see them because of their actual or perceived sexual orientation in the year prior. *Id.* (internal quotation marks and alterations omitted). HHS also acknowledged the

correctly is the standard of care. *See* Sagar Decl. ¶ 3(p), (q). HHS also persistently and gratuitously misgenders transgender people throughout the Preamble. *See, e.g.*, 85 Fed. Reg. at 37,180 & n.90-91 ("[Aimee] Stephens 'quite obviously' is not 'a woman' because 'Stephens's sex' is male"); *id.* at 37,189 (referring to a hypothetical "transgender patient [who] self-identifies as male" as "her"); *id.* (referring to a pregnant transgender man as "her" and "in fact a . . .woman"); *id.* at 37,191 (referring to the decedent in *Prescott v. Rady Children's Hospital*, who died by suicide following severe mistreatment because of his transgender status, as "her"—despite quoting the court opinion correctly referring to him as a boy). The Rollback Rule further permits denying reproductive health care to people just because they are transgender. *Id.* at 37,185 (claiming it does not violate Section 1557 to "limit[] access to lactation rooms and gynecological practices to female users and patients," after defining "female" based on sex assigned at birth).

crucial role of the ACA in preventing discrimination against women and other people capable of pregnancy in health care and coverage, noting that historically, women paid more for coverage that often excluded preventive services and obstetric and gynecological care. *Id.* HHS recognized that individuals subject to discrimination are "denied opportunities to obtain health care services provided to others, with resulting adverse effects on their health status." 81 Fed. Reg. at 31,444.

While *Whitman-Walker* acknowledged that the Rollback Rule cited "scientific studies, government reviews, and comments[,]" 485 F. Supp. 3d at 47, the Rule does nothing to refute the findings of the 2016 Rule—much less provides facts, studies, or data to support the provisions that are at issue in this case. Indeed, the Rollback Rule fails to acknowledge the over 150,000 comments received by HHS, many of which addressed discrimination against LGBTQI+ people, women, pregnant people. These comments noted that repealing the 2016 Rule's protections would invite covered health care providers and insurers to discriminate against transgender people, pregnant people, and people who have previously had an abortion; cause confusion about patients' rights; lead to coverage exclusions; and exacerbate people's fear of discrimination, substandard care, denials of care, and coercion, including during emergencies. 85 Fed. Reg. at 37,164-65, 37,170–74.[44] All of this, commenters explained, would result in worse health outcomes and exacerbate existing crisis-level racial disparities in the rates of pregnancy-related mortality.[45]

HHS apparently ignored the multitude of concerns that major medical organizations, patient advocacy organizations, and individuals raised. Where, as here, an agency fails "to consider an important aspect of the problem," it is "one of the hallmarks of arbitrary and capricious" agency action. *Util. Solid Waste Activities Grp. v. EPA*, 901 F.3d 414, 430 (D.C. Cir. 2018). This failure

[44] *See supra* Factual Background; Sagar Decl. ¶ 3(hh), (ii), (ll).

[45] *See* Sagar Decl. ¶ 3(ll), (bbb), (eee).

permeated the entire rulemaking process, rendering the Rollback Rule arbitrary and capricious.

2. This Court Should Vacate The Rollback Rule In Its Entirety Because HHS Failed to Conduct an Adequate Regulatory Impact Analysis.

"As a general rule, the costs of an agency's action are a relevant factor that the agency must consider before deciding whether to act," and "consideration of costs is an essential component of reasoned decisionmaking under the Administrative Procedure Act." *Mingo Logan Coal Co. v. EPA*, 829 F.3d 710, 732-33 (D.C. Cir. 2016) (Kavanaugh, J., dissenting). In promulgating the Final Rule, HHS conducted an economic and regulatory impact analysis as required by "Executive Order 12866 on Regulatory Planning and Review" and "Executive Order 13563 on Improving Regulation and Regulatory Review," 85 Fed. Reg. at 37,222, and relied on that analysis in promulgating the Final Rule. *see id.* at 37,224. "When an agency decides to rely on a cost-benefit analysis as part of its rulemaking, a serious flaw undermining that analysis can render the rule unreasonable." *Nat'l Ass'n of Home Builders v. E.P.A.*, 682 F.3d 1032, 1039-40 (D.C. Cir. 2012) (reviewing Executive Order 12866 cost-benefit analysis under arbitrary and capricious standard).

The Rollback Rule disregards costs to patients, misrepresents costs to the health care industry, and fails to account for costs transferred to the States. Meanwhile, the only quantifiable benefit provided as justification—"approximately $2.9 billion in cost savings"—allegedly comes from "repealing . . . provisions related to mandatory notices." *See* 85 Fed. Reg. at 37,162. These repealed notice provisions are entirely disjointed from the swath of other regulatory changes challenged here and cannot support a "reasoned determination that [the Rule's] benefits justify its costs." Exec. Order No. 13563 § 1(b). A cost-benefit analysis is, by definition, an exercise in considering both "side[s] of the equation." *California v. BLM*, 277 F. Supp. 3d 1106, 1123 (N.D. Cal. 2017). An agency may not "put a thumb on the scale" by undervaluing key effects while overvaluing others. *Ctr. for Bio. Diversity v. Nat'l Highway Traffic Safety Admin.*, 538 F.3d 1172,

1198 (9th Cir. 2008). But the Rule squarely ignores *all* negative effects on vulnerable populations.

As commenters predicted, the Rollback Rule has reduced access to care for LGBTQ people, women, and pregnant people. *See supra* Factual Background & Part B. Remarkably, HHS *acknowledged* that some covered entities would revert to discriminatory policies and practices. 85 Fed. Reg. at 37,225. But it simply concluded that it was "uncertain as to the total number of covered entities that will change their policies," and that it lacked "the data necessary to estimate" the harm, including the "greater public health costs, cost-shifting, and expenses" from the Rule. *Id.*

That is so despite several comments that proposed quantitative models to estimate cost. For example, one comment suggested a model estimating that solely with respect to four types of cancer, the Rule would produce $1.4 billion in excess costs over ten years, an 18% increase in preventable mortality among LGBTQ people, and $39 billion to the U.S economy, citing survey data showing that LGBTQ individuals forgo care due to discrimination. *Id.* at 37,238. HHS acknowledges this and other models but dismissively concludes that it lacked "reliable data or methods to calculate the economic impacts." *Id.* That is the *opposite* of the analysis that is required of HHS. Even when "some important benefits and costs . . . may be difficult or impossible to quantify or monetize given current data and methods," agencies must still carefully evaluate non-quantifiable and non-monetized benefits and costs. Office of Mgmt. & Budget, Circular A-4 on Regulatory Analysis (2003). The "mere fact" that the effect "is uncertain is no justification for disregarding the effect entirely." *Pub. Citizen*, 374 F.3d at 1219.

CONCLUSION

For these reasons, this Court should grant Plaintiffs' Motion and vacate the Rollback Rule.

Dated: March 19, 2024

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on March 19, 2024, a copy of the foregoing was filed and served via ECF on all counsel of record.

/s/ Gregory F. Noonan
Gregory F. Noonan

EXHIBIT A

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; Indigenous Women Rising; NO/AIDS Task Force (d/b/a CrescentCare); and Transgender Emergency Fund of Massachusetts,

Plaintiffs,

v.

United States Department of Health and Human Services; Alex M. Azar II, *in his official capacity as secretary of the U.S. Department of Health and Human Services*; Roger Severino, *in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services*; and Seema Verma, *in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*,

Defendants.

Civil Action No. 1:20-cv-11297

DECLARATION OF TONY HOANG, EXECUTIVE DIRECTOR, EQUALITY CALIFORNIA

I, Tony Hoang, declare as follows:

1. I am the current Executive Director of Equality California, the nation's largest statewide lesbian, gay, bisexual, transgender, and queer plus (LGBTQ+) civil rights organization.

I have served as the Executive Director since 2021. I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. Equality California is a nonprofit organization with over 900,000 members that advocates locally, statewide, and nationally on behalf of LGBTQ+ individuals and other marginalized groups to which LGBTQ+ people belong.

3. Originally founded in 1999 as the California Alliance for Pride and Equality (CAPE), we became Equality California in 2003 and then merged with Marriage Equality California in 2004. This year Equality California will celebrate 25 years of fighting for LGBTQ+ civil rights and social justice.

4. The mission of Equality California is to bring the voices of LGBTQ+ people and allies to institutions of power in California and across the United States, striving to create a world that is healthy, just, and fully equal for all LGBTQ+ people. We advance civil rights and social justice by inspiring, advocating, and mobilizing through an inclusive movement that works tirelessly on behalf of those we serve. Equality California believes that a core part of our mission is advocating for access to quality, affordable health care. We accomplish this through a wide variety of education, mobilization, and advocacy programs.

5. As my predecessor explained in our prior declaration, Equality California has run a variety of programs to advance the health care of LGBTQ+ people in California and nationwide over the years. For example, through the *Health Happens with Equality* program, Equality California trained over 2,800 health care providers and health clinic staff across California, Nevada, and Arizona, empowering them to provide culturally competent quality care to LGBTQ+ patients. The curriculum included educational context about basic LGBTQ+ terminology, data on health disparities that affect the LGBTQ+ community, what it means to be LGBTQ+, HIV/AIDS,

Pre-Exposure Prophylaxis (PrEP), transgender health issues, and how to create a welcoming environment as a health care provider. Through the *Take It: I'm PrEP'd* campaign, Equality California works to educate the LGBTQ+ community and health care providers on the availability and benefits of PrEP and other forms of HIV treatment and prevention. And through our Health Resource Center, we provide information about Mpox (formerly Monkeypox) to help our members make informed choices and protect their health. In addition, our *OUT Against Big Tabacco program*, Equality California fights against big tobacco companies that have specifically targeted the LGBTQ+ community. This program focuses on promoting health equity and reducing tobacco-related health consequences through education and local policy ordinance reforms.

6. Our efforts to promote LGBTQ+ health have grown over the past few years as we have formed new partnerships with state agencies and grass-roots organizations. For example, starting in 2023 we partnered with the California Department of Health on the *Healthcare Access and Community Outreach Program*. Through that program we will provide technical support and oversight for subcontractor projects across the state that seek to address well-documented but largely unaddressed health inequities in the LGBTQ+ community, continuing the work we began with the *Health Happens with Equality* program. We will work to identify grassroots organizations that are deeply embedded in the communities they serve and that are proposing to launch or expand programs to increase access to health services and education for LBTQ+ Californians. We also work with partners to address harms to our members stemming from the COVID-19 pandemic. Starting in 2020, when the COVID-19 pandemic hit, Equality California launched the COVID-19 LGBTQ+ Health Center and Helpline to connect LGBTQ+ Californians with LGBTQ+ friendly resources and support services. In addition, we advocated for new emergency regulations to support the LGBTQ+ community, provided subgrants to help sustain other LGBTQ+

organizations, and developed a series of webinars on topics ranging from unemployment benefits, job applications, health care, and more.

7. Equality California's membership has nearly doubled since we last submitted a declaration—growing from 500,000 members in 2020 to more than 900,000 today. While most of our members reside in California, we also have members throughout the nation. Equality California's members include individuals who have contributed to the organization financially and those who have otherwise supported or participated in Equality California's education, mobilization, and advocacy work. Equality California regularly conducts surveys, holds town hall meetings, and hosts conferences to understand the needs of the broader LGBTQ+ community, including members of Equality California. Through their participation in such surveys, town hall meetings, and conferences, Equality California's members help inform and shape the mission and direction of Equality California and the organization's programs.

The Rollback Rule's Harm to Equality California Members

8. The Rule "Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority," 85 Fed. Reg. 37,160 (June 19, 2020) (the "Rollback Rule") has harmed and will continue to harm Equality California's members.

9. By eliminating explicit regulatory protections that were included in the previous rule implementing Section 1557, which was promulgated in May 2016 ("2016 Final Rule"), and importing new exemptions into Section 1557, the Rollback Rule has invited and emboldened health care entities to discriminate against Equality California members who identify as LGBTQ+, including those who have obtained or are seeking reproductive health care. In addition, by [permitting the] misgendering [of] transgender individuals, the Rollback Rule has fostered stigma and bias toward transgender people, harmed their status within the broader community, caused

them fear and trepidation in medical settings, and compromised their ability to receive equitable health care. The Rollback Rule has sent a message to all our members that they do not have a right to equal access to health care. This is particularly the case since HHS announced in the Rollback Rule that it will no longer enforce the full scope of Section 1557's prohibitions against sex discrimination.

10. As we described in the previous declaration, the Rule has caused our members to experience credible fear at the idea of seeking health care. As a result, our members are less likely to seek out the care they need despite the fact that delaying needed care leads to long term negative health effects.[1] The fear our members experience is well-founded—discrimination and violence against LGBTQ+ individuals in medical settings is far too prevalent.[2] Many transgender and gender nonconforming people already forgo health care due to fear of discrimination,[3] and some of our members avoid going to the doctor, receiving necessary treatments, or even sharing their gender identity, sexual orientation, pregnancy status, or reproductive health histories with their doctor or other health care provider out of fear of discrimination. In the years since the Rollback Rule was enacted, ongoing instances of discrimination against LGBTQ+ individuals have given

[1] Jennifer M. Taber et al., *Why do People Avoid Medical Care? A Qualitative Study Using National Data*, 30 J. GEN. INTERNAL MED. 290 (2015), https://link.springer.com/article/10.1007/s11606-014-3089-1#citeas (noting that "[a]voiding medical care may result in late detection of disease, reduced survival, and potentially preventable human suffering").

[2] For example, a survey by the Center for American Progress found that in 2020 alone, nearly 1 in 2 transgender individuals "reported experiencing mistreatment at the hands of a provider . . . including care refusal as well as verbal or physical abuse" and that 28% "reported postponing or not receiving necessary medical care . . . for fear of experiencing discrimination." Caroline Medina et al., *Protecting and Advancing Health Care for Transgender Adult Communities*, CTR. FOR AM. PROGRESS 16 (Aug. 2021), https://www.americanprogress.org/wp-content/uploads/sites/2/2021/08/Advancing-Health-Care-For-Transgender-Adults.pdf; *see also Minton v. Dignity Health*, 252 Cal. Rptr. 3d 616 (Cal. Ct. App. 2019) (hospital refused to perform hysterectomy that patient's physician determined was medically necessary to treat gender dysphoria).

[3] *See* Medina, *supra* note 2, at 17; Sandy E. James et al., *Early Insights: A Report of the 2022 U.S. Transgender Survey*, NAT'L CTR. FOR TRANSGENDER EQUAL. 16 (Feb. 2024), https://transequality.org/sites/default/files/2024-02/2022%20USTS%20Early%20Insights%20Report_FINAL.pdf (finding that "[n]early one-quarter of respondents (24%) did not see a doctor when they needed to in the last 12 months due to fear of mistreatment").

further credence to our members' fears.[4] In fact, legal claims have been brought against hospitals for exactly the type of discrimination our members feared; hospitals, emboldened by the Rollback Rule, have refused to provide medically needed care to transgender patients.[5]

11. These credible fears have been heightened in the past few years for our members who live or travel outside of California. The Rollback Rule—combined with a rash of recent legislation enacted across the country—has subjected our members to a new and increased threat of discrimination by health providers on the basis of their sex. Since we filed our previous declaration, the legal landscape across the country has become increasingly hostile to protecting LGBTQ+ health care.[6] Although the state of California protects against discrimination in health care, many of our members live or travel out of state and are harmed by these national trends.

12. As an illustration of this issue, Equality California has over 20,000 members living in the states of Texas, Nebraska, Kentucky, Kansas, Louisiana, Arizona, and Mississippi, all of which have demonstrated intent to discriminate against individuals on the basis of sex. These states filed litigation in federal court challenging the 2016 Rule in which they represented that the 2016 Rule "forced" them to provide transition and abortion care at state health care facilities, to post patient notices of non-discrimination encompassing the full scope of Section 1557's protections against sex discrimination, and to train employees not to discriminate in accordance with Section

[4] The 2020 U.S. Transgender Survey found that "of those who saw a health care provider within the last 12 months, nearly one-half (48%) reported having at least one negative experience because they were transgender, such as being refused health care, being misgendered, having a provider use harsh or abusive language when treating them, or having a provider be physically rough or abusive when treating them." James et al., *supra* note 3, at 16.

[5] *See e.g.*, *Hammons v. Univ. of Md. Med. Sys. Corp.*, 649 F. Supp. 3d 104 (D. Md. 2023) (hospital refused to perform hysterectomy to treat gender dysphoria, despite physician determination of medical necessity).

[6] *See generally Mapping Attacks on LGBTQ Rights in U.S. State Legislatures in 2024*, ACLU, https://www.aclu.org/legislative-attacks-on-lgbtq-rights-2024 (last accessed Feb. 9, 2024) (currently tracking 411 anti-LGBTQ bills across the U.S.); Annette Choi, *Record number of anti-LGBTQ bills were introduced in 2023*, CNN (Jan. 22, 2024), https://www.cnn.com/politics/anti-lgbtq-plus-state-bill-rights-dg/index.html; Caroline Medina, *Discrimination and Barriers to Well-Being: The State of the LGBTQI+ Community in 2022*, CTR. FOR AM. PROGRESS 16 (Jan. 12, 2023), https://www.americanprogress.org/article/discrimination-and-barriers-to-well-being-the-state-of-the-lgbtqi-community-in-2022/ ("In 2022 alone, state lawmakers introduced more than 300 bills targeting the rights of LGBTQI+ people.").

1557. *See Franciscan All., Inc. v. Burwell*, Brief in Support of State Plaintiffs' Renewed Motion for Summary Judgment, Docket No. 133 at 50, 7:16-cv-00108-O (N.D. Tex. Feb. 4, 2019). In the years since our prior declaration, emboldened by the Rollback Rule, these states have further demonstrated intent to discriminate against individuals based on sex by passing laws that limit the ability of youth to access gender-affirming care.[7]

13. As a result of the Rollback Rule's failure to reaffirm Section 1557's prohibitions on sex discrimination in healthcare, the Rule's purported incorporation of exemptions that would allow and embolden denials of care, and the discriminatory legal landscape that the Rollback Rule has engendered, Members of Equality California in Texas, Nebraska, Kentucky, Kansas, Louisiana, Arizona, and Mississippi, as well as in other states without robust health care anti-discrimination protections, are thus at a substantial risk of experiencing discrimination or denials of medical care, including potentially in emergency situations. If one of our members has a medical emergency in those states, a hospital could refuse to treat them because they are transgender, could misgender them when providing care, or could deny life-saving emergency abortion care. This risk of discrimination is of particular concern for minors as a slew of laws have been introduced in the past three years that seek to deny needed medical care to LGBTQ+ youth.[8] These laws empower hospitals and medical providers to act in discriminatory ways towards LGBTQ+ youth, a

[7] S.B. 14, 88th Leg., Reg. Sess. (Tex. 2023); L.B. 574, 2023 Leg., Reg. Sess. (Neb. 2023); S.B. 150, 2023 Leg., Reg. Sess. (Ky. 2023); H.B. 463, 2023 Leg., Reg. Sess. (La. 2023); S.B. 1138, 55th Leg., 2d Reg. Sess. (Ariz. 2022); S.B. 2171, 2021 Leg., Reg. Sess. (Miss. 2021).

[8] *See generally Map: Attacks on Gender Affirming Care by State*, HUMAN RIGHTS CAMPAIGN (Nov. 23, 2023), https://www.hrc.org/resources/attacks-on-gender-affirming-care-by-state-map; *Bans on Best Practice Medical Care for Transgender Youth*, MOVEMENT ADVANCEMENT PROJECT, https://www.lgbtmap.org/equality-maps/healthcare_youth_medical_care_bans (last accessed Feb. 6, 2024); Koko Nakajima & Connie Hanzhang Jin, *Bills Targeting Trans Youth are Growing More Common—and Radically Reshaping Lives*, NPR (Nov. 28, 2022), https://www.npr.org/2022/11/28/1138396067/transgender-youth-bills-trans-sports.

population that already faces serious discrimination.[9] LGBTQ+ youth are also more likely to need medical care, putting them at greater risk of discrimination, due to higher rates of unmet reproductive health care needs, mental health crises, and family violence.[10] Thus, as a consequence of the Rollback Rule, Members of Equality California who are parents of LGBTQ+ youth have experienced increased fear for the safety of their children in medical settings, and youth members face increased risk of discrimination when they seek needed care. If instead of issuing the Rollback Rule, HHS had made clear that federal law prohibits such discrimination irrespective of state law, it could have mitigated some of the harm from these egregious state-level attacks.[11] Instead, the Rollback Rule encourages and emboldens such discrimination and compounds the fear our

[9] Erin Wingo et al., *Reproductive Health Care Priorities and Barriers to Effective Care for LGBTQ People Assigned Female at Birth: A Qualitative Study*, 28 WOMEN'S HEALTH ISSUES 350, 353-54 (2018) (reporting that discrimination, ignorance, and heteronormative assumptions were barriers to receiving adequate care); Stephen T. Russell & Jessica N. Fish, *Mental Health in Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth*, 12 ANN. REV. CLINICAL PSYCHOLOGY 465, 476 (2016), https://www.annualreviews.org/doi/pdf/10.1146/annurev-clinpsy-021815-093153 (postulating that anti-LGBT state policies have a detrimental effect on LGBT mental health); Sari L. Reisner, et al., *Analysis of Reported Health Care Use by Sexual Orientation Among Youth*, JAMA NETWORK OPEN 6-7 (Oct. 29, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2785601 (reporting that sexual minority youth are more likely to have unmet health care needs).

[10] Martha J. Decker et al., *Adolescents' Perceived Barriers to Accessing Sexual and Reproductive Health Services in California: a Cross-Sectional Survey*, 21 BMC HEALTH SERVS. RSCH. 2, 5-6 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8609799/ (reporting that transgender youth are more likely than their cisgender counterparts to face barriers to sexual and reproductive health services, including provider discrimination); Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Behaviors Among High School Students—19 States and Large Urban School Districts, 2017*, 68 MORBIDITY & MORTALITY WKLY. REP. 67, 69 (2019), https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6803a3-H.pdf (reporting that the rate of suicide attempts among transgender students was more than three times that of cisgender students); Brian Thoma et al., *Disparities in Childhood Abuse Between Transgender and Cisgender Adolescents*, 148(2) PEDIATRICS 1, 6 (2021), https://publications.aap.org/pediatrics/article/148/2/e2020016907/179762/Disparities-in-Childhood-Abuse-Between-Transgender (finding that transgender adolescents had higher rates of psychological, physical, and sexual abuse than their cisgender counterparts).

[11] A number of state laws enacted in the past three years that limit access to gender affirming care have been challenged for violating Section 1557 and the Equal Protection Clause. *See Poe v. Drummond*, No. 23-CV-177-JFH-SH, 2023 WL 6516449 (N.D. Okla. Oct. 5, 2023) (challenging Oklahoma statute prohibiting gender-affirming care for minors as a violation of Section 1557 of the Affordable Care Act); *Kadel v. Folwell*, 620 F. Supp. 3d 339 (M.D.N.C. 2022) (challenging North Carolina state employee health plan for excluding coverage of gender-affirming care as a violation of Section 1557); *Brandt v. Rutledge*, 47 F4th 661 (8th Cir. 2022) (challenging Arkansas's prohibition of gender-affirming care for minors as a violation of the Equal Protection and Due Process Clauses).

members and their families experience, often causing them to delay or forgo necessary care. This, in turn, only exacerbates existing health disparities.[12]

14. As we discussed in the previous declaration, harms from the Rollback Rule to Equality California's members have been compounded by the ongoing fallout from the COVID-19 pandemic, which has disproportionately harmed the LGBTQ+ community and made the need for equitable health care all the more pressing.[13] The LGBTQ+ community was hit hard by the COVID-19 crisis because of underlying health disparities and economic vulnerabilities.[14] LGBTQ+ people face higher rates of comorbidities such as HIV, asthma, and tobacco use,[15] are less likely to have adequate health insurance,[16] and are less likely to access care when they are sick out of fear of discrimination, as compared to the general public.[17] Members of the LGBTQ+ community were also overrepresented in the industries hit hardest by economic fallout, such as the restaurant and food services industries.[18] And LGBTQ+ elders were already more likely to face isolation and were less likely to reach out for support before the crisis began.[19] For many LGBTQ+

[12] Taber et al., *supra* note 1.
[13] *See* Lindsey Dawson, Ashley Kirzinger, & Jennifer Kates, *The Impact of the COVID-19 Pandemic on LGBT People*, KFF (Mar. 11, 2021), https://www.kff.org/coronavirus-covid-19/poll-finding/the-impact-of-the-covid-19-pandemic-on-lgbt-people/.
[14] *See* Charlie Whittington et al., *The Lives and Livelihoods of Many in the LGBTQ Community Are at Risk Amidst COVID-19 Crisis*, HUMAN RIGHTS CAMPAIGN FOUND. 1 (2020) https://hrc-prod-requests.s3-us-west-2.amazonaws.com/files/assets/resources/COVID19-IssueBrief-032020-FINAL.pdf (noting that "in addition to the greater risk of health complications as a result of COVID-19, LGBTQ Americans are more likely than the general population to live in poverty and lack access to adequate medical care, paid medical leave, and basic necessities during the pandemic").
[15] *Id.* at 5 (analyzing several primary data sources to demonstrate that LGBTQ+ individuals are disproportionately affected by respiratory and other chronic illnesses); *HIV and Transgender Communities*, CTRS. FOR DISEASE CONTROL & PREV. 1, https://www.cdc.gov/hiv/pdf/policies/data/cdc-hiv-policy-issue-brief-transgender.pdf (last accessed Feb. 8, 2024) (comparing the 9.2% HIV rate among the transgender population to the overall prevalence of 0.5%).
[16] Arielle Bosworth et al., *Health Insurance Coverage and Access to Care for LGBTQ+ Individuals (Issue Brief No. HP-2021-14)*, HHS (June 2021), https://aspe.hhs.gov/sites/default/files/2021-07/lgbt-health-ib.pdf ("uninsured rates in 2019 were 12.7 percent for LGB+ individuals vs. 11.4 percent for non-LGB+ individuals"); *see also* James et al., *supra* note 3, at 16 (finding that approximately "1 in 4 respondents (26%) had at least one issue with their insurance company in the last 12 months").
[17] Medina et al., *supra* note 2, at 16.
[18] Whittington et al., *supra* note 14, at 2.
[19] *Id.* at 4.

individuals, especially those who live in areas with limited options for LGBTQ+-affirming health care services, finding inclusive health care options is already a struggle. The Rollback Rule exacerbates this struggle by obfuscating the obligations of healthcare entities to provide nondiscriminatory healthcare under Section 1557 and instead emboldening that discrimination, which has resulted in even fewer options for inclusive health care.

15. Equality California counts among its members individuals and family members of individuals who have been discriminated against when seeking health care, as well as health care providers who have been affected by the Rollback Rule. Many of our members shared their experiences in our prior declaration, including Darren Lazor, Lisa Middleton, Dr. Andrea Cubitt, Ebony Ava Harper, Hillary and Jeffrey Whittington, and two Parent Members. Each of these members contributed statements in our prior declaration detailing their experiences with discrimination. All these individuals remain members of Equality California and have affirmed that their statements continue to reflect their experiences. Mr. Lazor and Dr. Cubitt each expressed that in the time between the prior declaration and now they have experienced increased anxiety about travel to certain states—specifically, they each stated that because of the Rollback Rule and the broader legal landscape it has emboldened, they fear needing emergency health care in an unfamiliar place and suffering discrimination based on their transgender status. In addition to the members included in our prior declaration, Equality California has among its members Ximena Lopez, M.D., a pediatric endocrinologist who was based in Texas but due to the lack of protections against discrimination for her patients had to relocate herself and her family to California. Dr. Lopez's experience is also detailed below.

16. Ximena Lopez was trained in pediatric endocrinology at Harvard Medical School before moving to Texas and opening her own clinic. As a physician, she provided gender affirming

medical care to several hundred transgender youth in Texas, something she describes as the greatest honor of her professional life. With access to treatment, she watched her young patients blossom and become functional and often happy adults.

17. In recent years, however, emboldened by the Rollback Rule and lack of clarity around federal protections, Texas has become increasingly hostile to transgender and nonbinary people seeking gender affirming healthcare. In this hostile legal landscape, Dr. Lopez was forced to deny gender affirming care to her patients, and therefore to discriminate against her transgender patients because of their transgender identity. As a result, she suffered from "moral distress," a term used to describe health providers who experience a failure of meeting a binding moral requirement when the requirement is impossible to meet. She witnessed the parents of her patients panicked from fear of losing the medical care that had been life saving for their children. Not only that, but she saw them start to isolate themselves due to fear of being targeted. They were afraid of taking their children to the primary care doctor or the emergency room due to fear of discrimination, of receiving substandard care, or of being denied care entirely. Dr. Lopez felt that both she and her patients had been abandoned by the health system and the government.

18. Ultimately, unable to treat her patients in a non-discriminatory manner, Dr. Lopez was forced to close her clinic 10 years after its founding. In order to continue helping transgender youth, Dr. Lopez had no choice but to leave Texas and move her family to California, which came at a great personal cost for her and her family. Now in California, she feels she can provide care in an environment that protects her patients from discrimination but thinks every day about the patients and doctors left behind in Texas and worries that without clarity from HHS that federal law requires nondiscriminatory access to care even in hostile states like Texas, they will give up on their futures. As a result of the Rollback Rule and the discriminatory policies it emboldened,

Dr. Lopez had to close her clinic, uproot her family, and abandon her patients, and she continues to live with anxiety and distress to this day.

19. Mr. Lazor, a named plaintiff, is a transgender man who lives in Ohio, a state without statewide protections against discrimination based on gender identity in health care. Mr. Lazor has experienced discrimination based on his gender identity in health care on multiple occasions. He has been denied treatment, misgendered, and mistreated by medical professionals. Mr. Lazor also has a recurring medical condition that causes shortness of breath, and for which he has previously sought emergency medical treatment. On one occasion when Mr. Lazor sought treatment for acute shortness of breath at the emergency room near his home—the emergency room to which he would be taken if he called an ambulance—the medical staff mistreated and discriminated against him based on his gender identity. Medical staff misgendered him, expressed disgust at the surgery scars from his mastectomy, stated "we don't know how to treat you," and then discharged him without any diagnosis or treatment plan, leaving him on his own to treat his acute shortness of breath. Because the Rollback Rule removes explicit regulatory prohibitions on such discrimination and removed recourse, he previously had to redress such discrimination, and because this hospital is not subject to state or local laws prohibiting discrimination based on gender identity, Mr. Lazor fears that discrimination at this hospital, as well as at other health care facilities, will only worsen. Given his medical history and past experiences, he believes that as a result of the Rollback Rule, there is a substantial likelihood that he will be faced with a situation where he must either forgo obtaining emergency care or risk suffering discrimination or substandard care that could lead to severe health consequences or even death. Mr. Lazor is particularly concerned in light of the COVID-19 pandemic, as his recurring condition may make him more susceptible to extreme respiratory COVID-19 symptoms.

20. Ms. Middleton is a 72-year-old transgender woman. Ms. Middleton has experienced health care discrimination in the past as a result of her transgender status and fears that under the Rollback Rule she is likely to encounter discrimination again. Ms. Middleton serves on the Palm Springs City Council and the California Public Employees' Retirement System Board of Administration. As a public official, Ms. Middleton often travels outside of California. Ms. Middleton and her wife also travel in their spare time throughout the Western United States. Particularly given her age, Ms. Middleton fears requiring medical assistance while traveling outside of California for work. As a result of the Rollback Rule, Ms. Middleton is afraid that she may be denied critical care by health care providers because of her gender identity or her sexual orientation when traveling outside of California.

21. Dr. Cubitt is a transgender woman. Dr. Cubitt regularly travels for work and attends scientific conferences in states outside of California that have limited protections for transgender individuals, including Texas, Nebraska, North Carolina, and South Carolina. As a 61-year-old transgender woman, Dr. Cubitt fears requiring medical assistance while traveling outside of California for work. As a result of the Rollback Rule, Dr. Cubitt is afraid that she may be denied critical care by health care providers because of her transgender status while she is traveling outside of California.

22. Ms. Harper is a transgender woman who lives in California and is receiving gender-affirming care. While some of this care is covered by her insurance, such as hormone therapy and laser treatment, she has experienced issues with insurance denying certain types of gender affirming care. Ms. Harper fears that her insurance company will be emboldened by the Rollback Rule to deny her coverage for needed care in the future, or even decide to stop covering treatments she has been receiving such as hormone care or laser treatments.

23. Mr. and Mrs. Whittington have a minor son and a minor daughter, and their son is transgender. The Whittingtons live in California but travel outside of California frequently for family vacations. They are concerned that, as a result of the Rollback Rule, their transgender son may experience discrimination if he needs health care while the family is traveling to other states that do not have state laws that explicitly prohibit health care discrimination on the basis of gender identity.

24. Two Parent Members have a minor daughter who is transgender. Their family lives in California but travels outside of California frequently. In the past, they traveled 3 to 4 times per year, often taking their children to national parks such as Sedona National Park in Arizona. Their daughter is currently receiving health care at a gender-inclusive clinic, but that was not always the case. At a previous clinic, when Parent Members asked a pediatric endocrinologist about seeing their daughter, the doctor replied: "I don't do that." Parent Members now pay a higher copayment so that their daughter can receive pediatric endocrinological care at the gender-inclusive clinic. Parent Members have also had to fight with their insurance company over coverage for their daughter's medically necessary gender affirming care. Parent Members are concerned that, as a result of the Rollback Rule, both they and their transgender daughter will experience increased discrimination in the form of more denials of care, higher out of pocket costs for needed care, and lengthy and resource intensive battles with their insurance company for coverage of medical care. They fear that doctors and insurance companies will take advantage of the confusion caused by the Rollback Rule to deny care to their daughter. Given their experiences with health care refusals in California—a state with LGBTQ+ protections in health care—they fear that their daughter may be discriminated against if she needs health care while on a family vacation to a state such as Arizona that lacks state-level protections against LGBTQ+ discrimination in health care.

I declare under the penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on March 19th, 2024 at Los Angeles, California.

Tony Hoang
Executive Director, Equality California

EXHIBIT B

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

BOSTON ALLIANCE OF GAY, LESBIAN, BISEXUAL AND TRANSGENDER YOUTH, et al.,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

Civil Action No. 1:20-cv-11297

DECLARATION OF PATRICK MCGOVERN, CHIEF EXECUTIVE OFFICER OF CALLEN-LORDE COMMUNITY HEALTH CENTER

1. I am the Chief Executive Officer of Plaintiff Callen-Lorde Community Health Center ("Callen-Lorde"). In this capacity, I am responsible for overall organizational performance, including clinical, administrative, finance, and governance functions to ensure the mission of the organization is maintained as per the strategic direction-setting of the Board of Directors.

2. Callen-Lorde is a federally qualified health center whose mission is to provide sensitive, quality health care and related services primarily to New York's lesbian, gay, bisexual, transgender, and queer communities—in all their diversity—regardless of ability to pay; and in furtherance of that goal, to promote health education and wellness and to advocate for gay, lesbian, bisexual, transgender and queer (LGBTQ+) health issues.

3. Callen-Lorde provides primary care, dental care, behavioral health care, care coordination and case management, as well as health education services, to a primary care patient base of nearly 18,581 people at four locations in New York City.

4. Primary care is the provision of preventive healthcare and treatment throughout a person's life cycle, which serves as the centralized foundation for the management of comprehensive clinical needs. Primary care services are the foundation through which we provide most of our other healthcare services as well as our referrals to others' services. For our population, primary care includes the provision of gender-affirming care, such as hormone replacement therapy, as treatment for gender dysphoria. It also includes other care focused specifically on LBGTQ+ populations, such as sexual and reproductive healthcare, pregnancy testing, and contraceptive counseling. We also offer referral services for patients who need care we do not provide. Most of our surgical referrals are for gender-affirming surgical procedures, such as breast/chest and gonadal/genital surgery or facial feminization surgery. We also refer for prenatal care and assisted reproductive technology.

5. Callen-Lorde's patient population is almost entirely LGBTQ+: about seventy percent identify as lesbian, gay, bisexual, or having a sexual orientation other than heterosexual; and nearly 6,000 identify as transgender or nonbinary—the largest such outpatient practice in the US and likely the world. Callen-Lorde's patients also have limited financial resources and come from across NYS's five boroughs and beyond. Roughly 1 of every 3 service area residents are living below 200% of the federal poverty line, and twelve percent are homeless or unstably housed. Many patients also lack or have insufficient health insurance coverage. We subsidize the patients' care through providing services on a sliding-fee scale based on ability to pay; many patients pay nothing. About eight percent of Callen-Lorde's patient population is uninsured, and about fifty-six percent receive Medicaid or other income-based public insurance. The remainder have insurance through private and public sector employment, the marketplace, or Medicare. A

significant proportion of our patients have a criminal history. About 2.4% of our patients report that English is not their first language.

6. Through its telehealth services, Callen-Lorde also provides direct health services to patients outside of the New York City area. This has been particularly beneficial to our diversely abled patients who face barriers to in-person visits. Telehealth services encompasses episodic, medical, mental, and dental healthcare. Our primary telehealth services encompass most forms of primary care that don't require physical examinations, including chronic condition management and gender affirming care through hormone replacement therapy management.

7. About ten percent of our patients visit us from outside of New York City. These patients come to us largely because they have been unable to find adequate or affirming healthcare in their local communities.

8. Callen-Lorde also provides an eConsult service to assist other clinicians with providing competent healthcare to transgender and non-binary people around the nation. The clinicians served through Callen-Lorde Community Health Center's eConsult service are largely in community health centers, correctional facilities, or rural areas. This program improves patient care quality and avoids unnecessary procedures and referrals as well as referrals to the wrong specialty.

9. Callen-Lorde also undertakes and participates in federally and privately funded research into improving healthcare outcomes among LGBTQ+ communities.

10. On June 14, 2019, the United States Department of Health and Human Services (HHS) issued a Notice of Proposed Rulemaking threatening the nondiscrimination provisions of the Affordable Care Act which protected against denial of care the basis of sexual orientation and gender identity. *See* Nondiscrimination in Health and Health Education Programs or Activities, 84

Fed. Reg. 27,846 (proposed June 14, 2019) ("2019 Proposed Rule"). In response to the 2019 Proposed Rule, Callen-Lorde submitted a Comment Letter to HHS. *See* Callen-Lorde, Comment Letter on 2019 Proposed Rule (Aug. 7, 2019), https://bit.ly/38s6rVf. The Comment Letter succinctly expressed that the 2019 Proposed Rule:

> would severely threaten LGBT patients' access to all forms of health care, create confusion among patients and providers about their rights and obligations, and promote discrimination. The proposed rule would encourage hospitals to deny care to LGBT people and enable insurance companies to deny transgender people coverage for health care services that they cover for non-transgender people. The rule would also make it harder for other people experiencing discrimination in health care to know and exercise their rights . . . .

11. On June 19, 2020, HHS published a final rule that adopts the entirety of the 2019 Proposed Rule, with only a few minor changes that do not affect its impact on LGBTQ+ people. *See* Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts 438, 440, 460) ("the Rollback Rule"). The Rollback Rule largely ignores or summarily dismisses the concerns that we raised and instead erased the definition of sex discrimination while incorporating exemptions that greenlit denials of care, specifically kind of care we provide to the LGBTQ+ community that had been explicitly protected under the previous iteration of this rule. Thus, the Rollback Rule emboldened the very discrimination and denial of care that Congress had sought to prohibit under Section 1557.

12. Most of Callen-Lorde's work is related in some way to addressing discrimination and its effects. The LGBTQ+ patient population disproportionately experiences and suffers from discrimination, which in turn, perpetuates disparities in health care access and outcomes. Patients, especially our transgender and nonbinary ones, come to us having been regularly treated with skepticism, contempt, judgment, ignorance, or fear by many in the healthcare system. Often, they

have been unable to obtain necessary care, or been unwilling even to seek it due to past bad experiences. Only recently has the healthcare system at large begun to demonstrate increased awareness of the need to provide affirming healthcare services to the LGBTQ+ population and to combat discrimination against them—a change that has been driven in great part by legal developments such the Affordable Care Act and its implementing regulations, which the Administration has now rolled back. We have seen the change in our patients' attitudes who now fear their ability to access healthcare as these developments chip away at discrimination and its legacy. Where barriers are eased by state rules, many have sought an accelerated timeline for receiving gender affirming healthcare over concerns about access and coverage hindered by the Rollback Rule. Further, the effect of the rule change has sewn confusion in our patients regarding what behavior is discriminatory and what behavior is permissible relative to how they are treated when seeking healthcare.

13. A study released by the Institute of Medicine in 2011 found that 56% of lesbian, gay or bisexual respondents and 70% of transgender respondents had experienced discrimination in healthcare settings. A 2001 study by the Gay and Lesbian Medical Association also found that a lack of culturally competent providers is a major barrier to healthcare, with 40% of respondents reporting a lack of adequately trained healthcare professionals. A Community Needs Assessment conducted in 2021 in New York revealed that overall, a lack of knowledge about LGBTQ+ affirming services, a lack of LGBTQ+ providers in general were the greatest barriers to seeking care.

14. Due in great part to many providers' substandard treatment of transgender patients, transgender patients are often reluctant to seek care. Before Section 1557's implementing regulations first came out, twenty-eight percent of transgender New Yorkers reported not having

a regular health care provider and therefore utilizing fewer preventative services (Porsch et al., *An Exploratory Study of Transgender New Yorkers' Use of Sexual Health Services and Interest in Receiving Services at Planned Parenthood of New York City*, 1 Transgender Health 1, 2016). Another pre-Section 1557 survey found that 23 percent respondents nationwide did not see a provider for needed health care because of fears of mistreatment or discrimination. Nat'l Ctr. for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* 5 ("2015 Transgender Survey") (2016).

15. The enactment of Section 1557's implementing regulations and some state rules and laws about sex and gender identity discrimination had reduced but not eliminated these problems. When we recently surveyed a group of our own transgender patients, one-fifth reported having been denied care due to a provider's personal objections to caring for transgender patients. Structural barriers that have slowed progress include our patients' difficulties finding an LGBTQ+-friendly medical or mental health care provider, and a lack of provider focus/knowledge of health issues specific to the LGBTQ+ community. Short provider visits may compromise building of trust between an LGBTQ+ patient and provider. These barriers continue to exist in part because rules against discrimination against LGBTQ+ patients are new and incomplete, and many providers have not yet developed competency in treating patients that they perceive as difficult or have long sought to avoid; or they are still unaware of what these rules require. The Rollback Rule makes these difficulties more pervasive, not less.

16. As an example of this second problem, Callen-Lorde's own research has shown that many health insurance plans do not yet comply with regulations protecting transgender and gender non-conforming people, such as New York State's requirement that they not withhold coverage of medically-necessary healthcare related to treating gender dysphoria (Ray Edwards,

Barriers to Accessing Gender Affirming Care: Insurance Coverage in New York State, Dec. 2019) ("Trans Health Advocacy Working Group Report"). Moreover, New York law does not mandate coverage for gender dysphoria treatments that many insurers erroneously deem "cosmetic," and such denials are the reason many transgender patients' gender dysphoria and related conditions are untreated or undertreated. (Trans Health Advocacy Working Group Report). As of 2018, approximately 16% of Callen-Lorde's patients seeking support for gender affirming care or surgeries were denied coverage, resulting in hundreds of hours of staff time and delayed or no care for patients. Because of the fears perpetuated by the rule, our Gender Affirming Perioperative Services (GAPS) program staff have implemented significantly more patient education on the insurance coverage process, which in turn, reduces the amount of patients we are able to serve. While we will always advocate for our patients where we can, the time lost completing peer-to-peer calls, writing appeals, referring patients to appropriate legal assistance, and emotional support to patients receiving denials is unnecessarily burdensome. Our GAPS staff have meticulously re-rewritten referral letters, collaborated with patients to ensure a sufficient amount of detail is captured, and conferenced with insurance plans to ensure that our patients are able to receive medically necessary, gender affirming care. The Rollback Rule has only further complicated our ability to ensure that our patients are able to receive appropriate medical treatment.

17. These barriers to accessing care can lead LGBTQ+ individuals to delay or avoid seeking treatment for medical needs or mental health/substance abuse issues. Delays in treatment can result in further exacerbation of medical/behavioral health issues. This in turn means that Callen-Lorde needs to work harder to address our patients' needs.

18. Because of the discrimination and delays they have faced, Callen-Lorde's patients often come to us sicker, and with greater healthcare and supportive service needs. Our patients'

more acute conditions therefore also require more treatment and medication to stabilize their conditions. Likewise, our nurses' chronic disease management care, our dental care, and our healthcare also require greater commitment of staff time and training to build trust and overcome the effects of discrimination. For example, over the past decade, while all demographic groups in New York people have seen significant decline in new HIV diagnoses, transgender persons encountered the smallest decline since 2001 (HIV Surveillance Annual Report, 2022). Our experience in HIV prevention reflects that which is found in national studies: transgender women need more programmatic support to initiate and maintain PrEP regimens (PrEP initiation and discontinuation among transgender women in the United States: a longitudinal, mixed methods cohort study, Journal of the International AIDS Society). Additionally, transgender people living with HIV are also more likely than the general population of people living with HIV/AIDS to have a history of one or more co-occurring challenges such as substance use (30%), incarceration (23%), homelessness (6%) and sexual abuse (2%) (NYCDOHMH, 2018 report).

19. Among our transgender patients, too many (especially those from distant states) have to come to us because they were unable to obtain coverage for hormone replacement therapy or gender affirming surgery, and so obtained them through underground means. Often, this meant obtaining hormone treatments from providers who were not operating in safe environments, or who provided harmful substances, which damaged our patient's health.

20. When our patients have access to gender affirming care, they have better health outcomes. Patients were more likely to be virally suppressed and maintain viral load suppression when they could access surgical procedures. *See* Rodriguez-Hart, C., Zhao, G., Goldstein, Z., Radix, A., & Torian, L. (2023), An Exploratory Study to Describe Transgender People with HIV

Who Accessed Medicaid and Their Viral Suppression Over Time in New York City, 2013-2017. *Transgender health*, *8*(5), 429–436, https://doi.org/10.1089/trgh.2021.0195.

21. In order to improve health outcomes and effectively engage our patients in ongoing primary care, Callen-Lorde knows that we must meet them where they are, and that includes addressing their health needs and barriers to healthcare access comprehensively. We have learned through experience that effective healthcare interventions must be centered around resiliency and relationship-building, earning the trust of each patient through trauma-informed care and a non-judgmental, harm-reduction approach. The more discrimination is permitted, or practiced, the harder this becomes. Callen-Lorde's healthcare services are aimed to address the health disparities faced by people who live with the stress of discrimination and actual or threatened violence in their day-to-day lives. In addition to understanding the clinical needs of our patients and striving to provide an affirming environment (including inclusive intake forms, inclusive sexual health history questionnaires, etc.) for people to be able to disclose and discuss sensitive psycho-social concerns as well as physical health needs, we strive to provide an environment of care that counteracts the devaluation of lives that many of our patients encounter outside of our doors.

22. For example, our clinical spaces include photographs of our own community members, as patients rarely see images of folks who look like them portrayed as beautiful, strong, empowered, or happy. As part of new staff orientation, all our new hires receive evidence-based transgender and gender-non-binary (TGNB) competency training, and anti-racism training. We provide periodic training regarding the LGBTQ+ community's specific health needs, including how to provide clinically and culturally competent care, such as trainings on cultural humility, and on undoing racism in the context of intersecting identities. We have grand rounds on topics like Black LGBTQ+ health and on racism within the LGBTQ+ community. We have detailed policies

on correct pronoun and gender marker usage and other ways to ensure that appropriate care is a part of our employees' work performance.

23. Callen-Lorde has spent considerable time, effort, and organizational resources over the last several years in assisting individual patients in understanding their denial of coverage and helping them to file complaints or legal actions against health plans refusing to cover gender affirming services. We have a Gender Affirming Perioperative Services (GAPS) team for our transgender and non-binary patients, staffed with surgical doulas, that facilitates access to surgery education, care planning and recovery check ins for patients. The GAPS program often connects patients to community organizations for support with recovery, social support, and daily care needs while on physical restrictions and/or limited income after surgery. We have worked to identify the gaps throughout the medical system that tend to fail our low-income and poorly resourced transgender patients most often, and created carefully curated programming that includes medical and behavioral health support as well as specialized patient navigation services. We operate a specialized clinic to serve transgender patients engaged in sex work and the street economy, in close coordination with community partners; many of these patients report resorting to sex work after discrimination or poor treatment in other areas of work. Our TGNB patients receive pre- and post-operative care planning, medical education, and insurance navigation to support their transition more fully. The catalyst for this work began with providing health policy education for our patients who struggled to navigate the complexities of their health plans.

24. In our care coordination programs, we work with patients who are wrongfully denied coverage by their insurance provider. We work with our patients directly to help them understand the grounds of their denial and the information required to present in consideration of that denial's reversal. We also have a referral service for patients to obtain counsel should their

appeals fail. We also do the same with many patients whom we refer to other providers for care, and whose coverage is denied, because many providers lack the requisite expertise, capacity, or ability to assist. This can be complicated by confusing out-of-network rules and patient misunderstanding around reimbursement and prior authorization, the maintenance of which requires extensive resources of our organization. Recently, we have seen an uptick in requests for out-of-network coverage due to network insufficiency, specifically, insurers failing to contract with providers in-network for gender affirming care services, such as pre-operative hair removal or feminizing hair restoration procedures. Our medical providers also regularly conduct peer-to-peer reviews with insurance carriers, to advocate on behalf of their patients who have been denied coverage for our services. We regularly offer this assistance at substantial financial cost to us as a safety net institution.

25. We also work with patients who are all too often unwilling to go to emergency rooms or even leave emergency rooms because of discrimination. Two recent cases (out of many) are illustrative. We had a patient come to our practice for an urgent appointment with possible stroke symptoms, and initially refused to go to an emergency room due to past experiences with discrimination. Another of our patients, needing inpatient care for an infected and blocked central line, left an emergency room bleeding and without treatment because the hospital tried to force him to be admitted and treated as a woman; he took an Uber to a different hospital.

26. The Rollback Rule has exacerbated these challenges. Much of the incipient progress we have seen in recent years in assisting our patients to overcome barriers brought about by discrimination has stalled. It has contradicted the message we have been trying to inculcate throughout the healthcare system that discrimination is harmful, wrong, and impermissible.

27. Our patients who are Medicare beneficiaries often face difficulties obtaining coverage for gender-affirming healthcare. Since the 2020 rule, specialty surgeons who are trained to provide gender affirming procedures have suddenly stopped accepting straight Medicare plans due to the uncertain reimbursement with their "case-by-case" policies. The Rollback Rule disempowered Medicare Administrative Contractors, such as National Government Services, Inc. (which services many of our patients), from creating effective regulations and guidance that would enable more beneficiaries to receive medically necessary gender affirming care. As a result, only our patients who can afford Medicare Advantage plans have been able to get their care covered, leaving our least financially resourced patients without the care they need to alleviate gender dysphoria. Given the likelihood for transgender Medicare beneficiaries to be disproportionately eligible for Medicare due to disability (compared to cisgender beneficiaries), the Rollback Rule discriminately penalizes our transgender patients. *See* Ewald, E. R., Guerino, P., Dragon, C., Laffan, A. M., Goldstein, Z., & Streed, C., Jr., Identifying Medicare Beneficiaries Accessing Transgender-Related Care in the Era of ICD-10 (2019). LGBT health, 6(4), 166–173. https://doi.org/10.1089/lgbt.2018.0175.

28. Private insurers have understood the Rollback Rule to mean that they are no longer constrained from offering plans that categorically exclude gender-affirming care or other sex-based treatment that HHS incorrectly asserts to be exempt from Section 1557's scope. This includes both care related to gender transition and sex-based care—things like preventative mammograms for transgender women and cervical pap smears for transgender men, which may be denied coverage based on the erroneous basis that such care is only necessary for people of one legal sex. For example, members of our transgender care coordination team recently communicated extensively with a patient's employer to ensure coverage for a gender-affirming

procedure that should not have been excluded from the patient's health plan under Section 1557; and yet they were unable to resolve the situation and get coverage for the patient. When we fail in our patient advocacy, our patients regularly foot the financial costs of denied tests, and as a safety net institution, Callen-Lorde loses thousands of dollars toward reimbursement annually. The end result: the rule partly renders Callen-Lorde less financially resourced to serve our patients.

29. Employers who use religious exemptions as an opportunity to prohibit employee coverage for medically necessary gender-affirming care, like hormone replacement therapy, have increased under the Rollback Rule. For example, our surgical doula has been unable to obtain coverage for a gender-affirming procedure for a patient whose employer offers a health plan through Fidelis Care, which is a plan originally founded under the auspices of the Catholic dioceses of New York City that may still be using legacy practices despite a recent change in ownership. While Fidelis has since been legally compelled to make changes to their policies, insurers and employers continue to argue that religious freedoms allow them to discriminate against LGBTQ beneficiaries, employees, and their families; the Rollback Rule further emboldens them to justify their case.

30. The Rollback Rule's resulting reduction in health insurance coverage has required us to devote even more staff time and resources to assisting patients with obtaining approval. We've integrated, as formal steps of our surgery navigation workflows, updated letter templates to provide the patient with information most relevant to the barriers to coverage, while developing specific support tools for navigating the various requirements of medical providers. To maintain best practices, we must assess and reassess coverage limitations, requirements, and pre-requisites per insurance plan. Callen-Lorde has also necessarily increased efforts to facilitate referral to legal services.

31. Increased denials of coverage have resulted in our patients having more un- and under-treated conditions, further exacerbating existing health disparities and taxing an already over-burdened safety-net system for behavioral health and primary care needs. The urgency to support and maintain a patient's health has become even more important as limited coverage and limited providers available have also increased the wait times to care. To accommodate those who are under-treated, we've had to integrate annual health care screenings and care gap protocols into our workflow to reconcile patient histories that have been reported incorrectly, or simply never occurred prior to their arrival to Callen-Lorde. One-third (33%) of transgender people in a recent survey reported that there was at least one time in the past year when they needed to see a doctor or other health care provider but did not because of cost (2015 Transgender Survey). When insurers do not cover transgender health care costs, it causes an enormous health problem for an economically disadvantaged population.

32. Insurance denials also affect Callen-Lorde's financial ability to provide care. All of Callen-Lorde's services are provided regardless of a patient's ability to pay and accessible on a sliding fee scale. In the face of widespread challenges resulting from the coronavirus pandemic, Callen-Lorde's financial position is not sufficiently strong to subsidize the expected increase in uncompensated care resulting from the Rollback Rule. We have no reason to expect additional state, federal, and local government support to help us to respond to the increase in community need from under and uninsured patients without significant reduction in spending on other services.

33. We have seen healthcare providers and facilities understanding the Rollback Rule to mean that they are no longer constrained by federal law from misgendering transgender patients, treating them as a curiosity or problem, or refusing to provide medically necessary gender

affirming care. For example, we have a patient who is currently seeking coverage for a hysterectomy; the surgeon who was slated to provide this care ceased returning the patient's communications after learning that the purpose of the surgery was to treat gender dysphoria, and we have been unable to rectify this situation, although we understand it to be illegal sex discrimination. We worked with a transgender patient looking for breast augmentation in New Jersey who was not able to find a provider willing to treat transgender patients and ended up having to seek care in New York. We have also heard multiple patients report they cannot find behavioral health providers willing to treat transgender patients.

34. Callen-Lorde also devotes time and effort to maintaining our preferred providers list for providers to whom to refer patients for care we do not provide; and ensuring that providers who discriminate against LGBTQ+ people. The Rollback Rule has required us to undertake greater efforts to ensure providers emboldened by the Rule are kept off of it. One of the resources we've developed is TransAtlas, a resource designed to give patients some transparency into the provider's care and practices with the trans community, elevating those providers who offer a safe and affirming experience for the patient.

35. Likewise, increased discrimination by providers and facilities has exacerbated the already significant problems faced by our patients in obtaining care and protecting their health, placing further strain on the fraying safety net systems available for this care, including Callen-Lorde. This has caused us to provide more care, and to more people. In 2018, we were treating around 3000 TGNB patients. Today, we provide healthcare to over 6,000 TGNB patients.

36. Much of this increase in patient numbers, and decreased insurance coverage, is due to the effect the Rollback Rule has had on allowing discrimination to persist for our out-of-state patients with state bans on gender-affirming care and abortion restriction, thus demonstrating a

need for clarity on home state providers' federal obligations. People travel great distances to us because the care they need is unavailable due to discrimination—for example, health plans that refuse to cover gender-affirming care, or providers who refuse to provide gender-affirming care or even properly care for TGNB patients at all. We have patients report uprooting their entire lives to move to New York City to ensure their access to gender-affirming medical care. As a result of the increased demand, many providers in New York City have wait lists several years long (sometimes, just for a consultation) and patients who have uprooted their lives have to plan for maintaining access to care in the meantime.

37. Our patients have expressed that the Rollback Rule is a barrier to seeking and access healthcare for them, which has required us to respond to increased demand for services, like our surgery doula program, that assist our patients overcoming such barriers to care. As one patient told us during the consideration of the Rollback Rule, "Having been born an FtM [i.e. a man assigned a female sex at birth] transgender individual, prior to access to all forms of medical care was fraught with huge financial and access related obstacles prior to Section 1557 of the Patient Protection and Affordable Care Act. For example, I was forced to leave the United States and go to Serbia for life saving and affirming gender corrective surgeries because my insurance would not cover the procedures. The Rollback Rule would reinstate insecurities and uncertainties concerning even basic treatment coverage going forward for me as a post-operative FtM individual, including a fear of rejection from health related services such as a stress test, eye exam, yearly physical examinations, and dental work based on a doctor refusing service to transgender patients and the concern that medications, such as needed hormones, will no longer be covered by insurance." Since these fears were expressed, we have seen these fears come to fruition. Another patient recently told us about the Rollback Rule, "I've always been an optimist. But for the first

time ever I'm troubled about the future of protection for me and all LGBT. My family and I are seriously considering moving to another country." Another patient said simply, "As a trans person I have experienced discrimination in health care that has negatively impacted my health. The rollback has exacerbated these struggles by creating a patchwork of rules and protections that has sowed fear and confusion in my community." Another patient reported that there is now no way to protect their health information with the expansion of the large hospital system electronic health record, Epic, stating, "even if I want to protect some of my healthcare information, any one of my healthcare providers can now see that I am trans[gender] without my consent for them to know. Unless I know that there are regulations in place that guarantee my access to healthcare, I will have to constantly live in fear that someone will use my gender against me. I could die in an emergency room because one of my providers refuses to treat me because I am trans[gender]."

38. We have had to address all of the numerous inquiries from our patients about whether they still have rights to healthcare and how the Rollback Rule will affect them and try to calm their fears. The only reassurance we can provide at this time is that, "as long as we are here, we will be there to provide comprehensive care, free of judgment and regardless of ability to pay."

39. In sum, the Rollback Rule has caused our patients to become more fearful of seeking care and are now coming to us with greater needs. Our ability to educate providers and insurers about the need to cease discriminating for legal and community health outcome reasons and to provide care has been hampered. We have seen reduced health insurance coverage of our patients' needs, and for increased difficulties in referring patients for care we do not provide, including increased denials of care under circumstances that would have been prevented prior to the Rollback Rule. This has resulted in a decrease in our ability to fund our provision of primary care, while simultaneously increasing the demand for that care. The Rollback Rule has effectively

made our ability to serve our communities harder, demands more resources to ensure care, and facilitates fear that makes our patients sicker.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on March 11, 2024 at New York, New York.

Patrick McGovern
Chief Executive Officer
Callen-Lorde Community Health Center

EXHIBIT C

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

BOSTON ALLIANCE OF GAY, LESBIAN, BISEXUAL AND TRANSGENDER YOUTH (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; Indigenous Women Rising; NO/AIDS Task Force (d/b/a CrescentCare); and Transgender Emergency Fund of Massachusetts, *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Civil Action No. 1:20-cv-11297

DECLARATION OF ALICE RIENER

I, Alice Riener, declare under penalty of perjury and in accordance with the laws of the United States and of Massachusetts that:

1. I am the Chief Executive Officer of Plaintiff NO/AIDS Task Force, d/b/a CrescentCare. I received a J.D. from American University's Washington College of Law. I joined CrescentCare in 2011 as the Director of Housing, and have also held the positions of Chief Legal Officer and Chief of Staff. As Chief Executive Officer, I partner with the Board and leadership team to develop CrescentCare's strategic goals in pursuit of its mission while building a more sustainable future for the organization and community. In past CrescentCare roles, I have provided legal and regulatory advice, oversight of risk, compliance and audit requirements, administrative

support for grants, and guidance for human resources, and all of these areas still fall under my overall responsibility.

2. On November 18, 2020, I filed a declaration in this matter [ECF No. 27-7] on behalf of CrescentCare, in parallel with the declaration of then-Chief Executive Officer Noel Twilbeck [ECF No. 27-12]. The representations made in those declarations are true and accurate, and I incorporate them herein.

A. Introduction

3. CrescentCare is a federally qualified health center operating in Louisiana whose mission is to strengthen our entire community through whole-person healthcare and education. We envision a community without barriers to care, where all people have the power to be healthy and whole. CrescentCare aims to lead in quality-driven health and wellness care, and to meet existing and emerging need with active participation from the community we serve. We intend to pursue our mission of providing comprehensive health and wellness care with integrity, quality, respect, and compassion and ensure our care is safe, effective, patient-centered, timely and efficient, equitable and evidence-based.

4. Our services include primary care, dentistry, obstetrics and gynecology, pediatrics, psychiatry, specialty care, preventive health, and sexual health services. We also provide non-medical wraparound services, such as case management for people living with HIV, legal services, and outreach and education regarding discrimination and public benefits, to ensure our patients are empowered to lead healthy lives.

5. CrescentCare also operates research, training, education, and policy programs. CrescentCare collaborates with other community health centers and providers to advance clinical service strategies that result in higher engagement with medical care and better health outcomes

for its patient population. CrescentCare also works closely with community advocates to ensure that its patients' interests are represented across relevant policy areas, including housing, nutritional support, and nondiscrimination protections.

6. CrescentCare's patient population is incredibly diverse. Many of our patients identify as lesbian, gay, bisexual, transgender, queer, intersex, and gender non-conforming people ("LGBTQ+"), with around 36% reporting a sexual orientation other than heterosexual and over 12% identifying as transgender. Approximately 22% of our patients live with HIV. Many of our patients have limited resources, with around 26% of our patients having lived below the poverty line in 2023, and around 41% receive Medicaid.

7. CrescentCare has a diverse, experienced, and culturally competent staff of almost 275 employees and 200 volunteers. Employees include medical and behavioral health providers, case managers, support staff, medical adherence and insurance navigation professionals, community health workers, lawyers, administrators, and professionals working in finance and human resources. CrescentCare recruits from the communities it serves to ensure that staff is representative of the greater New Orleans community. CrescentCare's employees represent many different races, ethnicities, sexual orientations, gender identities, religious and spiritual traditions, and life experiences. To better serve our patients, some of our trans-identified and allied staff serve on our Transgender Advisory Committee to advise on programming and procedures for CrescentCare.

8. CrescentCare receives various forms of federal funding from HHS and from institutions affiliated with or funded by the United States Department of Health and Human Services ("HHS"), including but not limited to funds under the Public Health Services Act, direct grants, funding under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990,

42 U.S.C. § 300ff et seq., funds under the 340B Drug Discount Program, research grants from the Centers for Disease Control and Prevention and Medicaid and Medicare reimbursements. CrescentCare also receives funds from the Health Resources and Service Administration ("HRSA") and is designated as a federally qualified heath center. In 2024, CrescentCare's federally funded research grants totaled more than $20 million.

9. I am aware that HHS issued a Notice of Proposed Rulemaking related to the nondiscrimination provisions of the Affordable Care Act on June 14, 2019. *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27,846 (proposed June 14, 2019) ("2019 Proposed Rule").

10. I understand that on June 19, 2020, HHS published a final rule that adopts, with only minor or technical alterations, the entirety of the 2019 Proposed Rule. *See* Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts 438, 440, 460) ("the Rollback Rule"). The Rollback Rule largely ignores or summarily dismisses the concerns that thousands of commenters raised.

11. I understand that HHS issued another Notice of Proposed Rulemaking related to the nondiscrimination provisions of the Affordable Care Act on July 25, 2022. *See* Nondiscrimination in Health and Health Education Programs or Activities, 87 Fed. Reg. 47,824 (proposed July 25, 2022) ("2022 Proposed Rule"). I also understand that this proposed rule has not yet been finalized and the proposed provisions are not currently in effect.

12. I understand CrescentCare to be subject to Section 1557 and its regulations as we are a health entity that receives federal financial assistance.

B. The Rollback Rule Will Cause CrescentCare to Divert Crucial Resources

13. The Rollback Rule causes CrescentCare to expend resources associated with training staff to address the confusion about the requirements of federal law. For example, CrescentCare's Transgender Advisory Committee held a training for our staff members about the 2019 Proposed Rule and potential changes that could occur for our patients. CrescentCare has since needed to formalize these training elements into the education required of all staff. CrescentCare conducts staff training at orientation, at the departmental level and at the all-staff level. In each of these areas, CrescentCare has found it necessary to advise staff of the effects of HHS's Section 1557 rulemaking. This includes reminders that while CrescentCare staff should always endeavor to treat our patients consistent with their gender identity, including by demonstrating the correct method for marking electronic medical records and by engaging in interpersonal role plays.

14. CrescentCare patients have experienced so much difficulty with brick-and-mortar pharmacies in accessing the hormone therapy and supplies needed to provide gender affirming care that CrescentCare has expended time and resources to develop a list of online sources for some of these items that patients may have to pay for out of pocket.

15. The Rollback Rule causes CrescentCare to expend resources associated with our responsibility to educate our patient community. CrescentCare providers routinely expend time during patient visits assisting our patients with the difficulties associated with navigating a discriminatory landscape. This includes helping transgender or nonbinary patients avoid sites for primary or routine medical care unrelated to gender that are known to be discriminatory. For similar reasons, it is not uncommon for CrescentCare patients to travel multiple hours or hundreds

of miles to access basic care in a non-discriminatory setting, such as CrescentCare. This is also a burden on our limited resources.

16. The Rollback Rule also causes CrescentCare to expend resources associated with our patient navigation services. Patient navigation services include health insurance assistance, claims support, and Medicaid enrollment assistance. CrescentCare is required to provide Medicaid enrollment assistance to remain eligible for funding as a federally qualified health center. CrescentCare staff members spend significant time helping patients determine what services are covered by their insurance plan and what prior authorization requirements may be applicable for specific services. During the lifetime of the Rollback Rule, we have needed to dedicate additional staff time to identifying policy changes. For example, CrescentCare has found it necessary to dedicate two patient navigators specifically to its Gender Services. These employees help patients navigate the complex web of insurance and payor policies that govern how and when their care is covered.

Additional staff time is spent assisting our patients during open enrollment periods to select plans that provide meaningful coverage of gender affirming care to avoid enrollment in coverage that is detrimental to some of our patients' health and financial well-being. For example, United Health Care's Medicaid Managed Care Organization categorically does not approve gender affirming surgery for adults. CrescentCare has always been rejected for such preauthorization requests, or informed of such rejections by the surgeon's office. Another example is the failure of Blue Cross Blue Shield plans to recognize nonbinary gender identity in patients' electronic medical records when approving claims.

17. By way of further example, one of the major Marketplace health insurance providers in Louisiana-- United Health Care-- continues to employ categorical coverage exclusions

for gender affirming care in its ACA Marketplace plans. *See* Out2Enroll, Transgender Health Insurance Guide to the Marketplace (2023), *available at* https://perma.cc/PN4R-GQB5. Were HHS to make clear that such health plans-- which receive federal financial assistance in the form of Marketplace subsidies-- are "health programs or activities" subject to Section 1557, and that such exclusions constitute sex discrimination, the harm to CrescentCare and its patients would cease.

18. By way of further example, CrescentCare recently performed a pap smear on a transgender man. When the claim was submitted to the patient's Ambetter Marketplace plan, it was denied. Ambetter's denial indicated that this was because the patient's gender designation was inconsistent with coverage for a pap smear. After nearly two months of investigation, advocacy and CrescentCare staff follow up, it was revealed that Ambetter unilaterally and inappropriately changed the patient's designation in the medical recordkeeping system such that the claim was denied.

19. With respect to obtaining third-party payor coverage for gender affirming care, CrescentCare staff describe a "throw spaghetti against the wall" approach to getting claims approved. Because there is no clear rule as to what constitutes sex discrimination and whether health insurance plans are subject to such rules, CrescentCare and its patients must navigate a patchwork of payor barriers that have grown in this regulatory vacuum. Whether it is Blue Cross Blue Shield's private plans refusing to cover facial feminization surgery for transgender women, Louisiana Medicaid managed care organizations requiring peer-to-peer prior authorization for routine hormone replacement therapy, or the experience of only gaining approval for gender affirming care after multiple insurance appeals, the principle is the same. In the absence of a clear, strong rule from HHS that health insurance plans accepting federal financial assistance are subject

to Section 1557 and thereby prohibited from engaging in sex discrimination, including discrimination on the basis of gender identity, CrescentCare and its patients continue to experience harm. This harm takes the form both of the expenditure of unnecessary CrescentCare staff time and resources to access coverage, as well as regular instances of patients delaying care or foregoing medically necessary services altogether, or being financially responsible for care that should be covered.

20. CrescentCare's patient services also include navigating referral processes and making health care as seamless as possible. Because of the Rollback Rule, CrescentCare expends additional resources to determine whether other providers will choose not to discriminate against our patient. CrescentCare provides referrals to outside providers when we are unable to provide the needed medical services in our facilities. Increased concern over the impact of the Rule, particularly on provider practices, has led CrescentCare to begin more systematic reviews of referral experiences. CrescentCare has found it necessary to expend staff time and training resources devoted to developing and using "do not refer" lists. These lists reflect individual and institutional providers that have been reported to CrescentCare as not being safe sites of care for transgender or nonbinary patients. Such reports routinely involve instances where patients are refused treatment on the basis of their gender identity. For example, one CrescentCare patient who sought treatment for chronic pain was told by a local provider that they would not be treated unless they ceased their CrescentCare prescribed hormone replacement therapy. In another example, a transgender CrescentCare patient broke their ankle and sought care from a nearby large hospital. The CrescentCare patient was repeatedly mocked and misgendered by the nursing staff and an anesthesiologist on the basis of their gender identity. The hospital had no means of logging the patient's preferred pronouns or any nondiscrimination policy in place to prevent this treatment.

These regular occurrences have given rise to the need to create the "do not refer" list by CrescentCare staff.

21. The Rollback Rule causes CrescentCare to expend resources associated with our legal services. Some of our funding streams require that we provide high-quality legal services to our patients. We currently have limited capacity to represent our patients in navigating or appealing discriminatory denials of coverage. The Rollback Rule's narrowing of the definition for "covered entity" and rescission of a uniform enforcement mechanism requires greater resources, particularly for patients who mistakenly assume their health care coverage does not need to comply with Section 1557.

22. Based on the atmosphere of emboldened discrimination occasioned by the Rollback Rule, CrescentCare has experienced increased demand for our services, including gender affirming care and mental health services related to anxiety. CrescentCare providers routinely see patients who have travel up to 5 hours by car or transit for something as simple as primary care. Patients report that this is because they do not feel safe obtaining these services in closer geographic settings, due to an atmosphere of emboldened discrimination and violence. CrescentCare staff often have to advocate with third-party payors for non-emergency transportation services related to accessing health care for these same reasons. This is also true for circumstances in which CrescentCare patients are forced to travel long distances because specialists in gender affirming care have abandoned their local area.

23. As a result of the Rollback Rule, CrescentCare also experiences increased demand for needles and syringes used by people injecting hormones as part of their gender affirming care. Many of our patients have faced discrimination at their pharmacies and have been unable to obtain necessary supplies for their hormone injections, despite explicit inclusion of appropriately-sized

needles and syringes on prescriptions. Without these supplies, our patients are unable to access their medication and turn to CrescentCare for appropriate needles and syringes. Thus, with an increased demand for these supplies, we need to expend more resources ensuring our patients can get the care we prescribe for them.

24. The Rollback Rule causes CrescentCare to lose revenue. Maximizing third-party reimbursement for healthcare services that CrescentCare provides is central to its financial wellbeing. CrescentCare provides healthcare, including gender affirming care, regardless of insurance status and regardless of ability to pay. To remain eligible for certain federal funding and to keep CrescentCare designated as a federally qualified health center, we are required to reduce fees on a sliding scale for patients who are unable to pay and whose income is no greater than 200% of the Federal Poverty Level, even when the patient has insurance. CrescentCare currently generates about 14% of its operating revenue from insurer reimbursement for patient services. Approximately 30% of that insurer reimbursement comes from commercial insurers. Some of those insurers are subject to limited or no state regulation. As I recounted in my 2020 declaration, for example, we have patients with Louisiana-sponsored health care coverage who are unable to get coverage for gender affirming treatment because their plan, offered by the Louisiana Office of Group Benefits, has a categorical exclusion for treatment related to gender dysphoria. That exclusion has remained in place in the interim years. *See* https://perma.cc/5XEP-DUVL (categorical exclusion for "[s]ervices and supplies for the treatment of and/or related to gender dysphoria" on page 75 of 2023 plan document). While many of our patients ultimately decline to file multiple appeals or claims against their insurer or employer when coverage continues to be denied, these regulatory changes directly harm CrescentCare, our patients, and our pool of potential patients we draw from, by diminishing the scope of third-party reimbursement for

necessary health care and leaving CrescentCare to provide an increased quantity of uncompensated care and to spend significant administrative time associated with understanding, applying, and appealing associated coverage decisions.

25. The Rollback Rule causes CrescentCare to expend resources ensuring that we are not excluded from insurance networks, as some insurance companies may now understand their products to be outside of the scope of Section 1557 and understand the Rollback Rule to no longer extend Section 1557 protections to associational discrimination. In the past, CrescentCare has been dropped abruptly from a major insurer's network. We believe that this insurer cancelled our contract partly because one-third of our patients insured by the company were HIV positive and may have high pharmaceutical and medical costs. The termination of this contract brought financial harm to CrescentCare, as we lost out on a significant source of third-party reimbursement and diverted resources to ensuring patients did not experience an interruption in care and services. The Rollback Rule's elimination of protections against associational discrimination and its narrower definition of "covered entities" create the conditions for such an incident to occur again, especially as many of CrescentCare's services have grown in size and reputation, including services for people living with HIV and people who are LGBTQ+.

26. The Rollback Rule causes CrescentCare financial harm through an increase in non-reimbursable costs. An increase in patient volume, whether insured or uninsured, leads to an increased demand in non-medical services. Our current funding streams either would not cover or would not adjust to cover these additional services in a timely manner. Additionally, several of these services, such as patient outreach and Medicaid enrollment assistance, are required for federally qualified health centers but are not billable to insurance. Based on CrescentCare's

obligation to provide such services to all patients who need them, an increased demand would require additional expenditure of our resources.

27. CrescentCare has finite financial resources to dedicate to its healthcare services, and it does not anticipate an increase in funding that will match the increase in need for services. Our funding streams do not rapidly account for increases in uncompensated services and will not offset expected cost increases in a timely manner. For example, federal funding from Human Resources and Services Administration (HRSA) will very likely not offset the costs associated with a rapid increase in demand and a decrease in covered services. CrescentCare's annual HRSA grants are not immediately increased based on an increased patient population. As an FQHC, CrescentCare is also eligible for the Community Health Center Fund ("CHCF"), which provides supplemental federal grants to respond to emerging priorities. While the amount of CHCF funding CrescentCare receives generally depends on patient volume, the funding calculation is not based on current patient volume.

C. The Rollback Rule Frustrates CrescentCare's Mission by Making it More Difficult to Access Care, Emboldening Discrimination and Causing Confusion

28. As recounted above, CrescentCare's mission places particular emphasis on strengthening our entire community through whole-person healthcare and education, and ensuring general access to healthcare for our patients through education, research, and advocacy.

29. The Rollback Rule frustrates CrescentCare's mission by making it more difficult for our patients to access healthcare, both care related to gender dysphoria and care that is not. As part of our routine healthcare practice, CrescentCare refers and counsels patients, especially in connection with healthcare services that we do not offer. For example, CrescentCare maintains and updates a network of providers who will accept referrals for reproductive care and gender

affirming surgery, including hysterectomy, oophorectomy, orchiectomy, breast reconstruction, and mastectomy, among other procedures and who will provide high-quality, non-discriminatory care and support services to our patients. In the past, CrescentCare has had to adjust certain referral procedures to avoid discriminatory care, such as not indicating when an imaging request is related to post-abortion care.

30. The Rollback Rule withdrew previous protections against discrimination on the basis of gender identity and sexual orientation, as well as discrimination against people related to pregnancy, miscarriage, and abortion. HHS's failure to make a rule that clearly prohibits such discrimination by all providers and health insurance plans that accept federal financial support emboldens the atmosphere of discrimination that CrescentCare is forced to operate in. Our patients have suffered from fear and confusion caused by this failure. CrescentCare patients have been forced to delay or forego care, or leave prior providers to seek us out in this atmosphere.

31. The need for clarity from HHS has never been higher. In January 2024, Act 466 became operative in Louisiana, prohibiting many forms of gender affirming care for minors. CrescentCare has observed a spillover effect that promotes an atmosphere of discrimination against the transgender community's health care needs more generally. With no action or enforcement from HHS under Section 1557 in response to such developments, CrescentCare patients are faced with a difficult, confusing, and fearful landscape in accessing medically necessary care.

32. The Rollback Rule frustrates CrescentCare's mission by making it more difficult for CrescentCare to ensure the non-discriminatory practices of those with whom we partner or do business. In order to safeguard CrescentCare's reputation as a beacon of inclusive healthcare, it is important that the contractors, vendors, and providers we partner or work with adhere to a strict

relationships to assess whether ongoing association is warranted. For example, due to increasing concern about provider discrimination, some employees who provide patient navigation services have begun following up with patients after their referral visits to ensure the outside provider did not provide services in a discriminatory way.

33. The Rollback Rule frustrates CrescentCare's mission by making it more difficult to advocate for the coverage of medically necessary care. CrescentCare furthers its mission by guiding and supporting our patients as they appeal discriminatory insurance decisions. By diminishing the scope of compliant insurance coverage and eliminating protections meant to explicitly protect patients from discrimination, the Rollback Rule will make such advocacy significantly more difficult. Our providers, patient navigators, and legal services teams have limited capacity for assisting in these cases, and an increased need for this support would impede our ability to provide the highest quality of care to our patients.

Dated: February 18, 2024 at New Orleans, Louisiana.

Alice Riener
CEO
CrescentCare

EXHIBIT D

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

BAGLY, *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Civil Action No. 20-cv-11297-PBS

DECLARATION OF JO-ANN SAGAR

1. I am an attorney in the Washington, D.C. office of Hogan Lovells US LLP and counsel to Plaintiffs in this action.

2. I submit this Declaration in support of Plaintiffs' Motion for Partial Summary Judgment.

3. Attached to this Declaration are true and correct copies of the following numbered exhibits, including parts of the administrative record.[1]

   a. Attached as Exhibit D-1 is the National LGBTQ Task Force, Comment Letter on Proposed rule on Nondiscrimination in Health and Health Education Programs or Activities (Aug. 11, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-114943.

   b. Attached as Exhibit D-2 is the American Academy of Dermatology Association, Comment on Proposed Rule on Nondiscrimination in Health and Health Education Programs or Activities (Aug. 1, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-66096.

[1] As this matter involves Administrative Procedure Act issues, this declaration identifies comments before the Government and in the administrative record.

c. Attached as Exhibit D-3 is the Human Rights Watch, Comment Letter on Nondiscrimination in Health and Health Education Programs or Activities (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-134881.

d. Attached as Exhibit D-4 is The Leadership Conference Education Fund, Comment Letter on Proposed Rule on Nondiscrimination in Health and Health Education Programs (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-138231.

e. Attached as Exhibit D-5 is the University of Virginia Health System, Comment Letter on Proposed Rule on Nondiscrimination in Health and Health Education Programs or Activities (Aug. 13, 2019), https://www.regulations.gov/comment/HHS-OCR-2019-0007-127438.

f. Attached as Exhibit D-6 is the National Women's Law Center, Comment Letter Responding to Proposed Rule on Nondiscrimination in Health and Health Education Programs or Activities (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-149018.

g. Attached as Exhibit D-7 is the APLA Health, Comment on Proposed rule on Nondiscrimination in Health and Health Education Programs or Activities (Aug. 12, 2019), https://www.regulations.gov/document?D=HHS-OCR-2019-0007-128354.

h. Attached as Exhibit D-8 is National Asian Pacific American Women's Forum, Comments on 2019 Proposed Rule (Aug. 13, 2019), https://bit.ly/2O9cvbW.

i. Attached as Exhibit D-9 is the Movement Advancement Project, Comment Letter on Nondiscrimination in Health and Health Education Programs or Activities (July 16, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-39962.

j. Attached as Exhibit D-10 is National Alliance of State & Territorial AIDS Directors, Section 1557 Comments (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-141103.

k. Attached as Exhibit D-11 is the Human Rights Campaign, Public Comment in Response to the Notice of proposed Rulemaking Addressing Nondiscrimination in Health and Health Education Programs or Activities (Aug. 12, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-145467.

l. Attached as Exhibit D-12 is the American Essentials Hospitals, Nondiscrimination in Health and Health Education Programs or Activities Comment Letter (Aug. 9, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-99445.

m. Attached as Exhibit D-13 is the National Council of Jewish Women, Comment Letter Regarding Nondiscrimination in Health and Health Education Programs or Activities (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-121279.

n. Attached as Exhibit D-14 is the Johns Hopkins Center Transgender Health, Public Comment on 1557 Proposed Rule Change (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-146355.

o. Attached as Exhibit D-15 is the Transgender Legal Defense & Education Fund (TLDEF) Comment on Section 1557 (Aug. 13, 2019), https://www.regulations.gov/comment/HHS-OCR-2019-0007-149238.

p. Attached as Exhibit D-16 is the National Immigration Law Center, Comment Letter on Section 1557 Rule (Aug. 5, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-73730.

q. Attached as Exhibit D-17 is the GLMA, Comment on Section 1557 NPRM (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-145199.

r. Attached as Exhibit D-18 is ACLU of West Virginia, Comment on Section 1557 (Aug. 9, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-116231.

s. Attached as Exhibit D-19 is the Civil Liberties Committee of the Chicago Counsel of Lawyers, Comment on Nondiscrimination in Health and Health Education programs or Activities Proposed Rule (Aug. 12, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-126688.

t. Attached as Exhibit D-20 is NARAL Pro-Choice Oregon Foundation, Section 1557 Proposed Rule Comments (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-151658.

u. Attached as Exhibit D-21 is American Nurses Association, Comment Letter to HHS on Section 1557 (Aug. 8, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-89147.

v. Attached as Exhibit D-22 is The Stonewall Democratic Club of Solano County, Comment on Section 1557 (Aug. 11, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-115309.

w. Attached as Exhibit D-23 is Pennsylvania Commission on LGBTQ Affairs, Public Comment Section 1557 (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-145582.

x. Attached as Exhibit D-24 is In Our Own Voice: National Black Women's Reproductive Justice Agenda, Section 1557 Comment Letter (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-140963.

y. Attached as Exhibit D-25 is the URGE, Section 1557 Organizational Comment (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-146120.

z. Attached as Exhibit D-26 is the HIV Health Care Access Working Group, Section 1557 Comments (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-146758.

aa. Attached as Exhibit D-27 is the Funders for LGBTQ Issues, Public Comments Section 1557 (July 25, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-126602.

bb. Attached as Exhibit D-28 is the MassHealth, Comments on HHS Proposed Rule on Nondiscrimination in Health and Health Education Programs or Activities (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-136510.

cc. Attached as Exhibit D-29 is the New York State Department of Health, Comment on Center for Medicare & Medicaid Services' notice of Proposed Rulemaking (Aug. 6, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-80207.

dd. Attached as Exhibit D-30 is the AccessMatters, Health Care Rights Law Proposed Rule (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-151147.

ee. Attached as Exhibit D-31 is the Equality North Carolina, Comment Letter on Section 1557 Proposed Rule (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-149961.

ff. Attached as Exhibit D-32 is the Northwest Health Law Advocates, Comment on Section 1557 NPRM (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-146600.

gg. Attached as Exhibit D-33 is the American Psychiatric Association, Comment on Nondiscrimination in Health and Education Programs or Activities (Aug. 9, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-107673.

hh. Attached as Exhibit D-34 is the Association of American Medical Colleges, Comment Letter on 2019 Proposed Rule (Aug. 12, 2019) ("AAMC Comments"), https://bit.ly/3dWBcD7.

ii. Attached as Exhibit D-35 is the Power to Decide, Comments on Health Care Rights Law Section 1557 (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-145672.

jj. Attached as Exhibit D-36 is the ACLU of Southern California, Section 1557 Public Comment (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-149859.

kk. Attached as Exhibit D-37 is the National Association of County and City Health Officials, Comment Letter on 2019 Proposed Rule (Aug. 13, 2019), https://bit.ly/2VKOQCV.

ll. Attached as Exhibit D-38 is The American College of Obstetricians and Gynecologists, Comment Letter on 2019 Proposed Rule (Aug. 13, 2019), https://bit.ly/2BYreDT.

mm. Attached as Exhibit D-39 is the Massachusetts Department of Mental Health, Comment Letter on 2019 Proposed Rule (Aug. 13, 2019), https://www.regulations.gov/comment/HHS-OCR-2019-0007-140910.

nn. Attached as Exhibit D-40 is the American College of Emergency Physicians, Comment Letter on 2019 Proposed Rule (Aug. 13, 2019), https://bit.ly/3gjO1sw.

oo. Attached as Exhibit D-41 is the Massachusetts Medical Society, Comment Letter on 2019 Proposed Rule (Aug. 13, 2019), https://www.regulations.gov/comment/HHS-OCR-2019-0007-138093.

pp. Attached as Exhibit D-42 is the National Health Law Program, Comment Letter on Proposed Rule on Nondiscrimination in Health and Health Education Programs and Activities (Aug. 12, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-127004.

qq. Attached as Exhibit D-43 is the Callen-Lorde Community Health Center, Comment Letter on 2019 Proposed Rule (Aug. 7, 2019) (AR 02273884-02273888), https://bit.ly/38s6rVf

rr. Attached as Exhibit D-44 is The Fenway Institute, Comment Letter on 2019 Proposed Rule (Aug. 13, 2019), https://www.regulations.gov/comment/HHS-OCR-2019-0007-144421.

ss. Attached as Exhibit D-45 is the Massachusetts League of Community Health Centers, Comment Letter on 2019 Proposed Rule (Aug. 13, 2019), https://www.regulations.gov/comment/HHS-OCR-2019-0007-152061.

tt. Attached as Exhibit D-46 is the Boston Children's Hospital, Comment Letter on 2019 Proposed Rule (Aug. 13, 2019), https://www.regulations.gov/comment/HHS-OCR-2019-0007-141769.

uu. Attached as Exhibit D-47 is an article by Wylie C. Hembree et al. titled *Endocrine Treatment of Gender- Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. Clinical Endocrinology & Metabolism 3869 (2017) (AR 01445138-01445172).

vv. Attached as Exhibit D-48 is the Endocrine Society's Comment Letter on the 2019 Proposed Rule (Aug. 13, 2019), https://www.regulations.gov/comment/HHS-OCR-2019-0007-137213.

ww. Attached as Exhibit D-49 is the ACLU of South Carolina, Section 1557 Comment (Aug. 9, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-116555.

xx. Attached as Exhibit D-50 is the ACLU of Nebraska, Section 1557 Comment (Aug. 12, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-114900.

yy. Attached as Exhibit D-51 is the Transgender Legal Defense & Education Fund, Comments on Section 1557 Proposed Rulemaking (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-149238.

zz. Attached as Exhibit D-52 is the PROMO, Comment on Section 1557 (Aug. 9, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-128437.

aaa. Attached as Exhibit D-53 is the Indiana Legal Services, Comment on Section 1557 Proposed Rulemaking (Aug. 12, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-126357.

bbb. Attached as Exhibit D-54 is the American Medical Association, Comment Letter on 2019 Proposed Rule (Aug. 13, 2019), https://bit.ly/3eZKijH.

ccc. Attached as Exhibit D-55 is the Health Care for All New York, Comment on Proposed rule on Nondiscrimination in Health and Health Education Programs or Activities (Aug. 13, 2019), https://www.regulations.gov/comment/HHS-OCR-2019-0007-146702.

ddd. Attached as Exhibit D-56 is the National Hispanic Leadership Agenda, NHLA Comment – 1557 NPRM (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-147313.

eee. Attached as Exhibit D-57 is the Planned Parenthood Federation of America, Comment on Proposed rule on Nondiscrimination in Health and Health

Education Programs or Activities, (Aug. 13, 2019), https://www.regulations.gov/document/HHS-OCR-2019-0007-154878.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on March 19, 2024 at Washington, DC.

/s/ *Jo-Ann Sagar*
Jo-Ann Sagar

EXHIBIT D-1

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August 11, 2019

submitted via www.regulations.gov

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

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

Dear Secretary Azar:

The National LGBTQ Task Force submits these comments in response to the Department of Health and Human Services' (HHS, the Department) and the Center for Medicare and Medicaid Services (CMS) Notice of Proposed Rulemaking (proposed rule) to express strong opposition to the proposed rule entitled "Nondiscrimination in Health and Health Education Programs or Activities," published in the Federal Register on July 14, 2019.

The National LGBTQ Task Force is the nation's oldest lesbian, gay, bisexual, transgender, and queer (LGBTQ) advocacy group. As a progressive social justice organization, the National LGBTQ Task Force works to achieve full freedom, justice, and equity for LGBTQ people and our families. The National LGBTQ Task Force vehemently opposes the proposed elimination or rollback of critical protections guaranteed by Section 1557 of the Affordable Care Act (ACA) and the 2016 Nondiscrimination in Health Programs or Activities final rule (2016 final rule).

LGBTQ people are in every community across the country. We are members of every race and ethnicity; we are members of every age group; we live with disabilities and chronic conditions. We demand that the proposed rule not be finalized. If finalized, the proposed rule would detrimentally harm the health and well-being of LGBTQ people—especially those of us who live with disabilities or chronic conditions, and who speak languages other than English, and who need access to reproductive health services like abortion. For those of us who hold multiple of these identities, the proposed rule could exacerbate the already existing barriers we face in attempting to access comprehensive, competent, and affirming health care.

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I. The intent of Section 1557 of the Affordable Care Act was to increase access to health care. The proposed rule will make it harder for people to get the health care they need.

The ACA, and especially Section 1557 and its 2016 implementing regulations, helped to increase access to health care for LGBTQ people, people with disabilities, people living with HIV/AIDS, people with limited English proficiency (LEP), and people needing reproductive health services—especially people who hold more than one of these identities.

Congress passed the ACA with the intent to make health care more accessible to people. Section 1557, in prohibiting discrimination in health care programs based on race, color, national origin, sex, age, and disability, acknowledged how these identities overlap and discrimination compounds to prevent people from getting the health care they need. With the intent of recognizing how people's identities overlap and intersect, Section 1557 aimed to take the different remedies under each civil rights law and provide broad civil rights protections and remedies under a single provision of the ACA.

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

Section 1557 and the 2016 final rule have been critical in removing barriers to accessing health coverage and care for many historically discriminated against communities, including the LGBTQ community. As a result of Section 1557 and the 2016 final rule, LGBTQ people are now more able to be covered by insurance and more able to access life-saving healthcare, including but not limited to gender-affirming care and treatment for HIV.

Now, the proposed rule poses significant risks to LGBTQ people, especially those who need reproductive health care, including abortion, are women of color, live with disabilities and/or chronic conditions, and whose primary language is not English–all people who already experience significant barriers to accessing health care. The proposed changes could create additional barriers and potentially lead to worse health outcomes,

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disproportionately impacting those living at the intersections of these identities. For example, a woman who is transgender and living with HIV could experience compounded discrimination based on her being a woman, being transgender, and living with HIV; a woman who is a lesbian and an immigrant with LEP could experience compounded discrimination based on her being a woman, being a lesbian, her national origin, being an immigrant, and being LEP; a man who is transgender and needs an abortion could be discriminated against for being transgender and for needing abortion care; or a nonbinary person who needs auxiliary aids could be discriminated against for being nonbinary and having a disability.

In order to reflect the ACA's clear intent and its overriding purpose of ensuring that no one should face discrimination in health care, the proposed rule should not be finalized.

II. The proposed rule impermissibly attempts to narrow the scope of Section 1557.

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

The proposed rule attempts to reduce the number of health insurance plans that are covered by claiming that if the issuer of a health plan is "not principally engaged in the business of providing health care (as opposed to health insurance), only its Marketplace plans would be covered and any plans it offers outside the marketplace would not be subject to Section 1557."[1] Additionally, the proposed rule improperly attempts to narrow that application of Section 1557's protections to only the portion of a health care program or activity that received federal financial assistance. These changes unlawfully narrow the scope of Section 1557's application.

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

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III. The proposed rule impermissibly attempts to eliminate protections against sex discrimination.

a. Sex discrimination based on gender identity

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

i. The 2016 final rule clarified that health care providers cannot refuse to treat someone because of their gender identity. The proposed rule could open the door for a health care provider to refuse to treat someone because of their gender identity.

Transgender, nonbinary, and gender nonconforming people already experience high rates of discrimination and harassment in health care. According to the 2015 U.S. Transgender Survey, 33% of respondents had at least one negative experience in a health care setting relating to their gender identity in the past year.[2] Rates were higher for Native respondents (50%), Middle Eastern respondents (40%), multiracial respondents (38%), and respondents with disabilities (42%).[3] According to a 2018 Center for American Progress Survey, 23% of respondents had a provider intentionally misgender or use the wrong name for them, 21% had a provider use harsh or abusive language when treating them, and 29% experienced unwanted physical contact, such as fondling, sexual assault, or rape, from a provider.[4]

As a result, transgender, nonbinary, and gender nonconforming people already often avoid care out of fear of discrimination. According to the 2015 U.S. Transgender Survey, 23% of respondents did not seek health care when they needed it due to fear of

[2] S.E. JAMES, ET AL., NAT'L CTR. FOR TRANSGENDER EQUALITY, REPORT OF THE 2015 U.S. TRANSGENDER SURVEY 96-97 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.
[3] *Id.*
[4] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

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being disrespected or mistreated as a transgender person.[5] Rates were higher for Native American respondents (37%) and Middle Eastern respondents (34%).[6] The proposed rule would only further discourage people from seeking necessary medical care. This is especially true for transgender immigrants. As of 2013, there were an estimated 20,000 undocumented transgender adults living in the U.S.[7] A 2013 UCLA Labor Center study found that 75% of undocumented transgender Latinas reported feeling depressed in the past 12 months, with only 32% seeing a therapist.[8] Additionally, the study found that 61% of undocumented transgender Latinas reported going to the emergency room if they needed to see a doctor.[9] The proposed rule could open the door to further discrimination and harassment and could result in more people avoiding necessary health care.

ii. The 2016 final rule clarified that insurance companies cannot categorically exclude or deny coverage for gender-affirming care. The proposed rule illegally attempts to again open the door to insurance companies categorically excluding coverage of gender-affirming care from their plans or denying individuals coverage of procedures used for gender affirmation.

Gender-affirming care is medically necessary and often lifesaving for transgender, nonbinary, and gender nonconforming people experiencing gender dysphoria.[10] Prior to the 2016 final rule, many insurers did not cover gender-affirming care, making it even more difficult to afford. However, as a result of the 2016 final rule, many insurers removed categorical coverage exclusions for transgender people and began to cover gender-affirming services,[11] increasing access to care. Still, gender-affirming care is notoriously difficult to access. The proposed rule would put gender-affirming care further out of reach

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[5] S.E. JAMES, ET AL., NAT'L CTR. FOR TRANSGENDER EQUALITY, REPORT OF THE 2015 U.S. TRANSGENDER SURVEY 96-98 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.
[6] *Id.*
[7] Imelda S. Plascencia et. al., The Dream Resource Center of the UCLA Labor Center, *Undocumented and Uninsured: A Five-Part Report on Immigrant Youth and the Struggle to Access Health Care in California, The Power of a Healthy Family* 4 (2017), https://www.labor.ucla.edu/wp-content/uploads/2018/06/UU-Part-4-Power-of-Healthy-Community_WEB.pdf.
[8] *Id.*
[9] *Id.*
[10] NAT'L HEALTH LAW PROGRAM, ET AL., MEDICAID AS AN LGBTQ REPRODUCTIVE JUSTICE ISSUE: A PRIMER, GENDER-AFFIRMING CARE IN MEDICAID 1 (2019), https://healthlaw.org/resource/medicaid-as-an-lgbtq-reproductive-justice-issue-a-primer/.
[11] OUT2Enroll, *Summary of Findings: 2019 Marketplace Plan Compliance with Section 1557*, https://out2enroll.org/out2enroll/wp-content/uploads/2018/11/Report-on-Trans-Exclusions-in-2019-Marketplace-Plans.pdf (last visited Jul. 17, 2019).

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by giving insurers the false impression that they could refuse to cover gender-affirming care.

The proposed rule could have an especially devastating impact on LGBTQ youth and young adults. Approximately 3.2 million young people ages 8-18 in the U.S. identify as LGBTQ[12] and 20% of people ages 18-34 identify as LGBTQ, with 12% of people ages 18-14 identifying as transgender or gender nonconforming.[13] In addition to the discrimination faced by LGBTQ youth based on their sexual orientation or gender identity, young people face further barriers to accessing comprehensive health care due to their age such as lack of confidentiality, access to health insurance, financial obstacles to accessing culturally competent medical providers, and access to transportation.[14] This is especially true for LGBTQ youth living at the intersections of multiple marginalized identities. This proposed rule would open the door to medical providers and insurance companies refusing to provide medically necessary services to a segment of the LGBTQ population that, because of their age, have little to no recourse.

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

Transgender, nonbinary, and gender nonconforming people already face unique barriers to accessing reproductive health care. For example, the vast majority of transmasculine individuals require cervical cancer screening, but only 27% reported that they had a Pap test in the past year due to high under- and uninsurance rates and

[12] Press Release, The Williams Inst., LGBT Youth Experiences Discrimination, Harassment, and Bullying in School (Mar. 22, 2018), https://williamsinstitute.law.ucla.edu/press/lgbt-youth-bullying-press-release/
[13] GLAAD, Accelerating Acceptance 3 (2017), http://www.glaad.org/files/aa/2017_GLADD_Accelerating_Acceptance.pdf.
[14] *How Section 1557 Affects Young People's Protections-A Webinar by the National Women's Law Center and Advocates for Youth* (Jul. 24, 2019).

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increased gender dysphoria due to the nature of the exam, compared to 43% of cisgender females.[15] Under the proposed rule, those barriers would only increase. For example, transgender, nonbinary, and gender nonconforming people assigned female at birth whose gender marker is male or nonbinary could be denied coverage for necessary care such as a pap smear or mammogram. Similarly, transgender nonbinary, and gender nonconforming people assigned male at birth whose gender marker is female or nonbinary could be denied coverage for necessary care such as a prostate exam.

b. Sex discrimination based on sex stereotyping

The 2016 final rule reiterated that sex stereotyping is a prohibited form of discrimination under the 1989 Supreme Court decision, *Price Waterhouse v. Hopkins.*[16] The proposed rule attempts to erase established Supreme Court precedent recognizing that discrimination on the basis of sex includes discrimination on the basis of sex stereotypes. This could result in health providers thinking they could turn a patient away because the patient does not conform with traditional stereotypes about their sex.

Federal courts have applied the reasoning of *Price Waterhouse* to LGBTQ people seeking relief for sex discrimination. Lesbian, gay, bisexual, and queer people already experience significant discrimination in health care. 7% had a provider refuse to recognize their family, including a child or a same-sex spouse/partner.[17] 9% had a provider use harsh or abusive language when treating them.[18] 7% experienced unwanted physical contact from provider, including fondling, sexual assault, or rape.[19] Again, transgender, nonbinary, and gender nonconforming people already experience high rates of discrimination and

[15] REBEKAH ROLLSTON, THE FENWAY INST., PROMOTING CERVICAL CANCER SCREENING AMONG FEMALE-TO-MALE TRANSMASCULINE PATIENTS (Sean Cahill & Tim Wang, eds., 2019), https://fenwayhealth.org/wp-content/uploads/TFIP-28_TransMenCervicalCancerScreeningBrief_web.pdf.
[16] 490 U.S. 228 (1989).
[17] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.
[18] *Id.*
[19] *Id.*

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harassment in health care.[20] The proposed rule could open the door to further discrimination.

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

The 2016 final rule made clear that sex discrimination under Section 1557 includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related conditions. The proposed rule attempts to roll back these protections. Although HHS acknowledges in the preamble to this proposed rule that the prohibition against sex discrimination includes termination of pregnancy, it refuses to state whether the Department would enforce those protections and proposes to delete the 2016 final rule's clarification that the ban on sex discrimination includes all pregnancy related care. In doing so, the Department illegally attempts to eliminate the express protections that apply to someone who has had an abortion or has experienced a miscarriage or ectopic pregnancy and needs care for those conditions.

The proposed rule could result in patients being denied critical care including miscarriage management. Transgender, nonbinary, and gender nonconforming people already face unique barriers to accessing abortion, pregnancy care, and miscarriage care. For example, a transgender man had a stillbirth after nurses misdiagnosed him as obese rather than pregnant.[21] The proposed rule would only make these occurrences more likely.

Further, the proposed rule seeks to unlawfully incorporate Title IX's "Danforth Amendment", which carves out abortion care and coverage from the ban on discrimination of sex in the education context. Congress did not include the Title IX exceptions, including the Danforth Amendment, either explicitly or by reference, in Section 1557. The proposed incorporation of the Danforth Amendment could embolden illegal discrimination that will fall heaviest on those least able to seek health care elsewhere, including LGBTQ people who need access to abortion.

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[20] S.E. JAMES, ET AL., NAT'L CTR. FOR TRANSGENDER EQUALITY, REPORT OF THE 2015 U.S. TRANSGENDER SURVEY 96-97 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

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

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LGBTQ people need access to abortion. "Unintended pregnancies are equally as common, if not more common, for cisgender lesbian and bisexual women as for cisgender heterosexual women. A majority of cisgender lesbian and bisexual women have reported having had intercourse with people who could get them pregnant, at least 30% have been pregnant, and at least 16% have had one or more abortions. Additionally, transgender men and nonbinary and gender nonconforming people assigned female at birth experience unintended pregnancies. Many trans, nonbinary, and gender nonconforming people have intercourse with partners who have the ability to get them pregnant. For example, in one study of almost 200 transgender men, 17% reported having experienced a pregnancy and roughly 12% of those who became pregnant reported having an abortion."[22]

d. Religious Exemptions

The 2016 final rule intentionally did not include any religious exemption. The proposed rule attempts to impermissibly apply Title IX's religious exemption to Section 1557's prohibition on sex discrimination, contrary to the express purpose of the statute and its language.

If implemented, this could allow for religiously-affiliated hospitals and other health care entities to discriminate against patients based on sex, disproportionately harming LGBTQ people, and especially LGBTQ people seeking reproductive health services. Religious exemptions disproportionately harm LGBTQ people, especially those who are transgender, nonbinary, gender nonconforming. LGBTQ people are often refused health

[22] BRIDGET ("B") SCHAAFF, NAT'L LGBTQ TASK FORCE, QUEERING REPRODUCTIVE JUSTICE: MINI TOOLKIT 10 (Candace Bond-Theriault ed., June 2019) (citing Caroline S. Hartnett, Lisa L. Lindley and Katrina M. Walsemann, *Congruence across Sexual Orientation Dimensions and Risk*, WOMEN'S HEALTH ISSUES JOURNAL (2016); J.M. Marrazzo & K. Stine, *Reproductive Health History of Lesbians: Implications for Care*, AM. J. OF OBSTETRICS AND GYNECOLOGY (2003); Elizabeth M. Saewyc, Linda H. Bearinger, Robert Wm. Blum & Michael D. Resnick, *Sexual Intercourse, Abuse and Pregnancy Among Adolescent Women: Does Sexual Orientation Make a Difference?*, 31 FAMILY PLANNING PERSPECTIVES 127 (1999); Porsch, L. M., Dayananda, I., & Dean, G., *An Exploratory Study of Transgender New Yorkers' Use of Sexual Health Services and Interest in Receiving Services at Planned Parenthood of New York City*, TRANSGENDER HEALTH, Vol. 1 (1) (2016), https://doi.org/10.1089/trgh.2016.0032; Obedin-Maliver, J., & Makadon, H.J., *Transgender men and pregnancy*, OBSTETRIC MEDICINE, Vol. 9(1) (2015), https://doi. org/10.1177/1753495X15612658; Alexis Light, et al., *Family planning and contraceptive use in transgender men*, CONTRACEPTION J., Vol. 9 (4) (2018), https://doi. org/10.1016/j.contraception.2018.06.006).

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care services because of their sexual orientation and/or gender identity.[23] A 2018 Center for American Progress study found that 8% of LGBQ people were refused health care *because of* their sexual orientation, 6% were refused care *related to* their sexual orientation.[24] Further, 29% of transgender people were refused health care *because of* their gender identity, and 12% were refused health care *related to* their identity (gender-affirming care).[25]

When LGBTQ people are refused treatment, it becomes difficult or impossible to find another provider. This is especially for those living in rural areas and for transgender people.[26] According to the 2018 Center for American Progress study, 18% of LGBTQ people said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 17% said it would be very difficult or not possible to find the same type of service at a different clinic.[27] These rates are higher for LGBTQ people living outside of a metropolitan area: 41% said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 31% said it would be very difficult or not possible to find the same type of service at a different clinic.[28] These rates are also higher for transgender people: 31% said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 30% said it would be very difficult or not possible to find the same type of service at a different clinic.[29] The proposed rule would make it harder for LGBTQ people to access the health services they need.

Similarly, LGBTQ people seeking access to abortion or other reproductive health services are doubly harmed by religious exemptions/refusals. LGBTQ people already face significant barriers to accessing competent and affirming abortion care. If LGBTQ people are refused abortion care because of a provider's religion, it would make it difficult or impossible to receive the care they need.

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[23] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] *Id.*

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IV. The proposed rule impermissibly attempts to amend unrelated regulations to exclude protections based on gender identity and sexual orientation.

The 2016 final rule did not touch other HHS health care regulations. The proposed rule attempts to erase all references to gender identity and sexual orientation in all HHS health care regulations. If implemented, this rule would eliminate express prohibitions on discrimination based on gender identity and sexual orientation from regulations that govern a range of health care programs, including private insurance and education programs. This could result in less health care and poorer health outcomes for LGBTQ communities across the country—especially poor LGBTQ people, poor LGBTQ people with disabilities, poor LGBTQ people of color; older LGBTQ adults; and people who are transgender, nonbinary, gender nonconforming.

a. The proposed rule could also result in less coverage and care for poor LGBTQ people.

Under the proposed rule, Medicaid managed care entities and state Medicaid programs could discriminate against LGBTQ beneficiaries in enrollment. LGBTQ people are more likely to live in poverty than the overall U.S. population;[30] as a result, LGBTQ people are more likely that non-LGBTQ people to use Medicaid.[31] The proposed rule would open the door to discrimination against the many LGBTQ people enrolled in Medicaid programs across the country, including LGBTQ people with disabilities, LGBTQ people of color, and transgender, nonbinary, and gender nonconforming people.

LGBTQ people are also people with disabilities. For example, 26% of gay men, 36% of bisexual women, 36% of lesbian women, 40% of bisexual men experience a form

[30] *See*, *e.g.*, INTERSECTING INJUSTICE: A NATIONAL CALL TO ACTION (Lourdes Ashely Hunter, Ashe McGovern & Carla Sutherland eds., 2018), http://socialjusticesexuality.com/intersecting_injustice/.
[31] Caitlin Rooney, Charlie Whittington & Laura E. Durso, *Protecting Basic Living Standards for LGBTQ People*, Ctr. for Am. Progress (Aug. 13, 2018, 12:01 AM), https://www.americanprogress.org/issues/lgbt/reports/2018/08/13/454592/protecting-basic-living-standards-lgbtq-people/. *See also* NAT'L HEALTH LAW PROGRAM, ET AL., MEDICAID AS AN LGBTQ REPRODUCTIVE JUSTICE ISSUE: A PRIMER, WHY MEDICAID IS AN LGBTQ ISSUE 2 (2019), https://healthlaw.org/resource/medicaid-as-an-lgbtq-reproductive-justice-issue-a-primer/ (citing Kerith J. Conron & Shoshana K. Goldberg, The Williams Inst., *LGBT Adults with Medicaid Insurance* 1 (2018), https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Medicaid.pdf (last visited May 02, 2019)).

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of disability.[32] Additionally, 28% of transgender, nonbinary, and gender nonconforming people experience a form of disability.[33] Within the LGBTQ community, LGBTQ people with disabilities (44.4%) are more likely than LGBTQ people with no disabilities (11.8%) to receive Medicaid.[34] The proposed rule would open the door to discrimination against the many LGBTQ people with disabilities enrolled in Medicaid programs across the country.

LGBTQ people are also people of color.[35] Within the LGBTQ community, LGBTQ people of color (24%) are more likely than white LGBTQ people (18.8%) to receive Medicaid.[36] The proposed rule would open the door to discrimination against the many LGBTQ people of color enrolled in Medicaid programs across the country.

Transgender, nonbinary, and gender nonconforming people are more likely than non-LGBTQ people and more likely than cisgender LGBQ people to use Medicaid.[37] Specifically, transgender people are roughly 1.6 times more likely than cisgender people LGBQ to receive Medicaid. The proposed rule would open the door to discrimination against the many transgender, nonbinary, and gender nonconforming people enrolled in Medicaid programs across the country.

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[32] Disabled World, *LGBT and Disability: Information, News and Fact Sheets*, https://www.disabled-world.com/disability/sexuality/lgbt/ (last updated Feb. 7, 2019).
[33] S.E. JAMES, ET AL., NAT'L CTR. FOR TRANSGENDER EQUALITY, REPORT OF THE 2015 U.S. TRANSGENDER SURVEY 247 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.
[34] Caitlin Rooney, Charlie Whittington & Laura E. Durso, *Protecting Basic Living Standards for LGBTQ People*, Ctr. for Am. Progress (Aug. 13, 2018, 12:01 AM), https://www.americanprogress.org/issues/lgbt/reports/2018/08/13/454592/protecting-basic-living-standards-lgbtq-people/.
[35] *See* GARY J. GATES, GALLUP, IN U.S., MORE ADULTS IDENTIFYING AS LGBT (2017), https://news.gallup.com/poll/201731/lgbt-identification-rises.aspx.
[36] Caitlin Rooney, Charlie Whittington & Laura E. Durso, *Protecting Basic Living Standards for LGBTQ People*, Ctr. for Am. Progress (Aug. 13, 2018, 12:01 AM), https://www.americanprogress.org/issues/lgbt/reports/2018/08/13/454592/protecting-basic-living-standards-lgbtq-people/.
[37] *Id. See also* NAT'L HEALTH LAW PROGRAM, ET AL., MEDICAID AS AN LGBTQ REPRODUCTIVE JUSTICE ISSUE: A PRIMER, WHY MEDICAID IS AN LGBTQ ISSUE 2 (2019), https://healthlaw.org/resource/medicaid-as-an-lgbtq-reproductive-justice-issue-a-primer/ (citing Kerith J. Conron & Shoshana K. Goldberg, The Williams Inst., *LGBT Adults with Medicaid Insurance* 1 (2018), https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Medicaid.pdf (last visited May 02, 2019)).

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b. The proposed rule could also result in less coverage and care for LGBTQ elders.

Under the proposed rule, Programs of All-Inclusive Care for the Elderly (PACE) organizations, who serve people ages 55+, could discriminate against LGBTQ people.[38] There are more than 3 million LGBTQ people age 55+ in the U.S., and that number is expected to double within the next 20 years.[39] Many older LGBTQ adults already feel reluctant to discuss their sexual orientations and gender identities with health providers due to fear of judgment and/or substandard care.[40] The proposed rule would only further discourage older LGBTQ adults from sharing information that may be relevant to the health services they need.

d. The proposed rule could result in less coverage and care for transgender, nonbinary, and gender nonconforming people.

In addition to being more likely to be impacted by the proposed changes to Medicaid managed care entities and state Medicaid programs,[41] transgender, nonbinary, and gender nonconforming people could be significantly impacted by additional proposed amendments to unrelated regulations.

Under the proposed rule, states and Marketplaces could discriminate against transgender, nonbinary, and gender nonconforming people in eligibility determinations, enrollment periods, and more. Similarly, agents and brokers who assist with enrollment in marketplace plans could discriminate against transgender, nonbinary, and gender

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

[39] ROBERT ESPINOZA, SERVS. & ADVOCACY FOR GAY, LESBIAN, BISEXUAL, & TRANSGENDER ELDERS, OUT & VISIBLE: THE EXPERIENCES AND ATTITUDES OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER OLDER ADULTS, AGES 45-75, 5 (2014), https://www.sageusa.org/wp-content/uploads/2018/05/sageusa-out-visible-lgbt-market-research-full-report.pdf.

[40] *Id.*

[41] *See* Caitlin Rooney, Charlie Whittington & Laura E. Durso, *Protecting Basic Living Standards for LGBTQ People*, Ctr. for Am. Progress (Aug. 13, 2018, 12:01 AM), https://www.americanprogress.org/issues/lgbt/reports/2018/08/13/454592/protecting-basic-living-standards-lgbtq-people/. *See also* NAT'L HEALTH LAW PROGRAM, ET AL., MEDICAID AS AN LGBTQ REPRODUCTIVE JUSTICE ISSUE: A PRIMER, WHY MEDICAID IS AN LGBTQ ISSUE 2 (2019), https://healthlaw.org/resource/medicaid-as-an-lgbtq-reproductive-justice-issue-a-primer/ (citing Kerith J. Conron & Shoshana K. Goldberg, The Williams Inst., *LGBT Adults with Medicaid Insurance* 1 (2018), https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Medicaid.pdf (last visited May 02, 2019)).

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nonconforming people. Further, under the proposed rule, insurance issuers could employ discriminatory marketing practices and benefit design. For example, issuers could inquire about an applicant's sexual orientation or gender identity and use that information for underwriting or determining insurability.[42] Issuers could also charge higher premiums for transgender, nonbinary, and gender nonconforming people, or could cancel or deny coverage for transgender, nonbinary, and gender nonconforming people.[43] As a result, transgender, nonbinary, and gender nonconforming people would face additional barriers to getting the health care they need.

V. The proposed rule impermissibly attempts to eliminate language access protections.

Over 21 percent of the U.S. population, or 66 million people, speak a language other than English at home, with 25 million speaking English less than "very well" and thus considered LEP.[44] The barriers that LGBTQ people face in accessing health care are exacerbated with a person is both LGBTQ and LEP.

A person who is both LGBTQ and LEP is more likely to experience the negative impacts of poor communication between patient and provider because of their compounded marginalized identities. Without the regulatory requirements outlined in the current regulations, people with LEP could face additional challenges in access to culturally and linguistically appropriate care, including information about accessing services and health insurance.

In particular, language barriers may prevent medical professionals from competently discussing and communicating health issues that are highly prevalent in the LGBTQ community, such as HIV and STIs (sexually transmitted infections). Fear of

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

[43] *Id.*

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

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discrimination already prevents LGBTQ individuals from accurately disclosing information to their health providers, leading to increased HIV transmission from lack of testing and treatment.[45] Under the proposed rule, miscommunication and fear will escalate between LGBTQ patients who are LEP, particularly those that are also living with HIV, and their providers. As a result, LGBTQ people living with HIV experiencing language barriers and fear of discrimination would have less access to HIV medication and treatment.

Further, though many LEP people living in the U.S. are not immigrants, the proposed rule could detrimentally impact the health and well-being of immigrants. As of 2013, the Williams Institute estimated that there were nearly one million LGBT adult immigrants in the United States.[46] LGBTQ immigrants already face significant barriers in getting the health care they need. For example, a 2013 UCLA Labor Center study that interviewed 550 immigrant youth found that more than half of them were unable to get the healthcare they needed that year because of lack of access to health insurance and cost.[47] If finalized, the proposed rule will increase barriers to accessing care by imposing additional fear of discrimination, which will discourage LGBTQ immigrants and their families from obtaining necessary medical care, leading to poor health outcomes.

a. Remote interpreting services

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

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[45] Human Rights Campaign, *How HIV Impacts LGBTQ People* (last updated Feb. 2017), https://www.hrc.org/resources/hrc-issue-brief-hiv-aids-and-the-lgbt-community

[46] GARY J. GATES, LGBT ADULT IMMIGRANTS IN THE UNITED STATES, THE WILLIAMS INST. 2 (Mar. 2013), available at http://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/us-lgbt-immigrants-mar-2013/. LGBT is used rather than LGBTQ because of the data collected.

[47] IMELDA S. PLASCENCIA, ALMA LEYVA, MAYRA YOANA JAIMS PENA & SAVA WAHEED, UCLA LAB. CTR., UNDOCUMENTED AND UNINSURED PART 4: THE POWER OF A HEALTHY COMMUNITY (2016), https://www.labor.ucla.edu/publication/undocumented-and-uninsured-part-4-the-power-of-a-healthy-community/.

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b. Taglines

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

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

c. Language access plans

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

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

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VI. The proposed rule impermissibly attempts to eliminate prohibitions of discrimination in insurance plan benefit design and marketing.

Over 133 million people in the U.S. live with at least one chronic condition.[48] Over 61 million people in the U.S. live with a disability.[49] Due to systemic barriers to health care, LGBTQ have a "higher prevalence and earlier onset of disabilities" and disproportionately experience chronic conditions.[50] Again, 26% of gay men, 36% of bisexual women, 36% of lesbian women, 40% of bisexual men experience a form of disability,[51] and 28% of transgender, nonbinary, and gender nonconforming people experience a form of disability.[52]

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

Under the 2016 final rule, covered entities are prohibited from designing benefits that discourage enrollment by persons with significant health needs. For example, insurers are prohibited from placing all or most prescription drugs used to treat a specific condition, such as HIV prescriptions, on a plan's most expensive tier.[53] Additionally, covered entities are prohibited from using discriminatory marketing practices, such as those "designed to encourage or discourage particular individuals from enrolling in certain health plans."[54] The proposed rule improperly attempts to eliminate these prohibitions.

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[48] *The Growing Crisis of Chronic Disease in the United States*, P'ship to Fight Chronic Disease, https://www.fightchronicdisease.org/sites/default/files/docs/GrowingCrisisofChronicDiseaseintheUSfactsheet_81009.pdf (last visited Jul. 17, 2019).
[49] Press Release, Ctrs. for Disease Control & Prevention, *CDC: 1 in 4 US Adults Live with a Disability* (Aug. 16, 2018, 1:00 PM), https://www.cdc.gov/media/releases/2018/p0816-disability.html.
[50] INTERSECTING INJUSTICE: A NATIONAL CALL TO ACTION 63 (Lourdes Ashely Hunter, Ashe McGovern & Carla Sutherland eds., 2018), http://socialjusticesexuality.com/intersecting_injustice/.
[51] Disabled World, *LGBT and Disability: Information, News and Fact Sheets*, https://www.disabled-world.com/disability/sexuality/lgbt/ (last updated Feb. 7, 2019).
[52] S.E. JAMES, ET AL., NAT'L CTR. FOR TRANSGENDER EQUALITY, REPORT OF THE 2015 U.S. TRANSGENDER SURVEY 247 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.
[53] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.
[54] *Id.*

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The proposed rule would disproportionately impact LGBTQ people of color living with disabilities and chronic conditions, including HIV. Due to systemic barriers to health care, LGBTQ people disproportionately experience chronic conditions,[55] including HIV.[56] HIV disproportionately affects gay, bisexual, and queer men of color and transgender women of color.[57] For example, more than 25% of Black and Brown transgender women are living with HIV,[58] and 60% (10,070) of Black or African American individuals who received an HIV diagnosis in 2017 were gay or bisexual men.[59] The final rule's prohibition on discriminatory plan benefit designs helped LGBTQ people living with HIV get the medications they need, but the proposed rule would make it harder for LGBTQ people to afford coverage and care.

VII. The proposed rule impermissibly attempts to undermine notice and enforcement requirements and remedies.

a. Nondiscrimination notice and grievance procedure requirements

The 2016 final rule requires covered entities with at least 15 employees to adopt a grievance procedure and designate at least one employee to coordinate its Section 1557 responsibilities.[60] The 2016 final rule also requires covered entities to provide notice of nondiscrimination policies in significant communications, in physical locations where the entity interacts with the public, and on the home page of their website. The notice of nondiscrimination must include information about the characteristics protected from discrimination under Section 1557, the availability of and how to access auxiliary aids and services, the availability of and how to access language assistance services, contact information for the designated employee coordinating the entity's Section 1557 responsibilities, the entity's grievance procedures, and complaint procedures for the Office of Civil Rights (OCR).

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[55] INTERSECTING INJUSTICE: A NATIONAL CALL TO ACTION 63 (Lourdes Ashely Hunter, Ashe McGovern & Carla Sutherland eds., 2018), http://socialjusticesexuality.com/intersecting_injustice/.
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *HIV and African Americans*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html (last updated March 19, 2019).
[60] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

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The proposed rule improperly attempts to eliminate these provisions entirely, which would have a disproportionate impact on LGBTQ people—especially those who could also be discriminated against due to their race, color, national origin (including limited English proficiency), sex (including not only sex stereotypes and gender identity but also pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions), age, and/or disability.

b. Private right of action and compensatory damages

The 2016 final rule, like the statute itself, allows for a private right of action in federal court. The proposed rule attempts to eliminate the regulatory provisions recognizing private right of action in federal court. Additionally, the 2016 final rule allows for money damages for violations of Section 1557 in both administrative and judicial actions brought under the regulation. The proposed rule attempts to eliminate the regulatory provision providing that money damages are available to those who are injured by violations of the statute, ultimately increasing confusion about what the law is and making it harder for those who are discriminated against to enforce their rights.

c. Enforcement Mechanisms

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

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Section 1557 recognizes the reality that discrimination may occur not solely because of the person's race or national origin, or not solely because of the person's sex or gender identity, disability status, or national origin, but because of the combination of those characteristics.[61] Thus, the law aimed to make it easier for people to file complaints of intersectional discrimination in one place. The proposed rule will only make it harder for people to file complaints, imposing harmful consequences for communities who have historically been discriminated against in health care, especially LGBTQ people of color.

VIII. In conclusion, the proposed rule should not be finalized.

By discouraging people from accessing health care out of fear of discrimination, the proposed rule will only increase barriers to accessing care for those who already experience the most significant barriers to health care, including LGBTQ people, people with disabilities and chronic conditions, people who have had abortions, people of color, and people with LEP—especially people who hold more than one of these identities. As a result, the proposed rule could lead to increased poverty, housing instability, and more, which LGBTQ people already disproportionately experience. For these reasons, HHS and CMS should not finalize the proposed rule.

Thank you for the opportunity to submit comments on the proposed rule. Please do not hesitate to contact Meghan Maury, Policy Director, at mmaury@thetaskforce.org to provide further information.

Sincerely,

National LGBTQ Task Force

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

EXHIBIT D-2

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August 1, 2019

Roger Severino, JD
Director, Office for Civil Rights
Department of Health and Human Services
Attention: Section 1557 NPRM, RIN 0945–AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Re: HHS Office for Civil Rights (OCR) [Docket No.: HHS–OCR–2019–0007] RIN 0945–AA11 Nondiscrimination in Health and Health Education Programs or Activities

Dear Mr. Severino:

The American Academy of Dermatology Association (Academy) represents close to 14,000 dermatologists nationwide. We appreciate the opportunity to provide comments on OCR's proposed rule seeking to overhaul the Affordable Care Act's Section 1557 regulations that impact patients and their health coverage, as well as dermatologists and their medical practices.

Dermatologists diagnose and treat more than 3,000 diseases, including skin cancer, psoriasis, immunologic diseases and many genetic disorders.[1] One in four Americans suffers or will suffer from a skin disease. As dermatologists at the forefront of the fight against skin cancer and treating numerous skin diseases, the Academy recognizes and embraces this opportunity to submit comments on affirming our nondiscrimination approach to delivering timely, affordable and quality-based patient care regardless of race, color, national origin, disability, age, sex, sexual orientation, gender identity and gender expression. Overall, this proposed rule represents an important step forward in certain areas in health care delivery and cost savings, though other aspects raise concerns.

General Comments

The Academy supports OCR's manifest commitment "to vigorously enforce civil rights in healthcare, including people with disabilities". We also acknowledge its policy constraints to conform to recent court decisions blocking enforcement of the 2016 final regulation that extends protection from discrimination that cover gender identify and abortion, including attempts to roll back to the narrower scope that returns to the longstanding interpretation of gender identity and sex discrimination. Notwithstanding this reality, we wish to affirm our approved policy statement on gender identity and patient access to dermatologic care.[2]

[1] The Academy's *Burden of Skin Disease* briefs are a set of informational resources that capture the scope and importance of various skin conditions, and can be accessed at https://www.aad.org/about/burden-of-skin-disease/burden-of-skin-disease-briefs.

[2] Position Statement on Sexual and Gender Minority Health in Dermatology.

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Separately, the Academy welcomes proposed changes to Section 1557 and its provisions governing major language access requirements—requiring dermatology practices to include translated taglines on notices and significant communications to patients. We generally agree that these notice requirements have proven unduly costly, inefficient, and largely ineffective. The projected five-year $3.6 billion cost-saving estimates expected from this proposed rule, if finalized, will continue to provide relief from regulatory burden which can be invested in future efforts to improve patient access to quality care.

Specific Comments

Nondiscrimination in Health Programs or Activities

The Academy recognizes OCR's rationale for proposing to overhaul the scope of the definition by narrowing the criteria of who is protected from discrimination to comply with recent federal court decisions. We remain concerned, however, that this proposed rule – if finalized – will create a number of problems for certain sections of the American population seeking access to care. For example, patients covered under Medicaid, Medicare Advantage programs, dealing with pregnancy termination or who identify as neither male nor female would be exposed to discrimination.

Although the longstanding implications of this proposed rule remain to be seen, we are concerned that the proposal will contribute to further confusion in how the law and its associated regulations are interpreted across the nation and across healthcare settings, increasing compliance burdens on employers, employees, physicians, patients, and their health insurance plans. While some segments of the gender minority population live in states and locales with their own explicit nondiscrimination protections, currently 39 percent of the US LGBTQ population lives in states that have no explicit policy regarding transgender health coverage and care in their Medicaid programs, and 12 percent lives in states that explicitly exclude such coverage. Given this precarious and hodgepodge legal landscape regarding gender identity discrimination with new judicial and legislative challenges consistently arising, we believe that clarity on such nondiscrimination protections is critical for the health and well-being of our patients regardless of their identity. The current Section 1557 nondiscrimination protections have safeguarded populations that have been among the most vulnerable to discrimination, including LGBTQ and sexual and gender minority individuals. We recognize, along with numerous other major medical associations and organizations, that transition-related care for the transgender community is not only effective but medically necessary. The current rule helps to ensure that these populations have equal access to healthcare and to appropriate coverage. We know that stigma is one of the most pressing problems for LGBTQ people, resulting in isolation and anxiety about accessing health care. In a recent survey, nearly one in four respondents did not see a physician when otherwise necessary due to fear of mistreatment.[3] This proposed rule will only serve to amplify those disparities and concerns. It is important to remember that current estimates suggest the percentage of the US population identifying as transgender or gender non-conforming exceeds that with a diagnosis of Type 1 diabetes mellitus.[4,5] Systemic disenfranchisement of such a significant segment of the population is simply unacceptable.

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[3] 2015 U.S. Transgender Survey Report.

[4] Menke A, Orchard TJ, Imperatore G, Bullard KM, Mayer-Davis E, Cowie CC. The Prevalence of Type 1 Diabetes in the United States. Epidemiology (Cambridge, Mass). 2013;24(5):773-774).

[5] Herman, J.L., Flores, A.R., Brown T.N.T., Wilson, B.D.M. Age of Individuals who Identify as Transgender in the United States. Los Angeles, CA: The Williams Institute. 2017.

The changes to the definitions section of the current rule, particularly “covered entity” and “on the basis of sex,” threatens to overhaul the designation of transgender and gender minority individuals as a protected class in healthcare. OCR believes the rule will be clear enough with the proposed definition revisions, but this is a fallacy that will only serve to disenfranchise gender minority patients, limiting their ability to access high-quality care without stigma. The definition of ‘sex’ as proposed by the Section 1557 revisions is narrow, vague, and medically inaccurate. We recognize that regardless of the definition used for ‘sex,’ discrimination based on gender identity invariably will be based on this definition, which reinforces the need for explicit protections.

Nondiscrimination protections such as those in Section 1557 are integral for LGBTQ patients to access care and of course do not obviate the use of professional medical judgment. Such protections simply ensure that patients are able to access the same quality care afforded to others regardless of their identity.

The following are some dermatologic examples of how this proposed rule, if finalized, may impact sexual and gender minority patients in terms of access, coverage, needs, disparity, quality of care and safety:

1. Currently, covered entities are required to treat patients in a manner consistent with their gender identity and cannot deny access to services or facilities based on that identity. With the proposed changes, for example, a hospital may now be able to assign a transgender woman to a male ward. Additionally, this threatens to reverse much of the progress that has been made in recent years to lift exclusions on medically necessary gender affirming care (e.g., hormone therapy, surgical procedures, and mental health counseling) for transgender individuals.
2. With weakened nondiscrimination measures, transition-related care that would be otherwise approved were it not related to transition can be denied. Additionally, in some cases it may be possible, for example, for a transgender man to be denied care for ovarian cancer.
3. Weakening of existing nondiscrimination protections through the proposed Section 1557 revisions will perpetuate further systemic discrimination; data supports that such structural discrimination leads to an increased health burden and greater risk of mental health issues, homelessness, and unemployment. LGBTQ patients have higher rates of suicide with 40 percent of transgender people reporting attempting suicide. We have data to show that this number substantially drops when transgender patients are able to access healthcare and receive gender-affirming treatments.
4. The 2015 U.S. Transgender Survey indicated that nearly 1 in 4 respondents did not see a physician when they needed to for fear of being mistreated. For those that had sought health services in the last year, respondents report having at least one negative experience. Structural weakening of existing nondiscrimination protections by the proposed revisions to Section 1557 would only serve to further these perceptions and reluctance to interface with the healthcare system.
5. Dermatologists provide care for a wide range of skin conditions that affect sexual and gender minority patients.[6] Our *Position Statement on Sexual and Gender Minority Health in Dermatology* [7] addresses sexual and gender minority health in dermatology by stating that the Academy “Opposes all bias and discrimination based upon gender identity, gender expression, and sexual orientation and supports development of gender-neutral policies in patient care and in healthcare facilities.”

[6] Yeung H, Chen S, Ginsberg B, Katz K. Dermatologic care for lesbian, gay, bisexual, and transgender persons: Epidemiology, screening, and disease prevention. JAAD. 2019 Mar; 80(3):591-602.

[7] Position Statement on Sexual and Gender Minority Health in Dermatology.

6. In dermatology, one fear is that benefits may be denied to transgender patients seeking isotretinoin therapy for severe acne resulting from hormonal affirmation therapy with testosterone. The same concerns apply to transgender patients seeking minimally invasive procedures for gender affirmation, including neurotoxin injections, soft tissue augmentation, and laser hair removal, the latter of which is often necessary in preparation for transition-related surgeries, including gender reassignment. This could make it more difficult or impossible for dermatologists to provide culturally competent, medically necessary care for their patients. For example, dermatologists have experienced multiple claims and prior authorizations denials for medications used to treat testosterone-induced acne in transgender and gender-nonconforming patients. These denials have not only included isotretinoin but also antibiotics and topical medications. We would anticipate that these coverage dilemmas might become increasingly more common if this proposed rule is finalized.
7. Dermatologists could be called upon to make medically irrelevant or impossible determinations of whether skin conditions including acne, medication hypersensitivities, or infections are related to an individual's gender identity or gender affirming therapy in order for them to receive coverage for medically necessary care.

Impact on Nondiscrimination in Health Coverage

To the extent that this proposed rule, if finalized, would remove other important regulatory prohibitions against discrimination in health insurance issuance, coverage, cost-sharing, marketing, and benefit design, the Academy is concerned that this course of action may result patient harm. Patients insured by health plans, subject to Section 1557, will likely face constraints in accessing care because of denials, coverage limitations and restrictions, cancellation and even insurance policy termination. By upending nondiscriminatory protections under the current regulation, we foresee health plans creating policies that either limit access to care for certain, if not all, segments of their beneficiaries population based on specific clinical conditions, penalizing beneficiaries by shifting them to higher-cost formulary tiers, imposing prior authorization barriers or step therapy protocols for critically indicated medications and limiting medical services regardless of their clinical effectiveness.

From our experience, we have observed that some health plans appear to discriminate against patients with chronic medical conditions, genetic variations in the population, cultural differences, ability to pay, and gender by structuring their plans in a way that discourages enrollment. Health plans designed with restrictive formularies and increased use of utilization review processes can put necessary life-changing and often life-saving medications out of reach of average Americans. Individuals covered under plans subject to this proposed change are at risk for losing access to necessary medications. This can disrupt the recommended course of treatment and discourage many of those suffering from chronic or serious conditions from re-enrolling in that specific plan. Individuals who have chronic or serious health conditions will not benefit from selecting plans that have formularies with clauses that restrict or do not fully cover specific medications. The Academy urges OCR to reconsider adopting the proposed provisions impacting specific nondiscrimination protection in health care coverage and plan benefits.

Taglines, Notices, Language Access Plans, and Video Interpretation Standards

The Academy applauds OCR's proposal to remove requirements for dermatology practices to distribute nondiscrimination notices and taglines translation notices in at least 15 languages in "significant communication" (larger than a postcard or brochure) to patients. We agree that these notice requirements have forced medical practices to incur significant resources that drive up the cost of care, and that have proven ineffective (with data showing that these notices have not resulted in benefits for patients with limited English proficiency (LEP) as most

patients receiving notices are proficient in English or ignore these notices). We welcome relief from these costly and burdensome requirements.

The Academy also welcomes OCR's proposal to retain requirements that dermatology practices take reasonable steps to ensure meaningful access to care for patients with limited English proficiency. To help solo and small group practices assess their readiness with complying with the proposed "flexible standard based on the particular facts of a situation," the Academy recommends that OCR develop further scalable guidance and practical resources tailored to help smaller practices manage and meet the need of LEP patients eligible to be served or likely to be encountered. One example of this scalable guidance would be OCR curating a list of translation apps that physicians could use in their practice to communicate with patients with limited English proficiency. These apps have proven to be low cost and effective in managing patients with limited English proficiency and additional guidance from OCR would be welcome.

We support replacing the video interpreting services requirements with audio-based services as a more reasonable, efficient and cost-effective compliance standard. Often audio-only services involve less wait time for patients needing care. Relative to hospitals or multispecialty clinics, smaller practices have a lesser number or face a lower frequency of patients needing interpreting services. Therefore, audio services rather than the expensive and unnecessary video interpreting technology are more suitable to smaller, disadvantaged medical offices.

Discrimination Against Persons with Disabilities

While OCR is proposing to not disturb the current rule's requirements with respect to individuals with disabilities, meaning that covered entities, including medical practices, must still provide auxiliary aids and services to individuals with impaired sensory, manual, or speaking skills regardless of the number of people the entity employs. The Academy supports and welcomes exempting "small entities" (i.e., medical practices with 15 or fewer employees) from this requirement. We believe that if OCR exercises its regulatory discretion by granting smaller entities compliance waivers this would not significantly impair the ability of these patients from receiving these services. The Academy also supports maintaining the current rule's requirement that medical practices make reasonable modifications to their policies, practices, and procedures when necessary to avoid discrimination based on disability.

Assurances & Grievances Procedures

Regarding retaining requirements that covered entities submit an assurance of compliance with Section 1557, the Academy supports the following regulatory relief reforms:

1. We urge OCR to remove the compliance assurance requirement for covered entities and to replace with a demonstration of "good faith" criteria bolstered by online resources to help drive compliance. Otherwise, the administrative burden imposed by this current requirement would remain unchanged and duplicative.
2. We also urge OCR to eliminate the requirement that each covered entity with 15 or more employees have a compliance coordinator and written grievance procedure to handle complaints about alleged violations of Section 1557.

Other Areas for Comments

Once finalized, the Academy recommends that OCR implement the following steps by offering practice support compliance guidance and online resources to help small entities sustain a robust nondiscrimination compliance program:

1. Small entities would benefit from OCR's assistance with providing them an updated list of requirements, best practices, FAQS, and other scalable tools that would preserve nondiscrimination against individuals with LEP and disabilities. Such valuable technical assistance would ensure that a final rule preserves the rights of these individuals under federal law while ensuring manageable and effective compliance obligations on covered entities.
2. Further, such online resources would minimize confusion as small entities with limited resources would be able to readily follow their nondiscrimination compliance responsibilities and offer eligible patients access to appropriate and affordable assistance. This would also strengthen the ability of small entities to meet other obligations that require written policies and processes for handling grievances regarding certain disability and sex discrimination claims under other, existing regulations.
3. OCR should explore offering appropriate technologies to help covered entities comply with their obligations under the final rule. Specifically, OCR should offer small entities a vetted, published list of vendors offering free audio and other technology-based assistance. We believe that leveraging technology can prove valuable, practical, effective, fiscally responsible and capable of being readily implemented.

The Academy appreciates the opportunity to provide comments on this proposed rule reforming the ACA's Section 1557 regarding nondiscrimination in health care, removing costly and unnecessary burdensome requirements while maintaining vigorous civil rights protections through continued compliance monitoring and enforcement. We look forward to additional opportunities to provide feedback that may help guide policy development. Please contact William Brady, Associate Director of Health Care Policy, at 847.240.1824 or wbrady@aad.org, if you require clarification or would like more information on the comments in this letter.

Sincerely,

George J. Hruza, MD MBA FAAD,
President
American Academy of Dermatology Association

CC: Marta J. Van Beek, MD, MPH, FAAD, Secretary-Treasurer
Irvin Bomberger, Interim Executive Director

EXHIBIT D-3

August 13, 2019

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

Re: RIN 0945-AA11, "Nondiscrimination in Health and Health Education Programs or Activities"

Dear Secretary Azar:

Human Rights Watch is an independent organization working to investigate, expose, and address human rights violations around the globe. We write to oppose the proposed rule on Nondiscrimination in Health and Health Education Programs or Activities, and to urge the Department of Health and Human Services to instead renew its efforts to eradicate discrimination on the basis of sex – including discrimination against transgender people – in healthcare settings.

In July 2018, Human Rights Watch published the report "*You Don't Want Second Best": Anti-LGBT Discrimination in US Health Care*.[1] The report documents the difficulties that lesbian, gay, bisexual, and transgender (LGBT) people encounter in accessing healthcare services in the United States. In November 2018, Human Rights Watch published the report *"Living at Risk": Transgender Women, HIV, and Human Rights in South Florida*.[2] Based on our research, we believe the proposed rule would exacerbate discrimination against transgender people in medical settings and would negatively affect their health and rights.[3] The proposed rule would narrow the Department's definition of discrimination based on sex; among other changes, it would exclude discrimination based on gender identity as a form of sex discrimination. In doing so, it would leave transgender people vulnerable to discrimination and refusals of service by insurers and healthcare providers, jeopardizing their health and rights.

I. The Proposed Rule Does Not Sufficiently Protect Patients

In the Final Rule issued in 2016, the Department of Health and Human Services observed that transgender individuals experience stark health disparities and often are unable to obtain insurance coverage, are not protected under covered entities' nondiscrimination policies, are harassed in healthcare settings, are refused care, and delay or forego needed healthcare

[1] Human Rights Watch, *"You Don't Want Second Best": Anti-LGBT Discrimination in US Health Care* (2018), https://www.hrw.org/sites/default/files/report_pdf/us_lgbt0718_web.pdf.
[2] Human Rights Watch, *"Living at Risk": Transgender Women, HIV, and Human Rights in South Florida* (2018), https://www.hrw.org/report/2018/11/20/living-risk/transgender-women-hiv-and-human-rights-south-florida.
[3] While this Comment primarily examines how the rollback of the rule would jeopardize the rights of transgender people, the rollback would also adversely affect LGB and pregnant people who are protected under existing regulations.

because of concerns about mistreatment.[4] The Department determined at the time that the Final Rule would help ameliorate these concerns and would benefit the health and well-being of women, transgender people, and the wider society.[5] It specifically found that "[b]y prohibiting discrimination on the basis of sex, Section 1557 [of the Affordable Care Act] would result in more women and transgender individuals obtaining coverage and accessing health services."[6]

A substantial body of research indicates that these conditions persist. Moreover, the potential benefits of the existing regulations have not yet been realized, as they have been enjoined by a federal court and the Administration has not enforced them or established alternative means of protecting transgender people from discrimination in healthcare. The Administration's decision to roll back the Final Rule does not address the weighty concerns that initially motivated rulemaking in this area, and leaves transgender individuals vulnerable to discrimination, mistreatment, and refusals of care by insurers and providers alike.

The failure to protect patients is exacerbated by other recent law and policy changes that weaken protections and permit insurers and providers to discriminate. Last year, Human Rights Watch expressed opposition to the Proposed Rule on Protecting Statutory Conscience Rights in Health Care; Delegations of Authority.[7] The Department ultimately adopted a version of this rule, expanding exemptions for religious and moral objectors and jeopardizing the ability of women and LGBT people to obtain the healthcare services they need. The Department's approach to nondiscrimination protections jeopardizes transgender health on two fronts; it substantially expands "exemptions" to nondiscrimination provisions by arguing these are necessary to preserve the rights of religious and moral objectors, while simultaneously rejecting or repealing the underlying nondiscrimination protections themselves.[8] The cumulative result of these regulatory changes is more pervasive discrimination and significantly reduced access to care. The changes facilitate discrimination against groups who already face persistent mistreatment and bias in healthcare settings.

II. LGBT People, Especially Transgender People, Already Face Stark Health Disparities and Barriers to Accessing Care; Federal Protection is Necessary

When LGBT people experience health problems, they may encounter a variety of barriers to obtaining the care they need. A nationally representative survey in 2017 found that 25 percent of transgender respondents were uninsured, compared to only 8 percent of cisgender

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[4] "Nondiscrimination in Health Programs and Activities; Final Rule," 45 CFR 92, Federal Register Vol. 81, No. 96, May 18, 2016, https://www.gpo.gov/fdsys/pkg/FR-2016-05-18/pdf/2016-11458.pdf.
[5] Ibid. at 31461.
[6] Ibid. at 31460.
[7] Human Rights Watch, "Human Rights Watch Letter to US Secretary of Health and Human Services Alex Azar," March 27, 2018, https://www.hrw.org/news/2018/03/27/human-rights-watch-letter-us-secretary-health-and-human-services-alex-azar.
[8] See Human Rights Watch, *"All We Want is Equality": Religious Exemptions and Discrimination against LGBT People in the United States* (2018), https://www.hrw.org/sites/default/files/report_pdf/lgbt0218_web_1.pdf.

respondents.[9] Transgender people also face high rates of discrimination and mistreatment in medical settings. The same survey found that 21 percent of transgender respondents had been subject to harsh or abusive language by healthcare providers in the year preceding the survey.[10] Over the same period, 29 percent of transgender respondents reported that a healthcare provider had refused to see them because of their gender identity or sexual orientation.[11] Similarly, a survey of almost 28,000 transgender people in 2015 found that 33 percent of respondents had experienced a negative interaction with a healthcare provider because of their gender identity in the year preceding the survey.[12]

When LGBT people experience discrimination or refusals from healthcare providers, this can prevent them from obtaining the care they need. One survey found that 41% of LGBT people outside of major metropolitan areas felt it would be "very difficult" or "not possible" to find an alternative provider if they were refused care at a hospital.[13]

The discrimination and mistreatment that transgender people experience throughout healthcare settings make expansive nondiscrimination protections important. In interviews, patients and advocates noted that they not only encountered discrimination from medical providers, but from administrative staff. Jeynce Poindexter, a victims advocate at the LGBT organization Equality Michigan, observed in an interview with Human Rights Watch: "The initial interaction in the emergency room, where you have to give your ID, info, insurance, that's mainly where the complaints come from… There's lots of misgendering, harmful terminology, intentional disrespect."[14] Connie L., a 31-year-old transgender woman in Miami, recalled: "This woman shouted for 'Kevin' to come to the desk. I shrunk in my seat, hoping she would see the note on the chart about my gender change. But she just kept yelling for Kevin. I finally had to get up and cross the room in a walk of shame. Will I ever go back there? No way."[15]

Other Human Rights Watch interviewees faced humiliation or discrimination from providers themselves. In 2018, Renae T., a transgender woman in Memphis, Tennessee, told Human

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[9] Kellan Baker & Laura E. Durso, "Why Repealing the Affordable Care Act is Bad Medicine for LGBT Communities," Center for American Progress, March 22, 2017, https://www.americanprogress.org/issues/lgbt/news/2017/03/22/428970/repealing- affordable-care-act-bad-medicine-lgbt-communities (accessed August 11, 2019).

[10] Shabab Ahmed Mirza & Caitlin Rooney, "Discrimination Prevents LGBTQ People from Accessing Health Care," Center for American Progress, January 18, 2018, https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing- health-care (accessed August 11, 2019).

[11] Ibid.

[12] Sandy James et al., Executive Summary of the Report of the 2015 U.S. Transgender Survey, National Center for Transgender Equality (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Executive-Summary-Dec17.pdf (accessed August 11, 2019).

[13] Shabab Ahmed Mirza & Caitlin Rooney, "Discrimination Prevents LGBTQ People from Accessing Health Care," Center for American Progress, January 18, 2018, https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing- health-care (accessed August 11, 2019).

[14] Human Rights Watch interview with Jeynce Poindexter, Equality Michigan, Detroit, MI, January 16, 2018.

[15] Human Rights Watch interview with Connie L., Miami, Florida, February 6, 2018.

Rights Watch about an incident where a nurse was treating her for cardiomyopathy (a heart condition), left the room, and audibly told another nurse to come look at the patient's breasts.[16] Judith N., a transgender woman in East Tennessee, described a pre-employment medical examination in which a doctor abruptly ended the appointment without giving her the exam as soon as he saw that she had shaved her legs.[17] Karen W., a transgender woman in Biloxi, Mississippi, recounted that she had been admitted and then ignored when seeking care at the emergency room at a local hospital.[18]

In some instances, transgender people are refused care outright because of their gender identity. Jessica Shea, a clinical social worker in Memphis, described how a religiously affiliated psychiatric practice turned away a transgender child:

> They accepted the person at first, but when they found out it was a trans client, the doctor said we don't see trans clients here. They got in the door, but then got turned away. It often takes months to get an appointment here, and the family felt they had invested a lot of time to get in, and was then turned away. It was the doctor there.... Once he found out the child was a trans child he said they would not be able to accommodate them for the psych evaluation. The family was told they don't provide services to trans clients.[19]

Other services that were offered to the general public were similarly withheld from transgender individuals. One interviewee in Memphis recounted the story of a transgender woman who "had a yeast infection, and five to six doctor's offices told her we don't treat trans patients. But a prescription for Diflucan isn't gendered! Unless you're talking about HRT or surgery, health care isn't different for trans people. It's a body that needs care."[20]

Such discriminatory incidents can deter people from returning for further medical care. As Carla B., the mother of a transgender teenager, told Human Rights Watch in 2017: "I said these are [my son's] name and his pronouns and he was sitting there, and the doctor uses his birth name and pronouns.... After the doctor left, [my son] cried for a solid ten minutes, and said I don't want to come back here ever again."[21]

Discrimination in health care can compound the isolation and discrimination in society that also contribute to health disparities. Researchers have found that the added stressors that members of marginalized groups experience – called *minority stress* – can adversely affect both physical

[16] Human Rights Watch interview with Renae T., Memphis, TN, January 12, 2018.
[17] Human Rights Watch interview with Judith N. (pseudonym), Johnson City, TN, December 10, 2017.
[18] Human Rights Watch telephone interview with Karen W. (pseudonym), Biloxi, MS, October 4, 2017.
[19] Human Rights Watch interview with Jessica Shea, Memphis, TN, January 11, 2018.
[20] Human Rights Watch interview with Holly Calvasina, Choices, Memphis, TN, January 10, 2018.
[21] Human Rights Watch interview with Carla B. (pseudonym), Knoxville, TN, December 9, 2017.

and mental health.[22] Levels of minority stress are influenced by the environment in which people live. Research shows that, in parts of the country with greater social and legal equality, LGBT people have better health outcomes and smaller disparities in comparison with their cisgender, heterosexual counterparts.[23]

Conversely, laws targeting LGBT people can contribute to stress. One recent study found that the passage of state-level religious refusal laws, for example, was associated with a 46 percent increase in the number of LGBT residents of the state reporting mental distress.[24]

Consistent with these findings, research has established that transgender people are at heightened risk of physical and mental health conditions.[25] Existing data from the United States indicates that transgender people are more likely to be overweight, be depressed, report cognitive difficulties, and forego treatment for health problems than their cisgender counterparts.[26] In the United States, the National HIV/AIDS Strategy designates transgender women as a "high-risk" and "key" population as a recent meta analysis found 14 percent of transgender women are HIV positive, with higher prevalence rates among transgender women of color.[27] This is grossly disproportionate to the overall prevalence of HIV in the US, which is under one percent.[28]

Despite these clear patterns regarding transgender health needs and challenges securing access to care, state-level nondiscrimination laws and policies are limited, leaving many transgender people in the US without sufficient protection.[29] Public insurance also varies considerably from state to state. While Medicaid expressly covers transition-related care in 19 states and the District of Columbia, it is silent on the issue in 24 states, and excludes transition-related care in

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[22] Brief of Ilan H. Meyer, PhD., and Other Social Scientists and Legal Scholars Who Study the LGB Population as Amici Curiae Supporting Respondents, Masterpiece Cakeshop v. Colorado Civil Rights Commission, No. 16-111 (U.S. 2017), p. 23-24.
[23] Ibid.
[24] Mary Elizabeth Dallas, "'Religious Refusal Laws May Take Mental Health Toll on LGBT Americans," US News & World Report, May 23, 2018, https://health.usnews.com/health-care/articles/2018-05-23/religious-refusal-laws-may-take-mental-health-toll-on-lgbt-americans (accessed August 11, 2019).
[25] See Centers for Disease Control and Prevention, "About LGBT Health," March 24, 2017, https://www.cdc.gov/lgbthealth/about.htm (accessed August 11, 2019).
[26] Carl G. Streed, Ellen McCarthy & Jennifer S. Haas, "Association Between Gender Minority Status and Self-Reported Physical and Mental Health in the United States," JAMA Internal Medicine, Vol. 177, No. 8 (2017), 1210-1212.
[27] US Centers for Disease Control, "HIV Among Transgender People," https://www.cdc.gov/hiv/group/gender/transgender/index.html (accessed August 11, 2019);"HIV among Transgender People Fact Sheet," https://www.cdc.gov/hiv/pdf/group/gender/transgender/cdc-hiv-transgender-factsheet.pdf (accessed August 11, 2019); US Office of National HIV/AIDS Strategy, "National HIV/AIDS Strategy for the United States, Updated to 2020," https://files.hiv.gov/s3fs-public/nhas-update.pdf (accessed August 11, 2019).
[28] Avert, "HIV and AIDS in the United States of America," https://www.avert.org/professionals/hiv-around-world/western-central-europe-north-america/usa (accessed August 11, 2019).
[29] Movement Advancement Project, "Healthcare Laws and Policies," http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies (accessed August 6, 2019).

seven states.[30] Rolling back federal protections would leave people especially vulnerable in states that lack comprehensive protections against gender identity discrimination in health care. In 2018, for example, the Iowa Supreme Court ruled that excluding transition-related care from public insurance violated the Iowa Civil Rights Act; in 2019, the legislature amended the Iowa Civil Rights Act to expressly permit such discrimination.[31] Federal protection is necessary to meaningfully prevent discrimination in healthcare for transgender people throughout the United States.

III. The Proposed Rule Would Exacerbate Documented Barriers to Accessing Health Care

Through interviews, Human Rights Watch has identified some of the many barriers that transgender people encounter when seeking healthcare services. The proposed rule would exacerbate each of these concerns.

First, as described above, transgender people face widespread discrimination, even when accessing routine health services. Existing nondiscrimination protections at the federal level ensure that individuals who need care receive that care, regardless of their gender identity or expression. The proposed rule would permit discrimination by providers, allowing them to decide whether to provide care based not on the patient's healthcare needs, but on their identity or expression. A foreseeable consequence is that some providers will feel emboldened to discriminate, and transgender individuals will be less certain that they will receive or can insist on fair treatment in the absence of clear protections.

Second, transgender people are often unable to obtain healthcare to meet specific needs related to their gender identity, and the current rule helps mitigate this situation by improving insurance coverage and ensuring that services available to cisgender patients are also available to transgender patients. Transgender people who medically transition, for example, may seek access to hormone replacement therapy (HRT) or gender-affirming surgeries as part of their transition.[32] Transgender women may have a greater need for HIV-related health care, including preventive care such as pre-exposure prophylaxis (PrEP), a daily pill that significantly lowers the risk of HIV infection. Some transgender people who decide to have children may seek out fertility specialists or utilize assisted reproductive technologies as part of the process. A change to the existing federal rule could jeopardize access to these services when a patient is transgender.

In interviews with Human Rights Watch, many LGBT individuals and service providers said there were few, if any, LGBT-friendly healthcare providers in their area – rendering a federal obligation to provide care even more important. As the head of one community center in rural

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[30] Ibid.

[31] Michael Ollove, "Iowa, Other States Diverge on Transgender Healthcare," *The Gazette*, July 17, 2019, https://www.thegazette.com/subject/news/nation-and-world/iowa-other-states-diverge-on-transgender-health-care-aidan-zingler-gender-dysphoria-reassignment-surgery-20190717 (accessed August 6, 2019).

[32] Human Rights Watch, *"Living at Risk": Transgender Women, HIV, and Human Rights in South Florida* (2018), https://www.hrw.org/report/2018/11/20/living-risk/transgender-women-hiv-and-human-rights-south-florida.

Michigan said, "I do not know of any trans-affirming healthcare providers in the area. And I've talked to many trans people in the area."[33] Interviewees told us that as a result of the lack of providers in rural areas, transgender individuals would drive two hours from Tennessee to attend a weekend support group for gender-expansive youth in Birmingham, Alabama;[34] would travel two hours from Mississippi to meet with a trans-affirming doctor in Memphis, Tennessee;[35] and would drive from East Tennessee to North Carolina for regular hormone injections.[36]

The lack of providers was especially acute in rural areas, but certain services were difficult to find in metropolitan areas as well. As one mother of a transgender child noted:

> In Knoxville, we have a lot of hospitals, a lot of doctor's offices, but even with all of that, finding hormone therapy is very difficult. So difficult. Gynecologists don't do hormones, GPs don't do hormones, you have to see an endocrinologist. And that can be cost prohibitive, or maybe you don't find one you like.... It's hard to find medical care for trans people even in a city around here—and that's just for hormones. Finding a GP where you can go in the office that you're comfortable in, where the doctor is good, the office is good—that's hard for anyone, even if you're not trans. But having them treat you like a normal human being when you're trans is even more difficult. If you're in a rural area, you're up a creek.[37]

While some of the scarce services were related to gender-affirming treatment, others were general medical services available to cisgender people that providers denied to transgender people. Interviewees noted that breast surgeries that were available to cisgender individuals, for example, were not similarly available to transgender individuals.[38] One sexual and reproductive health services provider estimated that in Memphis, Tennessee, with a population of 650,000, only four medical practices provide hormone replacement therapy – in contrast with menopausal hormone therapy for cisgender women, which she described as virtually identical to HRT and much more widely available.[39]

When protections are piecemeal, transgender patients may not know whether services are available to them. One doctor in a rural state noted that her hospital had extensive services for transgender youth, but was not allowed to market or advertise those services because administrators were concerned about repercussions from the state legislature.[40] The mother of

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[33] Human Rights Watch interview with Mary Jo Schnell, OutCenter, Benton Harbor, MI, January 17, 2018.
[34] Human Rights Watch telephone interview with Paula R. (pseudonym), September 7, 2017.
[35] Human Rights Watch interview with Gail Stratton, Oxford, MS, January 13, 2017.
[36] Human Rights Watch interview with Judith N. (pseudonym), Johnson City, TN, December 10, 2017.
[37] Human Rights Watch telephone interview with Sarah H. (pseudonym), Knoxville, TN, October 20, 2017.
[38] Human Rights Watch interview with Holly Calvasina, Choices, Memphis, TN, January 10, 2018; Human Rights Watch interview with Kayla Gore, OutMemphis, Memphis, TN, January 10, 2018; Human Rights Watch interview with Renae T., Memphis, TN, January 12, 2018.
[39] Human Rights Watch interview with Holly Calvasina, Choices, Memphis, TN, January 10, 2018.
[40] Human Rights Watch telephone interview with Paula R. (pseudonym), September 7, 2017.

a transgender child who had struggled to find a pediatric endocrinologist said, "The ones in this area, they've told us they're not certain about displaying something saying they're LGBT-friendly, out of fear of how people would react."[41] Judith N., a transgender woman in East Tennessee, said "I spent years looking for access to therapy and hormones and I just couldn't find it."[42] When a limited number of providers were known to the community to be competent and welcoming, they could be overwhelmed with demand.[43] Having federal protections in place can help establish a presumption that healthcare services are offered without discrimination.

By permitting insurers and providers to limit coverage and services without repercussion, the proposed rule would adversely affect those who cannot afford or access alternative options. When providers are limited, other forms of disadvantage and marginalization can make access practically impossible, particularly where lengthy travel or out-of-pocket expenses are required. Data from the 2015 U.S. Transgender Survey indicated that 15 percent of transgender respondents were unemployed and 29 percent were living in poverty.[44] Of those who had held or applied for a job in the previous year, 27 percent reported experiencing employment discrimination because of their gender identity or expression.[45] Without employment, individuals may have a more difficult time maintaining insurance and affording health care. In the same survey, a third of the transgender respondents indicated that they had foregone medical care they needed in the past year because of concerns about cost.[46] When accessible options are few and far between, a provider's hostility or unwillingness to see a transgender patient is not only an indignity and inconvenience, but may prevent the patient from obtaining treatment at all.

The proposed rule would exacerbate these barriers. Individuals would not only need to find accessible, affordable services in their areas, but would need to ensure that their insurers would cover those services and that their providers would deliver those services without discriminating based on gender identity. A foreseeable outcome is that many transgender individuals will simply be unable to obtain the care they need. Without adequate healthcare, workers are less able to contribute to the economy, tenants are less able to maintain stable housing, and parents are less able to care for their children.

Third, LGBT people, and especially transgender people, may be reluctant to seek out the care they need when they anticipate discrimination or have been subject to discrimination in

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[41] Human Rights Watch interview with Carla B. (pseudonym), Knoxville, TN, December 9, 2017.
[42] Human Rights Watch interview with Judith N. (pseudonym), Johnson City, TN, December 10, 2017.
[43] Human Rights Watch interview with Sam P. (pseudonym), Johnson City, TN, December 10, 2017; Human Rights Watch interview with Renae T., Memphis, TN, January 12, 2018.
[44] Sandy James et al., Executive Summary of the Report of the 2015 U.S. Transgender Survey, National Center for Transgender Equality (2016), p. 3, https://transequality.org/sites/default/files/docs/usts/USTS-Executive-Summary-Dec17.pdf (accessed August 11, 2019). Comparable rates for the general population of the United States were 5 percent and 12 percent, respectively. Ibid.
[45] Ibid.
[46] Sandy James et al., The Report of the 2015 U.S. Transgender Survey, National Center for Transgender Equality (2016), p. 98, https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf (accessed August 11, 2019).

healthcare settings in the past. Data suggest that discrimination deters many LGBT people from seeking care. In a nationally representative survey, eight percent of LGBT respondents had delayed or foregone medical care because of concerns of discrimination in healthcare settings—and those who had previously experienced discrimination were six times more likely to avoid going to a doctor's office than those who had not experienced discrimination.[47] In a National Center for Transgender Equality survey, twenty-three percent of respondents did not seek care they needed because of concern about mistreatment based on gender identity.[48]

Clara B., the mother of a transgender teenager in Knoxville, told Human Rights Watch: "The dentist is a good example—[my son] hasn't gone back in two years. They're very religious people and [my son] said, 'I don't know how they feel about me and I don't want to go.' We've yet to agree on finding another dentist."[49] Judith N., a transgender woman in East Tennessee, described how she had foregone medical care, attributing her decisions to "the combination of not having money anymore and the [low-quality] insurance that goes with it, and then worrying about how I'll be treated."[50]

As these examples suggest, many transgender people are already reluctant to seek out care because of how they are treated, and delay or forego that care as a result. The proposed rule would take the position that such discrimination is permissible, further deterring transgender people from seeking care.

IV. Rights at Stake

The Right to Health

Under international law, everyone has the right "to the enjoyment of the highest attainable standard of physical and mental health" without discrimination on the basis of sex, age, or other prohibited grounds.[51] The right to health is also inextricably linked to provisions on the right to life and the right to non-discrimination that are included in the International Covenant on Civil and Political Rights (ICCPR), which the US has ratified.[52]

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[47] Shabab Ahmed Mirza & Caitlin Rooney, "Discrimination Prevents LGBTQ People from Accessing Health Care," Center for American Progress, January 18, 2018, https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing- health-care (accessed August 11, 2019).

[48] Sandy James et al., Executive Summary of the Report of the 2015 U.S. Transgender Survey, National Center for Transgender Equality (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Executive-Summary-Dec17.pdf (accessed August 11, 2019).

[49] Human Rights Watch interview with Carla B. (pseudonym), Knoxville, TN, December 9, 2017.

[50] Human Rights Watch interview with Judith N. (pseudonym), Johnson City, TN, December 10, 2017.

[51] Committee on Economic, Social and Cultural Rights (CESCR), "Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights," General Comment No. 14, The Right to the Highest Attainable Standard of Health, E/C.12/2000/4 (2000), para. 12.

[52] International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, ratified by the United States on June 8, 1992, art. 10.

The Committee on Economic, Social and Cultural Rights, the United Nations body charged with interpreting and monitoring the implementation of the International Covenant on Economic, Social, and Cultural Rights (ICESCR), has identified four essential components to the right to health: availability, accessibility, acceptability and quality.[53] In General Comment 22, the Committee further affirmed that "[n]on-discrimination, in the context of the right to sexual and reproductive health, also encompasses the right of all persons, including LGBTI persons, to be fully respected for their sexual orientation, gender identity and intersex status."[54] Even though the US is not a party to the ICESCR, the Committee's interpretation represents a useful and authoritative guide to the steps governments should take to realize and protect the right to health and other human rights. The proposed rule will reduce the availability and accessibility of healthcare services, particularly for transgender people, in communities across the US.

When states enact laws allowing healthcare providers to discriminate, they undermine the right to health. Individuals may be denied services outright; have difficulty finding services of comparable quality, accessibility, or affordability; or avoid seeking services for fear of being turned away.

The Committee on Economic, Social and Cultural Rights has noted that the right to health is threatened both by direct discrimination and by indirect discrimination, in which laws appear neutral on their face but disproportionately harm a minority group in practice.[55] To promote the right to health, the Committee has thus urged states to "adopt measures, which should include legislation, to ensure that individuals and entities in the private sphere do not discriminate on prohibited grounds."[56]

The Right to Non-Discrimination

Non-discrimination is a central principle of international human rights law.[57] As a party to the ICCPR, the US is obligated to guarantee effective protection against discrimination in the

[53] Committee on Economic, Social and Cultural Rights (CESCR), "Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights," General Comment No. 14, The Right to the Highest Attainable Standard of Health, E/C.12/2000/4 (2000), para. 12.
[54] UN Committee on Economic, Social and Cultural Rights, "General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health," UN Doc. E/C.12/GC/22, May 2, 2016, para. 23. The "I" in "LGBTI" stands for "intersex."
[55] UN Committee on Economic, Social and Cultural Rights, General Comment No. 20: "Non-Discrimination in Economic, Social and Cultural Rights", U.N. Doc. E/C.12/GC/20, July 2, 2009, para. 10.
[56] Ibid., para. 11.
[57] International protections for the right to non-discrimination include: ICCPR, arts. 2, 4, 26; ICESCR art.2(2); Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted December 18, 1979, G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, entered into force September 3, 1981, art. 2; International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), adopted December 21, 1965, G.A. Res. 2106 (XX), annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195, entered into force January 4, 1969, ratified by the United States on October 21, 1994, art. 5; International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (Migrant Workers Convention), adopted December 18, 1990, G.A. Res. 45/158, annex, 45 U.N. GAOR Supp. (No. 49A) at 262, U.N. Doc. A/45/49 (1990), entered into force July 1, 2003, art. 1(1), art. 7.

enjoyment of rights, including discrimination based on sex, sexual orientation, and gender identity.[58] Existing protections, if implemented fully, would be a positive step toward fulfilling this obligation. Adopting the proposed rule would eliminate a clear nondiscrimination protection without any alternative proposal to ensure transgender people are able to access healthcare on equal terms with others.

V. Conclusion

Human Rights Watch has documented a range of barriers that transgender people face when seeking healthcare services in the United States. These findings are consistent with research by academic experts and nongovernmental organizations, as well as government data, including the findings cited by the Department when it issued the Final Rule protecting transgender individuals from discrimination in 2016. We believe that withdrawing explicit protection for transgender people will exacerbate existing health disparities and fail to uphold US commitments under international human rights law. For these reasons, Human Rights Watch urges the Department to reject the proposed rule and support inclusive nondiscrimination protections.

Sincerely,

Ryan Thoreson
Researcher, LGBT Rights Program
Human Rights Watch

[58] ICCPR, art. 26. The Human Rights Committee frequently expresses concern about discrimination based on gender identity in its concluding observations on state compliance with the ICCPR. See UN Human Rights Committee, Concluding Observations: Azerbaijan, U.N. Doc CCPR/C/AZE/CO/4 (November 16, 2016), paras. 8-9; UN Human Rights Committee, Concluding Observations: Burkina Faso, U.N. Doc CCPR/C/BFA/CO/1 (October 17, 2016), paras. 13-14; UN Human Rights Committee, Concluding Observations: Colombia, U.N. Doc CCPR/C/COL/CO/7 (November 17, 2016), paras. 16-17; UN Human Rights Committee, Concluding Observations: Costa Rica, U.N. Doc CCPR/C/CRI/CO/6 (April 21, 2016), paras. 11-12; UN Human Rights Committee, Concluding Observations: Denmark, U.N. Doc CCPR/C/DNK/CO/6 (August 15, 2016), paras. 13-14; UN Human Rights Committee, Concluding Observations: Ecuador, U.N. Doc CCPR/C/ECU/CO/6 (August 11, 2016), paras. 11-12; UN Human Rights Committee, Concluding Observations: Ghana, U.N. Doc CCPR/C/GHA/CO/1 (August 9, 2016), paras. 43-44; UN Human Rights Committee, Concluding Observations: Jamaica, U.N. Doc CCPR/C/JAM/CO/4 (November 22, 2016), paras. 15-16; UN Human Rights Committee, Concluding Observations: Kazakhstan, U.N. Doc CCPR/C/KAZ/CO/2 (August 9, 2016), paras. 9-10; UN Human Rights Committee, Concluding Observations: Kuwait, U.N. Doc CCPR/C/KWT/CO/3 (August 11, 2016), paras. 12-13; UN Human Rights Committee, Concluding Observations: Morocco, U.N. Doc CCPR/C/MAR/CO/6 (December 1, 2016), paras. 11-12; UN Human Rights Committee, Concluding Observations: Slovakia, U.N. Doc CCPR/C/SVK/CO/4 (November 22, 2016), paras. 14-15; UN Human Rights Committee, Concluding Observations: South Africa, U.N. Doc CCPR/C/ZAF/CO/1 (April 27, 2016), paras. 20-21.

EXHIBIT D-4

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August 13, 2019

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Re: Nondiscrimination in Health and Health Education Programs or Activities (Section 1557 NPRM), HHS-OCR-2019-0007, RIN 0945-AA11

Dear Secretary Azar and Mr. Severino,

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

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

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

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

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

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

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

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

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

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

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

[4] 2016 Final Rule.

[5] 2016 Final Rule.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[14] Id.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[26] Id.

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

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

[29] Id.

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

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

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

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

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

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[30] Quan, Kelvin and Lynch, Jessica. "The High Costs of Language Barriers in Medical Malpractice." *University of California, Berkley School of Public Health and National Health Law Program.* https://healthlaw.org/resource/the-high-costs-of-language-barriers-in-medical-malpractice/.

[31] Rodriguez, Carmen Heredia. "Non-English Speakers Face Health Setback If Trump Loosens Language Rules." *Kaiser Health News.* June 24, 2019. https://khn.org/news/foreign-language-health-notices-non-english-speakers-trump-administration-rules/.

[32] Green, Alexander R. and Nze, Chihioke. "Language-Based Inequity in Health Care: Who Is the 'Poor Historian'?" *AMA Journal of Ethics.* March 2017. Pg. 263. https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/medu1-1703.pdf.

[33] "Overcoming the challenges of providing care to LEP patients." *The Joint Commission.* May 2015. Pg. 1. https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_13_May_2015_EMBARGOED_5_27_15.pdf.

[34] Id.

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

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

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

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

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

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

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

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

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

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

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

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

The NPRM seeks comment on a number of proposals that if adopted would also negatively impact people with disabilities, weakening standards for accessibility in health care facilities and eliminating provisions regarding benefit design discrimination.

The current rule requires covered entities to provide appropriate auxiliary aids and services to people with impaired sensory, manual, or speaking skills. The proposed rule seeks comment on whether to propose an exemption from the auxiliary aids and services requirement for covered entities with fewer than 15 employees. An exemption for an entity with fewer than 15 employees would roll back the civil rights of people with disabilities. If these requirements were removed, certain health care entities would no longer be required to provide people who are deaf, hard of hearing, blind, or visually impaired with services that are necessary for them to receive the care that they need. Data shows that people with disabilities often obtain their health care from specialists or local providers with few employees—this is particularly true in rural areas. The American Medical Association's Physician Practice Benchmark Survey in the period from 2012-16 found that a majority of physicians continue to work in small practices, with 57.8 percent in practices of 10 or fewer physicians, and 37.9 percent working in practices with fewer than 5 physicians in

[38] Musumeci, MaryBeth; Kates, Jennifer; Dawson, Lindsey; Salganicoff, Alina; Sobel, Laurie; and Artiga, Samantha. "HHS's Proposed Changes to Non-Discrimination Regulations Under ACA Section 1557." *Henry J. Kaiser Family Foundation*. July 1, 2019. Pg. 4. https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

[39] Keith, Katie. "HHS Proposes To Strip Gender Identity, Language Access Protections From ACA Anti-Discrimination Rule." May 25, 2019. *Health Affairs.* https://www.healthaffairs.org/do/10.1377/hblog20190525.831858/full/.

2016.[40] Creating this exemption would therefore have a wide effect, harming the ability of people with disabilities to access care.

The current rule requires covered entities to make reasonable modifications in policies, practices, and procedures to avoid disability-based discrimination, unless doing so would fundamentally alter the nature of the health program or activity. The proposed rule seeks comment on whether this language should be revised, and whether health care entities can be exempted from abiding by this provision if it would impose undue hardship.

OCR also seeks comments on whether HHS should change certain accessibility standards. The rule asks about removing requirements for building construction and architectural standards. While the current rule adopts the 2010 ADA Standards for Accessible Design for entities that receive federal funding, the proposed rule seeks comment on whether these standards should be applied at all. The removal of these standards could permit health care entities to fail to have elevators, accessible entrances, accessible restrooms, or text telephones (TTYs) —which allow people who are deaf, hard of hearing, or have speech impairment to use the telephone by typing and reading text—among other crucial standards that allow people with disabilities equal access to care.[41]

VII. The Proposed Rule Would Eliminate the Prohibition on Discriminating Based on Association

Under the 2016 Final Rule, discrimination on the basis of association with a protected class is expressly prohibited.[42] The proposed rulemaking seeks to eliminate this provision, offering no explanation for doing so.

The current regulations note that the statute does not limit "the prohibition to discrimination based on the individual's own race, color, national origin, age, disability or sex." Further, we noted that a prohibition on associational discrimination is consistent with longstanding interpretations of existing antidiscrimination laws, whether the basis of discrimination is a characteristic of the harmed individual or an individual who is associated with the harmed individual."[43]

The language contained in the current regulation mirrors the language of Title I and Title III of the Americans with Disabilities Act (ADA), which protect against discrimination based on association or relationship with a person with a disability.[44] Congress intended that the Health Care Rights law provide at least the same protections for patients and provider entities. The current regulation recognizes that this

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[40] Cane, Carol K. " Policy Research Perspectives: Updated Data on Physician Practice Arrangements: Physician Ownership Drops Below 50 Percent." *American Medical Association.* 2017. Pgs. 4-5. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/health-policy/PRP-2016-physician-benchmark-survey.pdf. The Benchmark surveys are of practicing physicians who provide a minimum of 20 hours of patient care/week in one of the 50 states or the District of Columbia, and who are not employed by the federal government.

[41] "Guidance on the 2010 ADA Standards for Accessible Design." *Department of Justice.* Sep. 15, 2010. https://www.ada.gov/regs2010/2010ADAStandards/Guidance_2010ADAStandards.pdf.

[42] 45 C.F.R. § 92.209.

[43] 81 Fed. Reg. 31439.

[44] 42 U.S.C. §§ 12112, 12182 (2012).

The Leadership Conference Education Fund

protection extends to providers and caregivers, who are at risk of associational discrimination due to their professional relationships with patients, including those patient classes protected under Section 1557.[45]

Congress intended the Health Care Rights Law to protect against discrimination by association, and these provisions should be retained.

VIII. Conclusion

If implemented in whole, the proposed rulemaking would sow discrimination back into the health care system. The proposals suggested by HHS would result in a system where a health care provider could refuse care to someone because of their sexual orientation or transgender identity, someone who does not speak English could be denied information that is critical to their health and well-being, and a woman could face discrimination in receiving care after a miscarriage or ectopic pregnancy. It is also important to acknowledge that individuals may face discrimination due to multiple factors, and individual experiences often do not fit neatly into the categories outlined above.

The Leadership Conference Education Fund strongly encourages the administration not to finalize this rule. Rather than promoting discrimination in health care, HHS should be working to ensure robust implementation and enforcement of Section 1557 of the ACA throughout the health care system.

Thank you for the opportunity to submit The Education Fund's comments on this proposal. If you have any questions, please contact Emily Chatterjee at chatterjee@civilrights.org.

Sincerely,

Vanita Gupta
President and CEO
The Leadership Conference on Civil and Human Rights

[45] 28 C.F.R. pt. 35, app. B (2015) (interpreting Title I and Title III of the ADA to protect "health care providers, employees of social service agencies, and others who provide professional services to persons with disabilities").

EXHIBIT D-5

UNIVERSITY of VIRGINIA HEALTH SYSTEM

Office of the Chief Executive Officer of the Medical Center

Via Electronic submission at www.regulations.gov

August 12, 2019

Roger Severino
Director, Office for Civil Rights
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Section 1557 NPRM, RIN 0945–AA11, Nondiscrimination in Health and Health Education Programs or Activities

Dear Mr. Severino:

The University of Virginia Health System (UVAHS) welcomes this opportunity to comment on the Department of Health and Human Services' (HHS) proposed regulation on Nondiscrimination in Health and Health Education Programs or Activities.

UVAHS is an academic medical center located in Charlottesville, Virginia and includes: UVA Medical Center (UVAMC) with a level I trauma center, neonatology intensive care unit, organ transplant program, nationally recognized cancer and heart centers; primary and specialty clinics throughout Central Virginia; and UVA Transitional Care Hospital, a 40 bed long-term acute care hospital. Relative to most of the state's other hospitals, UVA Medical Center provides a disproportionate share of services to Virginia's indigent and Medicaid beneficiaries, thus serving as a key component of Virginia's safety net providers. More than 65 percent of UVA Medical Center's patients are Medicare, Medicaid and uninsured patients.

We urge HHS not to finalize changes that remove crucial nondiscrimination protections for patients based on sex. Specifically, we write to voice our opposition to certain aspects of the proposed rule that will eliminate: nondiscrimination on the basis of gender identity; specific health insurance protections for transgender individuals; the provision preventing health insurers from varying benefits in ways that discriminate against certain groups such as lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) individuals; and the provision preventing discrimination based on an individual's association with another person.

UVAHS is committed to serving all patients who enter our doors. In particular, UVAHS has made great strides in working to improve care for LGBTQ patients, especially transgender patients who face many challenges in gaining access to quality health care for their needs. Our

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work in this area has been guided by a multi-disciplinary Transgender Advisory Committee which has supported our efforts to provide affirming, comprehensive healthcare for adult and teen transgender patients. We believe that serving and caring for members of the transgender and LGBTQ communities requires a willingness to act with respect and compassion, to learn and speak their language and to gain a deeper understanding of their unique medical needs, and we are proud of the progress we are making in striving to provide health equity to all of our patients. In recent years UVAHS has participated in the Health Equality Index—a nationally recognized benchmarking tool—to gauge our progress in serving the unique needs and expectations of transgender and LGBTQ patients. We are proud that our 2019 Health Equality Index score was 100 out of 100. With this in mind, we are extremely disappointed with the direction that HHS is heading with respect to transgender and LGBTQ patients through the proposed regulations which will likely have a negative impact on this vulnerable population.

Elimination of the general prohibition on discrimination based on gender identity and sex stereotyping

The current regulation (42 CFR §92.4) expressly defines discrimination "on the basis of sex" to include, without limitation, "discrimination on the basis of … sex stereotyping, and gender identity."

In turn, "gender identity" is defined as "an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth. The way an individual expresses gender identity is frequently called ''gender expression,'' and may or may not conform to social stereotypes associated with a particular gender. A transgender individual is an individual whose gender identity is different from the sex assigned to that person at birth."

Additionally, the regulation expressly defines "sex stereotypes" to mean "stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics. These stereotypes can include the expectation that individuals will consistently identify with only one gender and that they will act in conformity with the gender-related expressions stereotypically associated with that gender. Sex stereotypes also include gendered expectations related to the appropriate roles of a certain sex."

These definitions clearly express the types of discrimination that currently are not permitted under Section 1557. However, the proposed regulation deletes the entire definitional section of the original rule (42 CFR §92.4). Although HHS states in the preamble to the proposed rule that the changes are meant to reduce confusion and reduce uncertainty about the scope of Section 1557, we believe the deletion of these key definitions will cause greater confusion as to whether discrimination on the basis of gender identity or sex stereotypes is permitted or not. Removing gender identity and sex stereotyping from the definition of sex discrimination could allow health care providers to refuse to serve transgender patients or those who do not conform to traditional stereotypes. The resulting inability to access needed health care services will clearly have a negative impact on the health of these patients.

In summary, UVAHS urges HHS not to finalize changes that remove key nondiscrimination protections for patients based on sex, including gender identity and sexual stereotyping. We also support the positions articulated by Americas Essential Hospitals (AEH) and the Association of American Medical Colleges (AAMC) on this issue.

Elimination of specific health insurance coverage protections for transgender individuals

Under the current regulations, covered entities are prohibited from discriminating in health insurance issuance, coverage, cost-sharing, marketing, and benefit design (45 CFR §92.207). Under the proposed regulation, HHS would delete 45 CFR §92.207 in its entirety, including the following provisions directly impacting transgender individuals:

> "(3) Deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available;
> (4) Have or implement a categorical coverage exclusion or limitation for all health services related to gender transition."

Under the existing regulation, health plans are not allowed to deny medically necessary treatment for ovarian cancer in a transgender man or prostate cancer in a transgender woman based on his or her gender identity; however, under the proposed regulation, the health plan could deny coverage in this circumstance. Similarly, health plans today cannot single out services for higher copays only when those services are related to gender transition, for example, bottom surgery. Under the proposed regulation, a health plan could impose greater cost-sharing in this case. Additionally, a health plan today could not deny coverage for a hysterectomy that a provider determines is medically necessary to transition a female to a male, but under the proposed regulation, the health plan would be allowed to deny coverage even though hysterectomies are covered in other circumstances. The denial and limitation of services contained in the proposed regulation will limit access to health care services for transgender patients, causing great distress and harm to such patients, and UVAHS strongly objects to the proposed changes. We urge HHS not to finalize the portions of the proposed regulation that will limit access to health care for transgender patients.

Elimination of Discrimination Based on Association

Finally, UVAHS objects to the proposed regulation's deletion of 45 CFR §92.209 which prohibits discrimination against an individual due to the race, color, national origin, sex, age, or disability of someone else with whom the individual has a relationship or association. The deletion of this provision would allow a provider or health plan to discriminate against a patient due to their relationship with another person in one of the protected classifications. UVAHS believes this to be morally reprehensible and urges HHS not to remove this protection.

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In conclusion, thank you for allowing UVAHS to weigh in on these important policy issues. Should you have additional questions or would like additional information, please contact the Office of State and Federal Government Relations at 434-243-5920.

Sincerely,

Pamela Sutton-Wallace, MPH
Acting Executive Vice President for Health Affairs, and
Chief Executive Officer, UVA Medical Center

EXHIBIT D-6

August 13, 2019

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

Submitted Electronically

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

Dear Secretary Azar,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Proposed Rule:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[38] The Establishment Clause of the First Amendment requires the government to adequately account for just these sorts of consequences when considering whether to grant religious exemptions and, in fact, bars granting an exemption when it would detrimentally affect any third party. *See* U.S. Const. amend. I; *Cutter v. Wilkinson*. 554 U.S. 709, 720, 722 (2005) (to comply with the Establishment Clause, courts "must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries" and must ensure that the accommodation is "measured so that it does not override other significant interests") (citing *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985)); *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).

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

ii. The Proposed Rule unlawfully targets abortion.

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

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

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

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

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

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

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

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

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

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

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

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

[46] *See, e.g., Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (holding that discrimination against hospital patient based on his transgender status constitutes sex discrimination under Section 1557 of the Affordable Care Act); *Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018) (holding that a Medicaid program's refusal to cover treatments related to gender transition is "text-book discrimination based on sex" in violation of the Affordable Care Act and the Equal Protection Clause of the Constitution); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. 2016) (holding exclusion invalid under the Medicaid Act and the Affordable Care Act); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090 (S.D. Cal. Sept. 27, 2017) (holding that discrimination against transgender patients violates the Affordable Care Act); *Tovar v. Essentia*

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

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

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Health, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018) (holding that Section 1557 of the Affordable Care Act prohibits discrimination on the basis of gender identity); *Boyden v. Conlin,* No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018) (holding that a state employee health plan refusal to cover transition-related care constitutes sex discrimination in violation of Title VII, Section 1557 of the ACA, and the Equal Protection Clause); *Gavin Grimm v. Glouchester Cty. Sch. Bd.*, No. 4:15-cv-00054-AWA-RJK, Docket # 229 (E.D. Va. Aug. 9. 2019) (holding school board violated Title IX and Equal Protection Clause by forcing transgender student to use bathroom inconsistent with his gender identity).

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

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

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

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

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

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

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

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

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

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

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

In a footnote, the Department advances the transphobic—and legally erroneous—position that policies "that result in unwelcome exposure to, or by, persons of the opposite biological sex where either party may be in a state of undress—such as in changing rooms, shared living quarters, showers, or other shared intimate facilities—may trigger hostile environment concerns under Title IX."[57] The Department cites *United States v. Virginia*,[58] and *Fortner v.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[69] *See* Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, CTR. FOR AM. PROGRESS (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

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

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

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

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

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

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

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

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

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

i. The Proposed Rule would allow insurers to discriminate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For example:

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

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

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

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

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

The Proposed Rule seeks to dramatically alter the remedies and enforcement mechanisms under Section 1557 by claiming that the remedies and enforcement mechanisms for each protected characteristic (race, color, national origin, age, disability or sex) are different and limited to those available under their referenced statute. As a result, the proposed rule would create a confusing mix of legal standards and available remedies under a single law and could

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

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

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

Additionally, the 2016 Final Rule allows for money damages for violations of Section 1557 in both administrative and judicial actions brought under the regulation. The Proposed Rule attempts to eliminate the regulatory provision providing that money damages are available to those who are injured by violations of the statute. This is contrary to the statute and court precedent.[90]

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

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

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

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

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

Certain groups of individuals have historically faced discrimination in health care. For example, despite the historic achievements of the ACA, women – particularly women of color – are far more likely to suffer verbal abuse, stigma, and discrimination by a health care provider.[91] Thirty-three percent of indigenous women reported mistreatment, followed by twenty-five percent of Latina women and twenty-three percent of Black women.[92] Moreover, when women are able to see a provider, women's pain is routinely undertreated and often dismissed.[93] And due to gender biases and disparities in research, doctors offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[94]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

Sincerely,

Fatima Goss Graves

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

EXHIBIT D-7

APLA Health
The David Geffen Center, Mid-City
Gleicher/Chen Health Center, Baldwin Hills
Long Beach Health Center
APLA Health – Olympic, Fairfax / Carthay Circle
Education Center, Baldwin Hills
Wilshire Dental Clinic, Downtown Los Angeles
The S. Mark Taper Foundation Center Dental Clinic, South Los Angeles
Vance North Necessities of Life Program in eight locations
AIDS Walk Los Angeles

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Environment, Land & Resources Department
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Ron Sylvester
President/CFO
Rx4tv, Inc

Tom Whitman
Senior Vice President
for Marketing

Craig E. Thompson
Chief Executive Officer

August 12, 2019

VIA ELECTRONIC SUBMISSION

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Section 1557 NPRM, RIN 0945-AA11
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue, SW
Washington, DC 20201

Re: Section 1557 of the Patient Protection and Affordable Care Act Comment

To Whom It May Concern:

Thank you for the opportunity to submit comments on the Department of Health and Human Services' ("HHS" or the "Department") notice of proposed rulemaking ("NPRM" or "Proposed Rule") on Section 1557 of the Patient Protection Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 through 124 Stat. 1025 (2010) (hereinafter "ACA"). APLA Health opposes the NPRM and urges the Department to withdraw it, as we believe the Proposed Rule would cause major harm to the health and wellbeing of LGBTQI+[1] individuals, youth who have received or may seek abortion or reproductive health services, women, individuals with disabilities, and individuals with limited English proficiency ("LEP").

APLA Health is a federally qualified health center that strives to achieve health care equity and promote well-being for the LGBT and other underserved communities and people living with and affected by HIV. We provide 20 different services from 16 locations throughout Los Angeles County, including medical, dental, and behavioral health care; Pre-Exposure Prophylaxis (PrEP) counseling and management; health education and HIV prevention; and STD screening and treatment; as well as a full portfolio of supportive services for people living with HIV (PLWH).

[1] Lesbian, Gay, Bisexual, Transgender, Queer, Intersex individuals and their partners.

LGBTQI+ individuals deserve to get the medical treatment they need, when they need it. Individually and in the aggregate, the elimination of protections and reduction of rights set forth in the NPRM would have severe consequences to the health and wellbeing of Americans seeking healthcare coverage, including most profoundly in traditionally underserved communities.
APLA Health is extremely distressed at the potential that the Proposed Rule will become final and halt the progress being made towards making the healthcare system more accepting of LGBTQI+ youth and other underserved communities made up of racial and ethnic minorities, immigrants, LEP individuals, individuals with disabilities, youth who have had abortions, and women. These rollbacks to the current scope of Section 1557's protections would be disastrous to the healthcare coverage for these communities and for all Americans. We therefore urge the Department to withdraw the Proposed Rule.

SECTION 1557 IS ESSENTIAL TO THE AFFORDABLE CARE ACT

Section 1557 of the ACA is a vital provision aimed at ensuring full and equitable access to essential services without discrimination. It, combined with the remainder of the ACA, has had a transformative impact on all aspects of healthcare, increasing the scope of benefits and improving access to coverage for millions of Americans.

Section 1557 provides a critical source of protection for health care access for America's traditionally underserved communities, and particularly LGBTQI+ individuals. LGBTQI+ young people already experience significant challenges in finding medical care that is free from judgement, abuse, and misconception. According to our data:

- 21% of transgender patients have experienced harsh or abusive language from a medical provider.
- 18% of LGBTQI+ individuals nationwide believe that if they were refused care at a hospital, it would be "very difficult" or "not possible" to find an alternative provider. Outside of major metropolitan areas like Washington, D.C. and New York City, that number spikes to 41%.
- 29% of transgender individuals said that a doctor or other health care provider refused to see them because of their actual or perceived gender identity.

The ACA has been fundamental to placing responsibility on health care providers to understand and sensitively address the needs of the LGBTQI+ community, and has had a tremendous impact on the health outcomes of the people living with HIV who we serve, many of whom belong to the LGBTQI+ community. Beyond the LGBTQI+ community, the ACA reduced the number of individuals without insurance to historic lows, including a reduction of 39 percent of the lowest income individuals.[1] These gains are particularly noteworthy for Latino/a/xs, African Americans,

[1] Kelsey Avery, Kenneth Finegold and Amelia Whitman, *Affordable Care Act Has Led to Historic, Widespread Increase in Health Insurance Coverage*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES ASPE ISSUE BRIEF, (Sep. 29, 2016) https://aspe.hhs.gov/system/files/pdf/207946/ACAHistoricIncrease Coverage.pdf.

and Native Americans. The nation and our communities cannot afford to go back to a time when they did not have access to comprehensive, affordable coverage.

Furthermore, the ACA has been instrumental in covering a wide range of preventive services, ensuring that individuals have access to life-saving cancer screenings and treatment and access to effective and affordable contraception and reproductive health care services.

Section 1557 prohibits discrimination not only in the specific program or activity receiving Federal financial assistance, but also to all other activities of health entities that operate a single covered program. Accordingly, it prohibits hospitals, doctors, and insurers from discriminating against persons seeking health care services or healthcare coverage. The Proposed Rule, however, would erode the scope of those protections and, correspondingly, impair access to critical services by communities who need health care the most.

- **B.** *Elimination of Nondiscrimination on the Basis of Gender Identity and Sex Stereotyping*—The Proposed Rule would remove the inclusion of gender identity[2] and sex stereotyping[3] from discrimination on the basis of sex by eliminating the definitional provisions of the regulation.

- *Elimination of Nondiscrimination on the Basis of Termination of Pregnancy*—The Proposed Rule no longer explicitly includes termination of pregnancy as a prohibited basis of discrimination on the basis of sex.

- *Narrowing Scope of Nondiscrimination Protections by Eliminating Definition of "Covered Entity"*—The Proposed Rule would narrow Section 1557's application to a more limited set of entities. Under the proposed rule, health insurers that do not receive any Federal financial assistance are no longer subject to Section 1557 at all and an entity that is principally or otherwise engaged in the business of providing health insurance *shall not* be considered to be principally engaged in the business of providing health care. Thus, Section 1557's protections would no longer extend to all of a health insurer's operations. Instead, under the Proposed Rule, Section 1557 would apply only to the subset of an insurer's operations that receive Federal financial assistance from HHS such as qualified health plans offered on an exchange.

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[2] The current regulation defines "gender identity" as ''an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth.'' 81 Fed. Reg. at 31467 (codified at 45 CFR § 92.4). The regulation requires covered entities to treat individuals ''consistent with their gender identity'' except that covered entities ''may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.'' 45 C.F.R. §§ 92.206 and 92.207(b)(3).

[3] The Final Rule defines ''sex stereotypes'' as ''stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics. These stereotypes can include the expectation that individuals will consistently identify with only one gender and that they will act in conformity with the gender-related expressions stereotypically associated with that gender. Sex stereotypes also include gender expectations related to the appropriate roles of a certain sex.'' 81 Fed. Reg. at 31468 (codified at 45 C.F.R. § 92.4).

- *Elimination of Notice Requirements and Narrowing of Language Access Requirements*—The Proposed Rule would eliminate the requirement that a covered entity post nondiscrimination notices, that timely language assistance and other aid is available without charge upon request, and information on how to file a complaint. The Proposed Rule also would eliminate the requirement that covered entities include taglines in the top 15 languages spoken by LEP persons in the relevant state.

I. ARGUMENTS

A. The Proposed Rule's Narrow Interpretation of the Scope of Covered Entities under Section 1557 Would Fundamentally Frustrate Congress's Intent to Prevent Discrimination in the Provision of Health Care.

The Proposed Rule would abandon the definition of "covered entity" and the corresponding extension of nondiscrimination protections, thereby narrowing the scope of Section 1557. Notably, unlike the 2016 Final Rule which applied to "all of the operations of an entity principally engaged in providing or administering health services or health insurance coverage,"[4] the Proposed Rule draws a distinction between "health insurance" and "health care."[5] The Proposed Rule argues that an entity principally or otherwise engaged in the business of providing health insurance shall not be considered to be principally engaged in the business of providing health care.[6] Thus, Section 1557's protections would no longer extend to all of a health insurer's operations.

Instead, under the Proposed Rule, Section 1557 would apply only to the subset of an insurer's operations that receive Federal financial assistance from HHS such as qualified health plans offered on an exchange. This means the proposed rule would not apply to self-funded health plans under ERISA, or the Federal Employees Health Benefits Program because those programs do not receive Federal financial assistance from HHS, and the entities operating them would not be considered to be principally engaged in the business of providing health care. OCR justifies this change by citing the Civil Rights Restoration Act ("CRRA"): "The CRRA… defined "program or activity"…to cover all the operations of entities only when they are 'principally engaged in the business of providing education, *health care*, housing, social services, or parks and recreation.'"[7] However, the text of Section 1557 of the ACA is much more expansive and was passed after the CRRA, therefore a broader interpretation should govern.

The legislative text states that that this title will apply to "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title [1] (or amendments)."[8] This language strongly suggests that Congress intended for the law to apply to entities receiving a contract of insurance from the

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[4] HHS Office of Civil Rights, "Nondiscrimination in Health Programs and Activities," 81 Fed. Reg. 31375, 31385 (May 18, 2016).

[5] 84 Fed. Reg. 27862.

[6] *Id.* at 27862-27863.

[7] 84 Fed. Reg. 27862.

[8] 42 U.S. Code § 18116.

Federal government, such as a Federal Employees Health Benefits Program plan. In the Final Rule, HHS also stated that including issuers of health insurance coverage was appropriate because "[t]his interpretation serves the central purposes of the ACA, and effectuates Congressional intent, by ensuring that entities principally engaged in health services, health insurance coverage, or other health coverage do not discriminate in any of their programs and activities, thereby enhancing access to services and coverage."[9] This rationale is still true today. The proposed rule ignores the fact that health insurance programs are vital to the provision of health care in the United States. In controlling how health care is paid for, how benefits are designed and which providers are within their networks, health insurance programs have vast influence over access to and the provision of health care to Americans.

Indeed, the Proposed Rule even cites a definition of health insurance coverage at 42 U.S.C. § 300gg-91 that includes "benefits consisting of *medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care)* under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer."[10] (Emphasis added). This very definition makes it clear that the provision of health insurance coverage is inextricably linked to the provision of health care itself. Excluding health insurance programs from the scope of Section 1557 would fundamentally frustrate the objective of Congress, which was to avoid discrimination in the provision of health care, including denial of benefits. This change would not only encourage unlawful discrimination against specific groups, including the LGBTQI+ community and women, but it would also negatively impact the health and well-being of LGBTQI+ youth and other underserved communities made up of racial and ethnic minorities, immigrants, LEP individuals, individuals with disabilities, and youth who have had abortions.

B. Repealing the Final Rule's Definition of "On the Basis of Sex" Would Encourage Unlawful Discrimination Against LGBTQI+ People and Women in Direct Conflict with Constitutional and Statutory Protections.

The Final Rule's definition of discrimination "on the basis of sex" explicitly "includes, but is not limited to, discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity."[11] In the Proposed Rule, HHS would remove the inclusion of termination of pregnancy, gender identity,[12] and sex stereotyping[13] by eliminating the definitional provisions of the

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[9] 81 Fed. Reg. 31386.

[10] 84 Fed. Reg. 27862.

[11] 81 Fed. Reg. at 31,467/3.

[12] The current regulation defines "gender identity" as "an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth." 81 Fed. Reg. at 31467 (codified at 45 CFR § 92.4). The current regulation The regulation requires covered entities to treat individuals "consistent with their gender identity" except that covered entities "may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available." 45 C.F.R. §§ 92.206 and 92.207(b)(3).

regulation.[14] Currently, health insurers are prohibited from excluding coverage of health care services for persons seeking gender transition or limiting coverage on the basis of a person's gender identity or their termination of a pregnancy. And health care providers may not discriminate against such persons, such as by refusing to provide services to them. The Proposed Rule would encourage those types of discrimination. HHS provides essentially three justifications: (1) one federal district court issued a preliminary injunction against implementation of the definition; (2) HHS should be consistent among definitions within HHS and across federal agencies; and (3) the decision regarding how to implement "on the basis of sex" should be left to the States. By encouraging discrimination, the Proposed Rule is both unconstitutional and contravenes the very statute it purports to interpret.

1. The Proposed Changes are Inconsistent with Section 1557 Case Law and other Anti-Discrimination Laws that Prohibit Discrimination on the Basis of Sex

The preliminary injunction issued in *Franciscan Alliance* does not require a change in HHS policy, and in any event is contrary to the weight of case law. Over twenty years ago a court recognized that discrimination based on the fact that a woman had had an abortion was sex discrimination, *i.e.*, discrimination "on the basis of sex" under Title VII.[15] Moreover, being prohibited from discriminating against someone because they had an abortion is in no way related to any requirement to provide abortions. Indeed, Title IX itself expressly does not permit penalties based on a woman's prior termination of pregnancy.[16] Furthermore, numerous other courts have recognized that *Section 1557 itself* prohibits discrimination against transgender individuals.[17] Eliminating the definitional provisions of the regulation would create confusion by contradicting decades of case law regarding discrimination on the basis of sex.

A purported need for consistency with other definitions is likewise no compelling rationale to allow discrimination. To the contrary, context is important, and any presumption that the phrase "on the basis of sex," and in particular, the term "sex," must mean the same thing regardless of context "readily yields whenever there is such variation in the connection in which the words are used as reasonably to warrant the conclusion that they were employed in different parts of the act with different intent."[18] To be sure, just as "age" is a word that "has several commonly understood meanings among which a speaker can alternate in the course of an ordinary

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[13] The Final Rule defines ''sex stereotypes'' as ''stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics. These stereotypes can include the expectation that individuals will consistently identify with only one gender and that they will act in conformity with the gender-related expressions stereotypically associated with that gender. Sex stereotypes also include gender expectations related to the appropriate roles of a certain sex.'' 81 Fed. Reg. at 31468 (codified at 45 C.F.R. § 92.4).

[14] 84 Fed. Reg. at 27,852.

[15] *Turic v. Holland Hosp., Inc.*, 85 F.3d 1211, 1214 (6th Cir. 1996) (holding an employer who discriminates against an employee who has exercised right to access abortion violates Title VII prohibition on sex discrimination).

[16] 20 U.S.C. § 1688.

[17] *See Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 953 (D. Minn. 2018); *Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 949–50 (W.D. Wis. 2018); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1098–1100 (S.D. Cal. 2017).

[18] *Gen. Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581, 595 (2004) (quoting *Atl. Cleaners & Dyers, Inc. v. United States*, 286 U.S. 427, 433 (1932)) (ruling that "age" means "old age" when coupled with the term "discrimination").

conversation, without being confused,"[19] so too with "sex." In the context of a statutory provision expressly incorporating protections against discrimination in a range of statutes, giving the term its broadest possible meaning is more important than any claimed consistency rationale. This argument also ignores the fact that several courts have interpreted other definitions of discrimination on the basis of sex to include discrimination against transgender individuals[20] and people who have exercised their right to access abortion.[21]

Finally, HHS claims that removing the definition of "on the basis of sex" would "significantly restore the ability of States to establish policies in this area, based on their weighing the competing interests at stake."[22] HHS nowhere explains what "competing interests on questions related to gender dysphoria" could possibly exist, or what "questions" could lead to such competing interests, much less counsel in favor of allowing discriminating against individuals seeking care. What this rule really would do is to allow states to decide that some groups are not deserving of civil rights protections. HHS's rationale that states are "heavily reliant on the continued receipt of Federal funds subject to Title IX requirements,"[23] and therefore they cannot be expected to extend civil rights protections, could be used to justify rolling back all progress since states first accepted federal funds. In the case of "on the basis of sex," states cannot reasonably argue that they could not have been "cognizant" of the consequences of their participation. Federal regulations should recognize civil rights protections stemming from federal statutes, without delegating that responsibility to states; although states may be "laboratories of democracy" in certain instances, civil rights protections should not be one of them. Federal laws provide protection for discrimination on the basis of sex because "since the Civil War, the Federal Government and the federal courts have been the '*primary* and powerful reliances' in protecting citizens against such discrimination."[24] Individuals should not be afforded less protections simply due to moving from one state to another.

C. The Proposed Rule Would Harm Patients by Encouraging Providers to Deny Care Based on Their Personal Beliefs on Patients.

The Proposed Rule fails not only as a matter of policy but also under the Constitution. By enabling institutions and individuals to prevent others from obtaining necessary health care services using religious- or conscience-based justifications, the Proposed Rule places an

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[19] *Id.* at 596.

[20] For example, the court in *Adams v. School Board of St. Johns Cty.* held that "the meaning of 'sex' in Title IX includes 'gender identity' for the purposes of its application to transgender students." 318 F. Supp. 3d 1293, 1325 (M.D. Fla. July 26, 2018); see also *A.H. v. Minersville Area Sch. Dist.*, 290 F. Supp. 3d 321 (M.D. Pa. Nov. 22, 2017) (holding that plaintiff successfully stated a claim where plaintiff alleged discrimination based on gender identity). *See also*, *Smith v. City of Salem, Ohio*, 378 F.3d 566, 575 (6th Cir. 2004) ("Sex stereotyping based on a person's gender non-conforming behavior is impermissible discrimination, irrespective of the cause of that behavior."); *Johnston v. Univ. of Pittsburgh of Com. Sys. of Higher Educ.*, 97 F. Supp. 3d 657, 680 (W.D. Pa. 2015), appeal dismissed, No. 15-2022 (3d Cir. Mar. 30, 2016) (applying Title VII sex-stereotyping rulings to Title IX claims of transgender individual).

[21] *Turic v. Holland Hosp., Inc.*, 85 F.3d 1211, 1214 (6th Cir. 1996) (holding an employer who discriminates against an employee who has exercised right to access abortion violates Title VII prohibition on sex discrimination).

[22] 84 Fed. Reg. at 27,857.

[23] *Id.*

[24] *Cannon v. University of Chicago*, 441 U.S. 677, 708 (1979)(citing to *Steffel v. Thompson*, 45 U.S. 452, 463 (1974))

unconstitutional thumb on the scales in favor of one set of beliefs over another. APLA Health strongly believes Constitutional protections must ensure that no patient should be refused care that they need and that it is unacceptable for federally funded institutions to use taxpayer money to discriminate.

The Final Rule provides: "Insofar as the application of any requirement of this part would violate applicable Federal statutory provisions for religious freedom and conscience, such application shall not be required." 45 C.F.R. § 92.2. Nothing more is necessary to adequately protect the religious and conscience-related beliefs as required by current law. But by expressly incorporating more than the law requires, the Proposed Rule indicates that it would be enforced in a more lenient manner than allowed under current law. The overemphasis on these exceptions could encourage an unwarranted expansion of claims of such beliefs. Combined with the removal of protections against discrimination, not to mention the narrowing of the application of the rule with regard to certain federal health care programs, the changes to the conscience provisions have a compounding negative effect on the people most in need of civil rights protections at this time.

Perversely, the Proposed Rule would encourage institutions that wish to discriminatorily restrict the care they offer to instruct their providers regarding what care they may or may not provide, ignoring the many providers who want to provide patients with health care, including abortions and transition-related care. The institution's violation of civil rights is thus two-fold: both on the provider *and* the patient. Moreover, the provider prohibited from furnishing necessary care could also face negative repercussions if such denials would result in violations of professional and ethical duties separately required of the provider.

Furthermore, the combination of the exemptions the Proposed Rule would incorporate and the removal of definitions related to discrimination leave a gaping hole in protections for individuals' right to equal treatment. For example, one provision of the Church Amendments allows individuals who work for or with entities receiving grants or contracts for biomedical or behavioral research entities to refuse to participate in "any lawful health services or research activity" based on religious beliefs or moral convictions *specifically related to the service or research activity to which they object.*[25] But the Proposed Rule contains no such limitations, implying that the exemptions are broader than existing law allows. This is a real concern, because individuals are at serious risk of experiencing discrimination based on who they are, not based on what care they seek.

Discrimination or other violations of an individual's civil rights should not be permissible based on religious or conscience exemptions.[26] APLA Health firmly believes that the Proposed Rule

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[25] The Church Amendments, 42 U.S.C. § 300a-7 (2018).

[26] *Cf. Miller v. Davis*, 123 F. Supp. 3d 924, 941 (E.D. Ky. 2015) (finding it unlikely that clerk refusing to issue marriage licenses to same-sex couples would succeed in establishing a violation of her constitutional rights if required to do so, and instead that allowing her to refuse to issue such licenses would likely violate others' constitutional rights); *see also Obergefell v. Hodges*, 135 S.Ct. 2584, 2607 (2015); *Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm'n*, 138 S. Ct. 1719,1727 (2018) ("Nevertheless, while those religious and philosophical objections are protected, it is a general rule that such objections do not allow business owners and other actors in the (Continued...)

violates the First Amendment because it encourages providers to make patient care decisions based on their religious objections that may in effect severely limit or even deny care options for marginalized patient populations, like LGBTQI+ individuals. The First Amendment to the Constitution reads, "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press . . . ." The Proposed Rule violates the Free Exercise and Establishment of Religion Clauses of the First Amendment because it enables an individual or institution receiving government funds to discriminate against a patient due to the patient's beliefs or very being. Both clauses regulate how government policy interacts with moral and religious belief. In interpreting these cases, the Supreme Court has held that both the Establishment and Free Exercise clauses of the First Amendment prevent the government from shifting the cost of religious and moral accommodation from those who practice to third parties.[27] The Proposed Rule would do just that by shifting the cost of religious and moral accommodations for health insurers and health care providers onto LGBTQI+ individuals and women by denying them access to services and forcing them to delay or forgo care, which can come with a cost to both their health and their pocketbook.

Discrimination or other violation of an individual's civil rights should not be permissible based on religious or conscience exemptions.[28] The government's ability to accommodate the free exercise of religion does not relieve its burden of ensuring that they do not compel others to subsidize religious practices that they do not support.[29] Faith-directed health programs are among the most prevalent providers of health care in the United States. One out of every five hospital beds resides in a religious hospital.[30] Catholic hospitals make up three-quarters of those

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economy and in society to deny protected persons equal access to goods and services under a neutral and generally applicable public accommodations law.").

[27] *See Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 710 (1985) (stating, "The First Amendment . . . gives no one the right to insist that in pursuit of their own interest others must conform their conduct to his own religious necessities."); *United States v. Lee*, 455 U.S. 252 (1982) ("When followers of a particular sect enter into commercial activity as a matter of choice, the limits they accept on their own conduct as a matter of conscience and faith are not to be superimposed on the statutory schemes which are binding on others in that activity. Granting an exemption from social security taxes to an employer operates to impose the employer's religious faith on the employees."); *see e.g. Cutter v. Wilkinson*, 544 U.S. 709, 720, 722 (2005) (to comply with the Establishment Clause, courts "must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries" and must ensure that the accommodation is "measured so that it does not override other significant interests") (citing *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985)); *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).

[28] *Cf. Miller v. Davis*, 123 F. Supp. 3d 924, 941 (E.D. Ky. 2015) (finding it unlikely that clerk refusing to issue marriage licenses to same-sex couples would succeed in establishing a violation of her constitutional rights if required to do so, and instead that allowing her to refuse to issue such licenses would likely violate others' constitutional rights); *see also Obergefell v. Hodges*, 135 S.Ct. 2584, 2607 (2015); *Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm'n*, 138 S. Ct. 1719,1727 (2018) ("Nevertheless, while those religious and philosophical objections are protected, it is a general rule that such objections do not allow business owners and other actors in the economy and in society to deny protected persons equal access to goods and services under a neutral and generally applicable public accommodations law.").

[29] *United States v. Lee*, 455 U.S. 252 (1982).

[30] Lori Freedman and Debra Stulberg, University of California, San Francisco, "The Growth of Religious Healthcare Systems," ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH, *available at*: https://www.ansirh.org/research/growth-religious-healthcare-systems (last accessed Aug. 9, 2019).

hospitals, representing four of the largest health systems in the United States[31] and accounting for one out of every six hospital beds.[32] Furthermore, the federal government has labeled a Catholic institution the "sole community hospital" in 46 regions in the United States.[33] Catholic healthcare services restrict the types of services they provide as outlined in the "Ethical and Religious Directives for Catholic Health Care Services," (or, the "ERDs") a creation of the U.S. Conference of Catholic Bishops.[34] These restrictions have real consequences for the diverse populations the hospitals serve, particularly for LGBTQI+ individuals, and especially in geographic regions where a Catholic-sponsored or -affiliated facility is the sole community provider.[35]

By incorporating the broadest possible set of religious- and moral-based exceptions for health care discrimination, the Proposed Rule would encourage not just faith-directed health programs, but employers, health care institutions and providers to restrict access to healthcare services, especially for LGBTQI+ individuals. The Proposed Rule would encourage discrimination against patients and impact their access to care, procedures and information by health programs over religious policies that will disproportionately affect women and LGBTQI+ individuals. In addition, in May 2019, HHS promulgated a Denial of Care Rule (described by some as the "Conscience Rule")[36] that broadens the application of at least 25 federal laws related to the application of religious- or conscience-based beliefs to health care. Immediately challenged in court, HHS has agreed to delay implementation of the Denial of Care Rule pending the outcome of a legal challenge.[37] At issue in those legal challenges are issues that are also implicated in the Proposed Rule. At the very least, HHS should delay finalizing any rule, such as this Proposed Rule, that could fail on the same grounds.

In addition to the Constitutional arguments under the First Amendment, the Fifth and Fourteenth Amendments explicitly prohibit the federal government and the states from depriving individuals

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[31] *Id.*

[32] Michael Hiltzik, "UC's deal with Catholic Hospitals threatens the health of woeman and LGBTQ patients," *L.A. Times*, (Apr. 12, 2019) *available at*: https://www.latimes.com/business/hiltzik/la-fi-hiltzik-uc-dignity-health-discrimination-20190412-story.html.

[33] Lois Uttley, MPP and Christine Khaikin, JD, "Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage of Medicine Report," MERGERWATCH, *available at*: http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf?token=cHO2jBYG017RabAXAdQXC4c9rps%3D

[34] United Stated Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services, 6th ed. (June 2018), *available at*: http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf. The ERDs, amongst other restrictions on services and therapies that may be provided, place judgment on whether certain procedures or care should be provided on local bishops, not doctors, regardless of a patient's medical needs or desires.

[35] Lori Freedman and Debra Stulberg, University of California, San Francisco, "The Growth of Religious Healthcare Systems," ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH, *available at*: https://www.ansirh.org/research/growth-religious-healthcare-systems (last accessed Aug. 9, 2019).

[36] U.S. Dep't of Health and Human Servs., "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," 84 Fed. Reg. 23,170 (May 21, 2019).

[37] Katie Keith, "Provider Conscience Rule Delayed Due to Lawsuits," HealthAffairs (July 2, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190702.497856/full/.

of their "life, liberty, or property" without due process of law.[38] The Fourteenth Amendment, applicable to the states, expressly extends "equal protection of the laws" to "any person," and although the Fifth Amendment does not contain such a clause, it has been interpreted as embodying principles of equality and anti-discrimination as against the federal government.[39] By rescinding protections from groups that courts have already ruled are deserving of them, such as women[40] and gender non-conforming individuals,[41] the Proposed Rule violates the equality principles embodied in the Fifth Amendment, expressly applicable to the federal government, and encourages states to violate the Equal Protection clause of the Fourteenth Amendment.

D. The Proposed Rulemaking for Section 1557 of the ACA Should Be Rejected Because It Will Restrict Language Access and Encourage Discrimination in Health Care Based on National Origin.

APLA Health recognizes that individuals who are at the intersection of the LGBTQI+ community and a racial or ethnic minority are more likely to face increased levels of health disparities. The intersection of the multiple sources of bias against these communities compounds the difficulties that these individuals face in accessing care.

Equal access to healthcare should be a fundamental human right—regardless of one's national origin or language. The proposed revisions to Section 1557 of the ACA seek to eliminate the ACA's provisions that provide individuals with limited English proficiency (LEP) with necessary language services. These changes include: eliminating notice and tag line requirements; relaxing the standards governing access to language assistance services for individuals with limited English proficiency (LEP); replacing the current test to determine when covered entities must provide language access services with one that removes the emphasis on the importance of the communication to the specific individual; eliminating the current remote video interpreting standards and instead including standards only for remote audio interpreting services; eliminating provisions that recognize the right of private individuals and entities to file lawsuits in federal court to directly challenge alleged violations of Section 1557; and eliminating the requirement for a compliance director appointed by each covered entity. Eliminating these requirements and procedures would largely defeat the purpose of the regulations in the first place.

The Proposed Rule itself acknowledges the chilling effect removing notice requirements along with eliminating the requirement of having a compliance director will have in enforcing the

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[38] U.S. CONST. amend. V; U.S. CONST. amend. XIV; *see also Frontiero v. Richardson*, 411 U.S. 677 (1973) (applying Fifth Amendment as barring discrimination between men and women in context of military benefits and explaining that "classifications based upon sex, like classifications based upon race, alienage, and national origin, are inherently suspect and must therefore be subjected to close judicial scrutiny"); *United States v. Virginia*, 518 U.S. 515 (1996) (prohibiting state of Virginia from treating women differently in context of military education).

[39] *E.g.*, *Frontiero*, 411 U.S. at 680 n.5.

[40] *Virginia*, 518 U.S. at 531–33.

[41] *E.g.*, *Smith v. City of Salem, Ohio*, 378 F.3d 566, 575 (6th Cir. 2004) (ruling that "[s]ex stereotyping based on a person's gender non-conforming behavior is impermissible discrimination, irrespective of the cause of that behavior").

protections this rule was intended to protect.[42] The proposed rule's provision to focus on LEP individuals in general, as opposed to each individual, in evaluating the need for language access could result in some individuals not receiving the services they need for meaningful access and can, quite literally, be life threatening. HHS's speculation that cost savings from changes to language access plans justify the elimination of or changes to these programs is untenable. In underserved communities, laws such as Section 1557 can make all the difference in ensuring that persons receive the care they need and are entitled to. The proposed revisions would open the door to national origin discrimination in healthcare, and the existing protections of Section 1557 should remain in place.

Ensuring language access touches the lives of millions of Americans—25 million of whom are LEP.[43] As discussed more below, research has shown that language barriers negatively impact the quality of care and ability of a person to access care and maintain coverage. The existing protections ensure LEP persons understand their rights and help limit the barriers they have to accessing quality healthcare. The revisions to Section 1557, on the other hand, would raise language barriers and thus alienate already disadvantaged individuals by restricting their access to health care. While HHS seeks to justify the revision on the ground that it might save money, this justification does not outweigh the pernicious impact the rule change will have on individuals with LEP. And further, the proposed change does not account for the increased costs the healthcare system will ultimately bear when LEP individuals are placed at higher risk when they do not understand how to access available health care and, as a result, do not seek it until their problems escalate.

The resulting discrimination and reduction in language access would only be further compounded by the proposed rule's changes to the systems currently in place to ensure an entity's compliance as well as the elimination of the requirement for the covered entity to have a designated compliance officer to enforce Section 1557 and the removal of private right of action in asserting a complaint for discrimination by a covered entity.

In short, eliminating the protections that Section 1557 provides would encourage covered entities to cut back on services for LEP persons, which would invariably result in lesser care—that is, discriminatory care—for such persons.

E. The Proposed Rule's Changes Violate Principles of the Administrative Procedure Act.

Finally, APLA Health believes HHS's Proposed Rule violates the Administrative Procedure Act ("APA"). The APA imposes procedural requirements on the actions of executive branch agencies, including when agencies are "formulating, amending or repealing" a rule.[44] Here,

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[42] 84 Fed. Reg. 27846-27895, 27883 (June 14, 2019), https://www.federalregister.gov/documents/2019/06/14/2019-11512/nondiscrimination-in-health-and-health-education-programs-or-activities.

[43] Migration Policy Institute (MPI) tabulations from the U.S. Census Bureau's 1990 and 2000 Decennial Censuses and 2010 and 2013 American Community Surveys (ACS), available at: https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states.

[44] 5 U.S.C. § 551(5).

HHS proposes to remove important protections offered by its previous rule for Section 1557,[45] without a reasoned analysis, and presents a Proposed Rule that is in conflict with existing constitutional and statutory protections. On these grounds, the Proposed Rule violates the requirements provided under the APA and must be rejected.

1. Agency Action That Is Arbitrary and Capricious or Otherwise Exceeds Agency Authority Is Unlawful Under the Administrative Procedure Act

The APA requires courts to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,"[46] "contrary to a constitutional right,"[47] or "in excess of statutory jurisdiction."[48] Therefore, the APA prohibits an agency action, including issuing final regulations, which will violate any of these legal standards.

In *Fox Television*, the Supreme Court clarified that an agency change is analyzed the same as when an agency acts in the first instance.[49] Nonetheless, the agency must "display awareness that it is changing position" and "show that there are good reasons for the new policy."[50] The agency must provide a more detailed justification when "its new policy rests upon factual findings that contradict those which underlay its prior policy; or when its prior policy has engendered serious reliance interests that must be taken into account."[51] Ultimately, "a reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy."[52] Moreover, the agency decision must be justified by facts in the rulemaking record, and not a record created after the fact in court.

2. The Proposed Rule Is Procedurally Invalid Under the APA

The proposed rule violates the procedural requirements of the APA for at least three reasons. First, HHS's proposed rule is arbitrary and capricious by improperly narrowing its interpretation of Section 1557. Second, the NPRM fails to provide a reasoned explanation for its policy change. Third, the NPRM fails to engage in a proper cost-benefit analysis.

a. The NPRM Is Arbitrary and Capricious.

HHS's grounds for its proposed rule, as provided by the NPRM, are arbitrary and capricious in violation of the APA.[53] An agency action is arbitrary and capricious if "the agency has relied on

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[45] 45 C.F.R. pt. 92.
[46] 5 U.S.C. § 706(2)(A).
[47] 5 U.S.C. § 706(2)(B).
[48] 5 U.S.C. § 706(2)(C).
[49] F.C.C. v. Fox Television Stations, Inc., 556 U.S. 502, 513-14 (2009).
[50] *Id.* at 515.
[51] *Id.*; *see also Perez v. Mortgage Bankers Ass'n*, 135 S. Ct. 1199 (2015) (reaffirming that an agency must provide "more substantial justification" when prior policy engendered serious reliance interests or new policy relies on facts contrary to those relied on for prior policy).
[52] 556 U.S. at 516.
[53] *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846, 27849-60 (proposed Jun. 14, 2019) (to be codified at 42 C.F.R. pts. 438, 440, and 460).

factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise."[54] Here, HHS improperly narrows Section 1557's enforcement mechanisms and improperly limits application to programs and activities administered by executive agencies.

First, HHS claims that the Final Rule improperly "made certain individualized requirements, prohibitions, or enforcement mechanisms apply across all protected classes without sufficient statutory or regulatory support."[55] On the contrary, the Final Rule properly blended the substantive requirements and enforcement mechanisms of the underlying statutes incorporated into Section 1557. Section 1557 incorporated the enforcement mechanisms of underlying civil rights statutes. It provides that the "enforcement mechanisms provided for and available under such [T]itle VI, [T]itle IX, [S]ection 504, or such Age Discrimination Act shall apply for purposes of violations of" Section 1557.[56] In each of these statutes, Congress set forth detailed procedures based on Title VI for administrative and judicial review of a governmental finding of discrimination and decision to withdraw federal financial assistance.[57] The Final Rule mirrored Congress' enforcement scheme. The Final Rule likewise adopts the procedural provisions applicable to Title VI "to administrative enforcement actions concerning discrimination on the basis of race, color, national[] origin, sex, and disability discrimination under Section 1557."[58] Therefore, the Final Rule's enforcement mechanisms are consistent with Congress' detailed scheme of administrative and judicial review under Section 1557 and underlying statutes incorporated into Section 1557. HHS's claims that the Final Rule failed to provide statutory and regulatory support for enforcement mechanisms are false, and therefore, do not provide support for removal of these protections sanctioned by Congress.

Second, the proposed changes are contrary to Section 1557's plain text because they improperly narrow the scope of application to health care programs and activities and to programs and activities administered by executive agencies.[59] The statute itself applies to "any health program or activity, any part of which is receiving Federal financial assistance," "any program or activity that is administered by an executive agency," and "any entity established under this title."[60] Under the new proposed rule, OCR would apply Section 1557 only to the specific operations and lines of business for which insurers receive federal financial assistance, which would make insurance access increasingly inaccessible to individuals who the law was

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[54] *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

[55] Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846, 27851 (proposed Jun. 14, 2019) (to be codified at 42 C.F.R. pts. 438, 440, and 460).

[56] 42 U.S.C. § 18116(a).

[57] *Accord* 20 U.S.C. §§ 1682, 1683 (Title IX); 42 U.S.C. §§ 6104, 6105 (Age Discrimination Act); 29 U.S.C. § 794a(a)(2) (Section 504) (cross-referencing "[t]he remedies, procedures, and rights set forth in [T]itle VI").

[58] 45 C.F.R. § 92.302(a).

[59] *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846, 27850 (proposed Jun. 14, 2019) (to be codified at 42 C.F.R. pts. 438, 440, and 460).

[60] 42 U.S.C. § 18116(a).

intended to protect.[61] OCR's interpretation of "health care program or activity" within the context of the ACA, which was supposed to expand insurance access to individuals, was intended to be broader than the scope provided for in the Civil Rights Restoration Act of 1987, which was passed a quarter century before. The changes HHS proposes would limit the statutorily defined beneficiary protections within Section 1557. Because Section 1557 on its plain text applies broadly, HHS's proposed narrowing denies these beneficiaries necessary and important protections in contradiction to its authority delegated by Congress.

b. The NPRM Fails to Provide a "Reasoned Explanation."

HHS is free to change policy positions, but it must provide a reasoned explanation for disregarding the factual findings relied upon in the previous rulemaking.[62] Here, the Final Rule's legal interpretation of the applicable civil rights laws was correct, and HHS's sudden departure from that interpretation violates the APA. Moreover, HHS's attempt to justify the new rule by citing to court decisions is selective and not reflective of existing case law.

First, HHS lacks support for its sudden departure from the Final Rule's legal interpretation of the applicable civil rights laws. The NPRM provides no "reasoned explanation" for disregarding the extensive history of healthcare discrimination that LGBTQI+ individuals and individuals seeking reproductive care have suffered. For example, the Final Rule relied on research demonstrating the barriers confronted by LGBTQI+ individuals, including refusal from medical treatment, lack of protection from gender identity discrimination, and challenges in obtaining health insurance coverage.[63] One such survey, cited by the Final Rule, found that a quarter of transgender individuals reported being subject to harassment in medical settings.[64] HHS received "many comments expressing anecdotal evidence of these statistics."[65] Additional research confirms the pervasiveness of these barriers. Eight percent of lesbian, gay, bisexual, and queer people and twenty-nine percent of transgender people reported that a doctor or other healthcare provider had refused to see them because of their actual or perceived sexual orientation in the year before the survey.[66] In a recent study, nearly one in five LGBTQ people, including thirty-one percent of transgender people, said that it would be very difficult or impossible to get the healthcare they need at another hospital if they were turned away.[67] That rate was substantially higher for LGBTQ people living in non-metropolitan areas, with forty-one percent reporting that it would be very difficult or impossible to find an alternative provider.[68] Here, HHS provides no reasoned

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[61] *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846, 27850 (proposed Jun. 14, 2019) (to be codified at 42 C.F.R. pts. 438, 440, and 460).

[62] *See F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515-16 (2009).

[63] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31375, 31460 (May 18, 2016) (codified at 45 C.F.R. pt. 92).

[64] *Id.*

[65] *Id.*

[66] *See* Jaime M. Grant et al., *Injustice at Every Turn: a Report of the National Transgender Discrimination Survey*, NATIONAL GAY AND LESBIAN TASK FORCE & NATIONAL CTR. FOR TRANSGENDER EQUALITY (2011), http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.

[67] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, 2016, https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care.

[68] *Id.*

explanation for disregarding these factual underpinnings of the prior policy, nor do they provide any facts, studies, or data to refute the findings in the Final Rule.

Second, HHS cannot justify its proposed changes by cherry-picking court decisions. HHS is not obligated to recommend changes to Section 1557 consistent with DOJ's disputed litigation positions in pending lawsuits, including *Franciscan Alliance*, which are still being litigated and therefore unsettled. Importantly, other courts have upheld gender identity protections in final rulings, unlike the preliminary injunction in *Franciscan Alliance*. For example, the NPRM never mentions that the Seventh Circuit held that transgender students may bring sex-discrimination claims under Title IX based upon a theory of sex-stereotyping.[69] Other cases supporting gender identity protections were mentioned only to demonstrate "inconsistency," such as *Adams v. Sch. Bd. of St. Johns Cty.*[70] The federal district court there likewise held that "the meaning of 'sex' in Title IX includes 'gender identity' for the purposes of its application to transgender students."[71] Moreover, the NPRM fails to mention that the Sixth Circuit held that "[d]iscrimination against employees, either because of their failure to conform to sex stereotypes or their transgender and transitioning status, is illegal under Title VII," which has importance here because Title IX adopts the substantive and legal standards of Title VII, as the NPRM acknowledges.[72] Relying on litigation positions in unsettled matters, or ignoring contrary law in settled cases, is insufficient to support HHS's policy change and does not provide a sound basis for a reasoned explanation under the APA.

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[69] *Whitaker v. Kenosha Unified Sch. Dist.*, 858 F.3d 1034 (7th Cir. 2017); *see also A.H. v. Minersville Area Sch. Dist.*, 290 F. Supp. 3d 321 (M.D. Pa. 2017) (plaintiff successfully stated claim of discrimination under Title IX based on gender identity); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 298 (W.D. Pa. 2017) (concluding that the plaintiffs "demonstrated a reasonable likelihood of showing that Title IX's prohibition of sex discrimination includes discrimination as to transgender individuals based on their transgender status and gender identity").

[70] *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846, 27855 (proposed Jun. 14, 2019) (to be codified at 42 C.F.R. pts. 438, 440, and 460) (surveying federal litigation involving Section 1557 regulation, Title IX, and Title VII).

[71] *Adams v. Sch. Bd. of St. Johns Cty.*, 318 F. Supp. 3d 1293, 1325 (M.D. Fla. 2018).

[72] *E.E.O.C. v. R.G. & G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 600 (6th Cir. 2018), *cert. granted in part*, *R.G. & G.R. Harris Funeral Homes, Inc. v. EEOC*, 139 S. Ct. 1599 (Mem) (2019). *Accord E.E.O.C. v. Boh Bros. Constr. Co., LLC*, 731 F.3d 444, 454 (5th Cir. 2013) (en banc) ("[N]umerous courts, including ours, have recognized that a plaintiff can satisfy Title VII's because-of-sex requirement with evidence of a plaintiff's perceived failure to conform to traditional gender stereotypes."); *Smith v. City of Salem*, 378 F.3d 566, 575 (6th Cir. 2004) ("Sex stereotyping based on a person's gender non-conforming behavior is impermissible discrimination, irrespective of the cause of that behavior."); *see also Roberts v. Clark Cty. Sch. Dist.*, No. 215CV00388-JAD-PAL, 2016 WL 5843046, at *9 (D. Nev. Oct. 4, 2016) (finding that discrimination based on transgendered status is a cognizable claim of sex discrimination under Title VII); *Fabian v. Hosp. of Cent. Conn.*, 172 F. Supp. 3d 509, 527 (D. Conn. 2016) (same); *Dawson v. H&H Elec, Inc.*, No. 4:14CV00583 SWW, 2015 WL 5437101, at *3 (E.D. Ark. Sept. 15, 2015) (same); *Finkle v. Howard Cty., Md.*, 12 F. Supp. 3d 780, 788 (D. Md. 2014) (same); *Lopez v. River Oaks Imaging & Diagnostic Grp., Inc.*, 542 F. Supp. 2d 653, 659-61 (S.D. Tex. 2008) (same); *Schroer v. Billington*, 424 F. Supp. 2d 203, 211 (D.D.C. 2006) (holding that plaintiff stated a claim under Title VII where the discrimination was based on sexual identity). The NPRM states "[b]ecause Title IX adopts the substantive and legal standards of Title VII, a holding by the U.S. Supreme Court on the definition of 'sex' under Title VII will likely have ramifications for the definition of 'sex' under Title IX, and for the cases raising sexual orientation or gender identity claims under Section 1557 and Title IX which are still pending in district courts." Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846, 27855 (proposed Jun. 14, 2019) (to be codified at 42 C.F.R. pts. 438, 440, and 460) (footnotes omitted).

c. The NPRM Fails to Engage in a Proper Cost-Benefit Analysis.

HHS claims the Final Rule imposes unnecessary and unjustified costs, but the NPRM's analysis fails to consider all relevant factors.[73] The NPRM cites data collected from covered entities on cost estimates,[74] yet fails to offer adequate evidence to show that need does not justify those costs. Focusing on the burdens imposed by the notice and tagline requirements,[75] the NPRM offers six reasons why need does not justify the costs.[76] Each one focuses on effectiveness, lack of evidence of benefit, or burden of implementation.[77] Here, the NPRM overstates the import of these regulatory costs of compliance, which alone do not justify the proposed changes. In addition to relying on questionable or attenuated data sets, HHS also fails to provide support for its position because it does not balance the considerations against any need. The NPRM fails to account for the negative impact on patients caused by defining discrimination narrowly. The Final Rule noted that discrimination contributes to health disparities.[78] While impossible to quantify, it concluded that "the benefits [of the Final Rule's prohibition of sex discrimination in health care] would include more people receiving adequate health care, regardless of their sex, including gender identity."[79] The NPRM does not provide a basis for disregarding these facts in its analysis.

The NPRM's regulatory impact analysis also falls short on similar grounds;[80] it fails to account for any impact on patients or providers, such as the statistics on discrimination in health care experienced by the LGBTQI+ community stated in Section I.A of these comments.

3. The Proposed Rule Is in Conflict with Existing Constitutional and Statutory Protections in Violation of the APA

As we describe in Section II.3 of these comments, HHS's NPRM creates significant conflict with other vital statutory individual protections that have been upheld as constitutional and directly reflective of congressional intent.

The proposed rule violates the APA by encouraging unlawful discrimination in direct conflict with constitutional and statutory protections. The APA requires courts to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of

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[73] *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846, 27857-60 (proposed Jun. 14, 2019) (to be codified at 42 C.F.R. pts. 438, 440, and 460).

[74] *Id.* at 27858.

[75] The Final Rule requires notices of nondiscrimination and taglines be appended to all "significant" publications and communications (larger than a postcard or brochure) sent by covered entities to beneficiaries, enrollees, applicants, or members of the public. 45 C.F.R. 92.8(f)(1).

[76] Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846, 27859 (proposed Jun. 14, 2019) (to be codified at 42 C.F.R. pts. 438, 440, and 460).

[77] *Id.*

[78] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31375, 31460 (May 18, 2016) (codified at 45 C.F.R. pt. 92).

[79] *Id.* at 31461.

[80] *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846, 27872-77 (proposed Jun. 14, 2019) (to be codified at 42 C.F.R. pts. 438, 440, and 460).

discretion, or *otherwise not in accordance with law*,"[81] "*contrary to a constitutional right*,"[82] or "*in excess of statutory jurisdiction*."[83] First, by eliminating the Final Rule's definition of "on the basis of sex," the proposed rule will encourage unlawful discrimination against LGBTQI+ people and women in violation the Equal Protection Clause. Second, these changes will encourage unlawful discrimination based on national origin in violation of the protections of Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act, and the Affordable Care Act. Third, the proposed changes would encourage health care workers to violate the Emergency Medical Treatment and Active Labor Act.

III. CONCLUSION

Implementing the Proposed Rule as drafted would have far reaching impacts on the health and wellbeing of LGBTQI+ individuals, women, individuals with disabilities, LEP individuals, and the broader health care system. As a direct result, many individuals could be left unable to access important health care services that are essential to preventing the onset of a disease, accurately diagnosing a health condition, or treating a debilitating or life-threatening illness. If implemented as proposed, many people will be less likely to access the health care they need, or be empowered to enforce their rights to obtain such care.

We urge the Department to immediately withdraw this Proposed Rule and dedicate its efforts to advancing policies that strengthen—rather than undermine—the ability of Americans to support the health and well-being of themselves and their families.

Thank you for the opportunity to submit comments on this rule. If you have any questions or would like to discuss these comments further, please contact Craig Pulsipher at 213.201.1378 or cpulsipher@apla.org

Sincerely,

Craig E. Thompson

Craig E. Thompson
Chief Executive Officer

[81] 5 U.S.C. § 706(2)(A) (emphasis added).
[82] 5 U.S.C. § 706(2)(B) (emphasis added).
[83] 5 U.S.C. § 706(2)(C) (emphasis added).

EXHIBIT D-8

August 13, 2019

VIA ELECTRONIC SUBMISSION

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

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

Dear Secretary Azar:

The National Asian Pacific American Women's Forum (NAPAWF) submits these comments in response to the Department of Health and Human Services' ("HHS", "Department") and the Center for Medicare and Medicaid Services ("CMS") Notice of Proposed Rulemaking ("proposed rule," "NPRM") to express our concerns with the proposed rule entitled "Nondiscrimination in Health and Health Education Programs or Activities," published in the Federal Register on July 14, 2019.

The National Asian Pacific American Women's Forum (NAPAWF) is the only multi-issue, progressive, community organizing and policy advocacy organization for Asian American and Pacific Islander (AAPI) women and girls in the U.S.

We imagine a country where AAPI women and girls have the agency to make decisions about our lives, our families, and our communities and to flourish in all aspects of our lives. We imagine a country where AAPI women and girls are no longer defined by the stereotypical perceptions of mainstream America but rather are known for our bold leadership and our deep, compassionate commitment to creating a just world where everyone thrives.

The National Asian Pacific American Women's Forum (NAPAWF) strongly opposes the proposed elimination or rollback of critical protections guaranteed by Section 1557 of the Affordable Care Act ("ACA") and the 2016 Nondiscrimination in Health Programs or Activities final rule ("2016 final rule"). We demand that this NPRM be rescinded in its entirety.

The National Asian Pacific American Women's Forum (NAPAWF) believes in the critical importance of ensuring that all people, including Asian and Pacific Islander American Communities, especially immigrants, and low-income women, do not face discriminatory barriers when seeking quality, affordable health coverage and care.

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

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

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

AAPI immigrant women with LEP face multiple forms of discrimination that threatens their ability to linguistically and culturally appropriate health care. Language barriers, compounded with existing discimination based on immigration status, make it difficult to receive appropriate reproductive health care services. Among all racial groups, AAPIs are the most likely to feel looked down upon by their providers and least likely to perceive their background was understood by their providers.[1]

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

In direct opposition to the text of Section 1557, the proposed rule improperly seeks to exempt many health insurance plans from the anti-discrimination provisions, as well as any health program or activity run by HHS that was not created by Title I of the ACA. It eliminates regulations pertaining to the fundamental requirement that all beneficiaries, enrollees, applicants, and members of the public receive notice of their rights under Section 1557 and removes important regulations that protect individuals with LEP. It improperly tries to incorporate Title IX's religious exemption, which could permit health care entities controlled by a religious organization to discriminate if the entity claims complying with the sex discrimination protections conflicts with its religious beliefs. The rule attempts to overrule decades of federal court precedent by trying to eliminate protections against discrimination on the basis of gender identity, and completely disregards Supreme Court precedent on discrimination based on sex stereotyping. Although the preamble to the proposed rule acknowledges that Section 1557 prohibits discrimination based on pregnancy, including termination of pregnancy, the Department refuses to state whether it would enforce those protections. Additionally, contrary to the plain language of the law, the proposed rule improperly seeks to incorporate an abortion carveout from Title IX to narrow the protection under Section 1557. This is an attack on all of our civil rights and will harm the very communities and people Section 1557 was intended to protect.

[1] Richard Castillo & Kristina L Guo. "A Framework for Cultural Competence in Helath Care Organizations. The Health Care Manager." *Health Care Manager* (2011).

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

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

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

The proposed rule attempts to reduce the number of health insurance plans that are covered by claiming that if the issuer of a health plan is "not principally engaged in the business of providing health care (as opposed to health insurance), only its Marketplace plans would be covered and any plans it offers outside the marketplace would not be subject to Section 1557."[2] Additionally, the proposed rule improperly attempts to narrow that application of Section 1557's protections to only the portion of a health care program or activity that received federal financial assistance. These changes unlawfully narrow the scope of Section 1557's application. Rather, the statute is clear that the law's provisions apply broadly to "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)." 42 U.S.C. § 18116(a).

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

Short-term plans are notorious for discriminating against consumers based on gender, age, and disability. If implemented, this proposed rule would be harmful to women, especially for AAPI women, for example. The proposed rule would embolden short-term plans to discriminate against women by refusing to cover reproductive health services, such as maternity, contraceptive care or fertility care and coverage, or deny coverage altogether for other conditions unique to women like breast or cervical cancer. A 2018 study for example, found that not a single short-term plan covered maternity care.[3] Short-term plans also discriminate based on gender identity by excluding coverage for transition-related services, such as surgery. Additionally, short-term health plans could charge women higher premiums than men. For example, according to data submitted to Wisconsin insurance regulators, a National Health Insurance Company short-term plan with a $5,000 deductible would cost $109 per month for a 40-year-old woman, compared to $90 per month for a man of the same age.[4]

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

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

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

AAPI communities face several challenges to care, and if implemented, this would only exacerbate this inequity and associated health disparities. Finding a provider who provides culturally and linguistically appropriate care is already challenging for many AAPs. When these barriers are coupled with an insurance plan that may not comply with the requirements of Section 1557, this only adds extraneous hurdles to accessing the care a person needs. The proposed rule would allow short-term plans to discriminate against women by refusing to cover reproductive health services, such as maternity, contraceptive care, or fertility care and coverage, or deny coverage altogether for other conditions like cervical cancer. AAPI women suffer from cervical cancer at a higher rate than African American and non-white women, with some AAPI ethnicities facing even higher rates of incidence.[5]

Women have long been the subject of discrimination in health care.[6] Despite the historic achievements of the ACA, women are still more likely to forego care because of cost[7]–particularly AAPI women and immigrants who face cultural discrimination from their providers. These barriers mean women are more likely not to receive routine and preventive care than men. Moreover, when women are able to see a provider, women's pain is routinely undertreated and often dismissed.[8]And due to gender biases and disparities in research, doctors offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[9]

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

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

a. Sex discrimination based on gender identity

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

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[5]Dang, Jeff H., Jessica H. Lee, and Jacqueline H. Tran. "Knowledge, Attitudes, and Beliefs Regarding Breast and Cervical Cancer Screening among Cambodian, Laotian, Thai, and Tongan Women." Journal of Cancer Education: the Official Journal of the American Association for Cancer Education 15, no. 4 (March 18, 2010): 596–601. https://doi.org/10.1007/s13187-010-0082-1.

[6] Prior to the ACA, women were charged more for health care on the basis of sex and were continually denied health insurance coverage for services that only ciswomen, transgender, and gender non-conforming patients need. *See Turning to Fairness*, Nat'l Women's L. Ctr. 1, 3-4 (2012), https://nwlc.org/wp-content/uploads/2015/08/nwlc_2012_turningtofairness_report.pdf (noting that while the ACA changed the health care landscape for women in significant ways, women still face additional hurdles).

[7] *See* Shartzer, et al., Health Reform Monitoring Survey, Urban Inst. Health Policy Ctr. (Jan. 2015), http://hrms.urban.org/briefs/Health-Care-Costs-Are-a-Barrier-to-Care-for-Many-Women.html.

[8] *See, e.g.,* Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29:1 J. of L., Med. & Ethics 13, 13-27 (2001).

[9] *See, e.g.,* Judith H. Lichtman et al., *Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction*, 10 J. of the Am. Heart Ass'n 1 (2015).

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

According to the 2015 U.S. Transgender Survey, 44 percent of Asian and Native Hawaiian/Pacific Islander respondents identified as non-binary,[10] 29 percent were transgender women, and 25 percent were transgender women.[11] Among Asian respondents, 46 percent identified as non-binary, while 46 percent of Native Hawaiian and Pacific Islander respondents identified as a transgender woman.[12]

Transgender, nonbinary, and gender nonconforming people already experience high rates of discrimination and harassment in health care. According to the 2015 U.S. Transgender Survey, 33 percent had at least one negative experience in a health care setting relating to their gender identity in the past year.[13] Rates were higher for Native respondents (50 percent), Middle Eastern respondents (40 percent), multiracial respondents (38 percent), and respondents with disabilities (42 percent).[14] Among AAPI respondents, 26 percent reported having at least one negative experience. These experiences included being refused treatment, being verbally harassed, being physically or sexually assaulted, or having to teach the provder about transgender people in order to recieve the care they needed. Thirty-five percent of AAPI transgender men and 31 percent of transgedner women were more likely to report mistreatment by health providers compared to 18 percent of non-bnary people.[15] The proposed rule could impermissibly open the door to further discrimination.

The 2016 final rule clarified that insurance companies cannot categorically exclude or deny coverage for gender-affirming care. The proposed rule illegally attempts to again open the door to insurance companies categorically excluding coverage of gender-affirming care from their plans or denying individuals coverage of procedures used for gender affirmation.

Gender-affirming care is medically necessary and often life-saving for transgender, nonbinary, and gender nonconforming people experiencing gender dysphoria.[16] Prior to the 2016 final rule, many insurers did not cover gender-affirming care, making it even more difficult to afford. Transgender, nonbinary, and gender nonconforming people are disproportionately living with low incomes. According to the 2015 National Transgender Survey, Asian, Native Hawaiian, and Pacific Islander respondents were unemployed at twice the rate in the U.S. population. Furthermore, 32 percent of Asian, Native Hawiian, and Pacific Islanders experience poverty, nearly three times the rate of the U.S. population (12 percent). Low-incomes and employment restrictions make gender-affirming care out of reach. In fact, 27 percent of

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[10] S.E. James, et al., Nat'l Ctr. for Transgender Equality, Report of the 2015 U.S. Transgender Survey, Report on the Experience of Asian, Native Hawaiian, and Pacific Islander Respondents 3-4 (2016). https://transequality.org/sites/default/files/docs/usts/USTS-ANHPI-Report-Dec17.pdf

[11] *Ibid.*

[12] *Ibid.*

[13] S.E. James, et al., Nat'l Ctr. for Transgender Equality, Report Of The 2015 U.S. Transgender Survey 96-97 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[14] *Ibid*.

[15] S.E. James, et al., Nat'l Ctr. for Transgender Equality, Report of the 2015 U.S. Transgender Survey, Report on the Experience of Asian, Native Hawaiian, and Pacific Islander Respondents 20 (2016). https://transequality.org/sites/default/files/docs/usts/USTS-ANHPI-Report-Dec17.pdf

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

Asian and Native Hawaiian and Pacific Islander respondents reported not going to a health provider due to financial constraints.[17] The proposed rule could put gender-affirming care further out of reach.

Prior to the 2016 final rule, many insurers did not cover gender-affirming care. 18 percent of Asian and Native Hawaiian and Pacific Islander respondents were denied coverage based on their gender identity.[18] However, as a result of section 1557 and the implementing regulation, many insurers removed categorical coverage exclusions harming transgender people and began to cover gender-affirming services,[19] increasing access to care. The proposed rule could give insurers the false impression that they could refuse to cover gender-affirming care.

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

Additionally, Section 1557 and the 2016 final rule prohibit covered entities from denying, limiting, or imposing additional cost-sharing for services based on sex or gender. If implemented, the proposed rule would eliminate the regulations that specifically address cost-sharing, adding confusion about whether covered entities may impose additional financial burdens on transgender, nonbinary, and gender nonconforming individuals.

LGBTQ people, and especially transgender, nonbinary, and gender nonconforming people already face unique barriers to accessing reproductive health care. Under the proposed rule, those barriers would only increase. For example, transgender, nonbinary, and gender nonconforming people assigned female at birth whose gender marker is male or nonbinary could be denied coverage for necessary care such as a pap smear or mammogram. Similarly, transgender nonbinary, and gender nonconforming people assigned male at birth whose gender marker is female or nonbinary could be denied coverage for necessary care, such as a prostate exam.

Anothe example of this could be a health care provider denying a transgender man coverage of cervical cancer treatment because of his gender identity. The National Transgender Discrimination Survey found that 8 percent of the transmasculine respondents (assigned female at birth) had a hysterectomy to remove their uterus and, in most cases, the cervix. This demonstrates that the vast majority of transmasculine individuals require cervical cancer screening, but only 27 percent reported that they had a Pap test in the past year.[20] Under the proposed rule, many AAPI transgender men will face increased barriers to preventative care.

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[17] S.E. James, et al., Nat'l Ctr. for Transgender Equality, Report of the 2015 U.S. Transgender Survey, Report on the Experience of Asian, Native Hawaiian, and Pacific Islander Respondents (2016). https://transequality.org/sites/default/files/docs/usts/USTS-ANHPI-Report-Dec17.pdf

[18] *Ibid.*

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

[20] Rebekah Rollston, The Fenway Inst., Promoting Cervical Cancer Screening Among Female-to-Male Transmasculine Patients(2019), https://fenwayhealth.org/wp-content/uploads/TFIP-28_TransMenCervicalCancerScreeningBrief_web.pdf.

b. Sex discrimination based on sex stereotyping

The 2016 final rule reiterated that sex stereotpying is a prohibited form of discrimination under the 1989 Supreme Court decision, *Price Waterhouse v. Hopkins*[21]. The proposed rule attempts to erase established Supreme Court precedent recognizing that discrimination on the basis of sex includes discrimination on the basis of sex stereotypes. This could result in health providers thinking they could turn a patient away because the patient does not conform with traditional stereotypes about their sex. Federal courts have applied the reasoning of *Price Waterhouse* to both LGBTQ and non-LGBTQ people seeking relief for sex discrimination.

AAPI lesbian, gay, bisexual, and queer people already experience significant discrimination in health care. For example, 7 percent had a provider refuse to recognize their family, including a child or a same-sex spouse/partner,[22] and 9 percent had a provider use harsh or abusive language when treating them.[23] Further, 7 percent experienced unwanted physical contact from provider, including fondling, sexual assault, or rape.[24] The proposed rule impermissibly attempts to open the door to further discrimination.

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

Sex discrimination takes many forms and has the potential to occur at every step in the health care system—from obtaining insurance coverage to receiving proper diagnosis and treatment to harrassment by a provider. Such discrimination has serious adverse impacts on the lives of women, causing them to pay more for health care and to risk receiving improper diagnoses and less effective treatments. The effects of sex discrimination for women of color may be compounded by other forms of discrimination they face, including racial discrimination and discrimination based on language proficiency.

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

The proposed rule also seeks to unlawfully incorporate Title IX's "Danforth Amendment", which carves out abortion care and coverage from the ban on discrimination of sex in the education context. Congress did not include the Title IX exceptions, including the Danforth Amendment, either explicitly or by

[21] 490 U.S. 228 (1989).
[22] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.
[23] *Ibid*.
[24] *Ibid*.

reference, in Section 1557. The proposed rule's unlawful incorporation of the Danforth Amendment is yet another Trump-Pence Administration attack on abortion care. These attacks could embolden illegal discrimination that will fall heaviest on those least able to seek health care elsewhere, including women living in rural areas and women of color, who already face harassment and discrimination by providers during pregnancy, contributing to Black and Native American women's unacceptably high rates of health related pregnancy complications and death.

The proposed rule could be used to deny AAPI communities' access to crucial services such as emergency contraception and prenatal care. Language and cultural barriers already prevent AAPIs from accessing culturally and linguistically appropriate care. AAPI women use less effective contraceptive methods at much higher rates compared to women of other races and ethnicities, placing AAPI women at greater risk of unintended pregnancy.[25] AAPI mothers are less likely than others to receive early and adequate prenatal care, especially Laotian and Cambodian women.[26] One study found AAPI women are twice as likely to die from pregnancy-related causes, including embolism and pregnancy-related hypertension.[27]

d. Religious Exemption

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

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

Allowing a religious exemption to Section 1557's protection against sex discrimination could have far reaching consequences. Incorporating Title IX's religious exemption could create new instances in which health care providers, including insurance companies, hospital, doctor, or nurses, can allow their beliefs to determine patient care, opening the door to illegal discrimination. This could impact a broad range of health care services, including birth control, sterilization, certain fertility treatments, abortion, gender-affirming care, and end of life care. Moreover, there is already a proliferation in the types of entities that are now emboldened to use religious beliefs to discriminate against patients and the number of religiously-affiliated entities that provide health care and related services and refuse to provide care

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

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

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

based on religious beliefs.[28] The proposed rule could encourage these entities to engage in illegal discrimination.

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

Providers, hospitals, or clinics that refuse to provide reproductive health services to a woman who is not married or because she does not conform to sex stereotypes force women to seek care elsewhere or forgo it completely. For many AAPI immigrant women, access to affordable contraception is often non-existent but is necessary to ensure that they can make the best decisions for them and their families.

Religious exemptions disproportionately harm LGBTQ people, especially those who are transgender, nonbinary, gender nonconforming. LGBTQ people are often refused health care services because of their sexual orientation and/or gender identity.[29] For example, 8 percent of LGBQ people were refused health care because of their sexual orientation, and 6 percent were refused care related to their sexual orientation. Similarly, 29 percent of transgender people were refused health care because of their gender identity,[30] and 12 percent were refused gender-affirming health care.[31] The proposed rule purports to allow further illegal refusals of care for LGBTQ people.

When LGBTQ people are refused treatment, it becomes difficult or impossible to find another provider, especially for those living in rural areas and for transgender people.[32] According to a 2018 study, 18 percent of LGBTQ people said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 17 percent said it would be very difficult or not possible to find the same type of service at a different clinic. Rates are higher for LGBTQ people living outside of a metropolitan area: 41 percent said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 31 percent said it would be very difficult or not possible to find the same type of service at a different clinic. Rates are also higher for transgender people: 31 percent said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 30 percent said it would be very difficult or not possible to find the same type of service at a different clinic. The proposed rule would make it harder for LGBTQ people to access the health services they need.

Religious exemptions have a particularly negative impact on people of color. Women and people of color are disproportionately served by Catholic hospitals. These institutions are "governed by strict guidelines that prohibit health care providers from providing contraceptives, sterilization, some treatments for

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

[29] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[30] *Ibid*.

[31] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[32] *Ibid*.

ectopic pregnancy, abortion, and fertility services regardless of their patients' wishes, the urgency of a patient's medical condition, the provider's own medical judgment, or the standard of care in the medical profession."[33] The proposed rule would make it harder for people of color, especially those that are LGBTQ and/or needing reproductive care, to access the health services they need.

Over the past several decades, religious refusals have helped systematically chip away at abortion access across the country. This limiting of abortion care has meant that individuals have been denied the care they need. Being denied an abortion has long-term negative impacts on an individual and reduces financial security and safety for themselves and their families. For example, women denied an abortion had almost 4 times greater odds of a household income below the federal poverty level and three times greater odds of being unemployed.[34] Additionally, women who were denied an abortion were more likely to not have enough money to pay for basic family necessities like food, housing and transportation.[35] A recent study found that continuing an unwanted pregnancy and giving birth is associated with more serious health problems than abortion.[36] Critically, lacking access to abortion care can also undermine the safety and security of the individual seeking services. For example, one study found that women who were unable to terminate unwanted pregnancies were more likely to stay in contact with their violent partners, putting them and their children at greater risk than if they had received the abortion.[37]

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

This proposed rule attempts to sow confusion about the critical protections against discrimination to which Title X-funded providers and others must adhere to. Although Section 1557 is still the law of the land, if implemented, the proposed rule could embolden providers to participate in the Title X program and other similar programs even though they intend to allow their personal beliefs to dictate patient care. We believe that providers currently enrolled in the program would continue to act in good faith and would not discriminate against those obtaining health care. However, the Trump-Pence administration has clearly demonstrated its preference for providers who would use their religious or moral beliefs as a license to discriminate over the needs of patients and this proposed rule would further that goal.

In many states, a Title X-funded provider is one of the few places women of color can access reproductive health care and preventive health care services and it is critical that those providers are not discriminating against the individuals that are able to make it through their doors. Title X-funded health centers are a lifeline for quality health care for underserved communities. Providers administer gynecological exams, contraception, counseling, pap tests, breast exams and screenings for HIV, AIDS and other STIs, and all services are provided confidentially. Their adherence to the protections Section 1557 is critical given their role in these underserved communities. Additionally, Title X health care providers also offer services for foreign-born individuals who are less likely to have coverage (46 percent) than U.S.-born people (75 percent). For those who have limited options for care, these services, which are available at an affordable

[33] *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, Columbia Law Sch. (Jan. 19, 2018), https://www.law.columbia.edu/events/bearing-faith-limits-catholic-health-care-women-color.
[34] Bixby Ctr. for Global Reprod. Health, University of Cal. S.F., *Turnaway Study*, https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf (last visited Jul. 23, 2019).
[35] *Ibid*.
[36] *Ibid*.
[37] Bixby Ctr. for Global Reprod. Health, University of Cal. S.F., *Turnaway Study*, https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf (last visited Jul. 23, 2019).

price at Title X-funded health centers, can mean the difference of a person receiving care or going without care. Given that many individuals who seek care at a Title X clinic live at the intersection of identities protected by Section 1557, the fact that the proposed rule seeks to rollback the protections for those individuals is both contrary to the plain language and spirit of the law.

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

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

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

Under the proposed rule, Medicaid managed care entities and state Medicaid programs could be emboldened to discriminate against LGBTQ beneficiaries in enrollment. LGBTQ people are more likely to live in poverty than the overall U.S. population.[38] According to the 2015 U.S. Transgender Survey, 32 percent of Asian respondents were living in poverty.[39] As a result, LGBTQ people are more likely that non-LGBTQ people to use Medicaid.[40] Within LGBTQ communities, LGBTQ people of color (24 percent) are more likely than white LGBTQ people (18.8 percent) to receive Medicaid; transgender people (21.4 percent) are more likely than LGBQ cisgender people (13.4 percent) to receive Medicaid; and LGBTQ people with disabilities (44.4 percent) are more likely than LGBTQ people with no disabilities (11.8 percent) to receive Medicaid.[41] The proposed rule would impermissibly open the door to discrimination against the many LGBTQ people enrolled in Medicaid programs across the country.

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

[39] S.E. James, et al., Nat'l Ctr. for Transgender Equality, Report of the 2015 U.S. Transgender Survey, Report on the Experience of Asian, Native Hawaiian, and Pacific Islander Respondents 20 (2016). https://transequality.org/sites/default/files/docs/usts/USTS-ANHPI-Report-Dec17.pdf

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

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

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

Over 21 percent of the U.S. population, or 66 million people, speak a language other than English at home, with 25 million of them speaking English less than "very well" and thus considered LEP.[42]

The inability to communicate or understand English, particularly healthcare or medical terminology, makes it difficult for AAPI women with LEP to navigate the healthcare system. About one in five Asian American households are linguistically isolated.[43] Disaggregated data reveals 20 percent or more of Vietnamese, Korean, Chinese, Bangladeshi, Laotian, Thai, Hmong, Indonesian, and Cambodian households are linguistically isolated, meaning no one in the household 14 years old and older speaks English exclusively or "very well".[44]

For LEP individuals, language differences often compound existing barriers to access and receiving appropriate care. LEP often makes it difficult for many to navigate an already complicated health care system, especially when it comes to medical or insurance terminology. Moreover, these barriers are often compounded by discrimination based on national origin, immigration status, race, ethnicity, sexual orientation, and gender/gender identity.

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

Language access services particularly impact AAPI and Native Hawaiian people. AAPI communities speak more than 100 languages, and 33 percent of AAPIs are considered LEP. Language barriers have been proven to contribute to health disparities for AAPI people; in particular, AAPI people with LEP are less likely to receive primary care and preventative care such as breast and cervical cancer screenings.[45]

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

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

[43] Karthick Ramakrishnan & Farah Z Ahmed, "Language Diversity and English Proficiency." Center for American Progress (27 May 2014). https://cdn.americanprogress.org/wp-content/uploads/2014/04/AAPI-LanguageAccess1.pdf

[44] *Ibid.*

[45] Elizabeth A. Jacobs, et al., *Limited English Proficiency and Breast and Cervical Cancer Screening in a Multiethnic Population,* Am. J. of Pub. Health (2005), https://ajph.aphapublications.org/doi/10.2105/AJPH.2004.041418.

English or inaccurately translated non-English languages, not understanding the benefits and costs of services in a health plan, or not having the appropriate cultural and language brokers to communicate with English-speaking physicians and pharmacists. Research has found that even in health care settings that provide a range of interpreters, communication remains a challenge because of the unique dialects tones, expressions, and terms surrounding reproductive and sexual terminology. For example, the Hmong language has few medical terms, making health care communication even more complex.[46]

Without adequate services addressing the needs of LEP individuals, many may be forced to seek assistance from those with whom they do not want to share sensitive or confidential health information, such as a child or an abusive partner. Many AAPI women and immigrants face high rates of sexual violence, including domestic violence. For immigrants with LEP, accessing resources in their languages is difficult, especially those trapped in abusive relationships. One-fifth of immigrant women reported their spouses had used immigration related abuse tactics to keep them in the relationship, denying the access to healthcare services they might need.[47] The proposed rule threatens AAPI women's ability to access information about services and health insurance.

a. Remote interpreting services

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

b. Taglines

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

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

The provisions in the 2016 final rule were justified by need and were not overly burdensome. The rollback of these provisions will actually increase public health costs by decreasing access to health services, leading to further health inequities. The Joint Center for Political and Economic Studies estimates that health inequities and premature deaths cost the U.S. economy $309.3 billion a year.[48]

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[46] Torry Grantham Cobb, "Strategies for providing Cultural Competent Health Care for Hmong Americanns." *Journal of Cultural Diversity* (2010).
[47]Giselle Aguilar Hass, Nawal Ammar, and Lesley Orloff, "Battered Immigrants and U.S. Citizen Spouses, Legal Momentum" (April 2005), http://www.ncdsv.org/images/LM_BatteredImmigrantsAndUScitizenSpouses_4-24-2006.pdf
[48] Thomas A. LaVeist, Darrel J. Gaskin., & Patrick Richard, *The Economic Burden Of Health Inequalities in the United States*, Joint Ctr. for Pol. and Econ. Stud.,

c. Language access plans

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

By eliminating critical protections for LEP individuals seeking care, the administration is discouraging entities from meeting individuals where they are, making health care access inaccessible and often convoluted for marginalized or linguistically isolated communities. The elimination of protections will disproportionately harm AAPIs, who have the highest population of residents who speak a language other than English at home.[49] Language proficiency should not determine whether or not people have access to care or the quality of a person's care.

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

Over 133 million people in the U.S. live with at least one chronic condition.[50] Over 61 million people in the U.S. live with a disability.[51]

According to the U.S. Census Bureau, about 21 million Asian Americans identify as being disabled.[52] Before the ACA, people with serious and/or chronic health conditions were often denied health insurance coverage or paid high prices for substandard plans with coverage exclusions, leaving many people unable to afford the health care they needed. Under the ACA, insurers can no longer charge higher premiums or deny coverage for people with pre-existing conditions. These protections have been lifesaving for many people.

Under the 2016 final rule, covered entities are prohibited from designing benefits that discourage enrollment by persons with significant health needs. For example, insurers are prohibited from placing all or most prescription drugs used to treat a specific condition, such as HIV prescriptions, on a plan's most expensive tier.[53] Additionally, covered entities are prohibited from using discriminatory marketing

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https://jointcenter.org/sites/default/files/Economic%20Burden%20of%20Health%20Inequalities%20Fact%20Sheet.pdf (last visited Jul. 23, 2019).

[49] Karthick Ramakrishnan & Farah Z Ahmed, "Language Diversity and English Proficiency." *Center for American Progress* (27 May 2014). https://cdn.americanprogress.org/wp-content/uploads/2014/04/AAPI-LanguageAccess1.pdf.

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

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

[52] Wendy Lu. "What It's Like Being Disabled And Asian in America," Huffington Post (May 24, 2019).https://www.huffpost.com/entry/disability-asian-americans-immigrants-stigma_n_5cd1c2c7e4b0548b7360bf26

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

practices, such as those "designed to encourage or discourage particular individuals from enrolling in certain health plans."[54] The proposed rule improperly attempts to eliminate these prohibitions.

The proposed rule would make it harder for LGBTQ people to afford coverage and care. The final rule's prohibition on discriminatory plan benefit designs helped LGBTQ people living with HIV get the medications they need. Due to systemic barriers to health care, LGBTQ have a "higher prevalence and earlier onset of disabilities" and disproportionately experience chronic conditions,[55] including HIV.[56] HIV disproportionately affects gay, bisexual, and queer men of color and transgender women of color.[57] Further, 26 percent of gay men, 36 percent of bisexual women, 36 percent of lesbian women, 40 percent of bisexual men experience a form of disability.[58] Additionally, 28 percent of transgender, nonbinary, and gender nonconforming people experience a form of disability.[59] The proposed rule would disproportionately impact LGBTQ people of color living with disabilities and chronic conditions.

Due to systemic barriers to health care, people of color experience higher rates of chronic conditions. For example, "[i]n the case of diabetes, the risk of being diagnosed is 77 percent higher for African Americans and 66 percent higher among Hispanics, than for whites. Asian Americans, Native Hawaiians, and Pacific Islanders [("AANHPIs")] are at twice the risk of developing diabetes than the population overall."[60] Further, in the case of HIV, people of color also are more likely to be living with HIV. In fact, in the U.S., more than one in five Asians living with HIV are unaware of their status.[61] AAPI people already face barriers to accessing care such as language barriers, fear of cultural and/or family pressures. Further, in 2017, about 9 in 10 Asian men who recieved an HIV diagnosis identified as gay or bisexual.[62] Native Hawaiians and Pacific Islanders have the fourth highest rate of HIV diagnoses in the U.S., although these numbers are likely low due to a lack of disaggregated data.[63]

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

a. Nondiscrimination notice and grievance procedure requirements

The 2016 final rule requires covered entities with at least 15 employees to adopt a grievance procedure and designate at least one employee to coordinate its Section 1557 responsibilities.[64] The 2016 final rule

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[54] *Ibid.*
[55] Intersecting Injustice: A National Call to Action 63 (Lourdes Ashely Hunter, Ashe McGovern & Carla Sutherland eds., 2018), http://socialjusticesexuality.com/intersecting_injustice/.
[56] *Ibid.*
[57] Intersecting Injustice: A National Call to Action 63-64 (Lourdes Ashely Hunter, Ashe McGovern & Carla Sutherland eds., 2018), http://socialjusticesexuality.com/intersecting_injustice/.
[58] Disabled World, *LGBT and Disability: Information, News and Fact Sheets*, https://www.disabled-world.com/disability/sexuality/lgbt/ (last updated Feb. 7, 2019).
[59] S.E. James, et al., Nat'l Ctr. for Transgender Equality, Report Of The 2015 U.S. Transgender Survey 247 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.
[60] Kenneth E. Thorpe, et al., *The United States Can Reduce Socioeconomic Disparities by Focusing on Chronic Diseases*, HealthAffairs (Aug. 17, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170817.061561/full/.
[61] Centers for Disease Control and Prevention, *HIV and Asians,* https://www.cdc.gov/hiv/group/racialethnic/asians/# (last updated May. 8, 2019).
[62] *Ibid.*
[63] Centers for Disease Control and Prevention, *HIV and Native Hawaiians and Other Pacific Islanders,* https://www.cdc.gov/hiv/group/racialethnic/nhopi/index.html (last updated April 30, 2019).
[64] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019),

also requires covered entities to provide notice of nondiscrimination policies in significant communications, in physical locations where the entity interacts with the public, and on the home page of their website. The notice of nondiscrimination must include information about the characteristics protected from discrimination under Section 1557, the availability of and how to access auxiliary aids and services, the availability of and how to access language assistance services, contact information for the designated employee coordinating the entity's Section 1557 responsibilities, the entity's grievance procedures, and complaint procedures for OCR. The proposed rule improperly attempts to eliminate these provisions entirely.

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

AAPI communities encompass more than 50 different ethnic groups and communicate in more than 100 languages. One in five Asian American households are linguistically isolated with 34 percent of Vietamese American households having the highest rates of linguistic isolation.[65] Under the proposed rule, it will be difficult for AAPI people who need auxiliary aids and/or language services to access the services they need to have meaningful health care. By eliminating these notice requirements, the proposed rule would make health care inaccessible. Notices of nondiscrimination are critical for AAPI women and LGBTQ communities with limited english proficiency (LEP). Notices tell individuals that an entity cannot discriminate and what to do if they face discrimination, including how to file a complaint with OCR.

b. Private right of action and compensatory damages

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

Many people who experience discrimination cannot access the court system due to cost.[66] When people can afford to bring judicial actions, they generally receive little in the form of compensatory relief.[67] This could make it even more expensive for AAPI women, especially immigrants who might be at risk of

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https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

[65] Karthick Ramakrishnan & Farah Z Ahmed, "Language Diversity and English Proficiency." *Center for American Progress* (27 May 2014). https://cdn.americanprogress.org/wp-content/uploads/2014/04/AAPI-LanguageAccess1.pdf

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

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

deportation or other discrimination based on their immigration status, to enforce their rights, deterring them from filing complaints of discrimination.

c. Enforcement Mechanisms

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

The proposed rule is unrealistic and overburdensome. Section 1557 as it stands recognizes the reality that discrimination "may occur not solely because of the person's race or not solely because of the person's sexual orientation or gender identity, [disability status, or national origin], but because of the combination."[68] Thus, the law aimed to make it easier for people to file complaints on accounts of not just single but multiple forms of discrimination. The proposed rule will only make it harder for AAPI women who live at the intersections of various discriminations to file claims. This would have harmful consequences for communities who have historically been discriminated against in health care settings.

VIII. Conclusion

This proposed rule could impose wide ranging harm, particularly falling hardest upon our most underserved populations who already struggle to access health care. The proposed rule is just the latest attack from the Trump-Pence Administration on people seeking reproductive health care, including abortion, LGBTQ individuals, individuals with LEP, including immigrants, those living with disabilities, and people of color. Moreover, this rule would embolden compounding levels of discrimination against those who live at the intersection of these identities. The proposed rule is dangerous and contravenes the plain language of Section 1557, specifically, and the ACA broadly.

The proposed rule will only increase barriers to accessing care for those who are most marginalized, including AAPI women, LGBTQ communities, people with disabilities and chronic conditions, people who have had abortions, immigrants, and AAPI people with LEP—especially people who hold more than one of these identities.

The proposed rule will discourage people from seeking health care. Nearly half of the U.S. population already avoids medical appointments when they need them due to cost,[69] and many already avoid care

[68] Brief for National LGBTQ Task Force as Amici Curiae Supporting Respondents, Masterpiece Cakeshop v. Col. C.R. Comm'n, 137 S.Ct. 2290 (2017), http://www.thetaskforce.org/wp-content/uploads/2017/10/16-111-bsac-LGBTQ-Task-Force.pdf.
[69] Bruce Jaspen, *Poll: 44% of Americans Skip Doctor Visits Because of Cost*, Forbes (Mar. 26, 2018, 8:00 AM), https://www.forbes.com/sites/brucejapsen/2018/03/26/poll-44-of-americans-skip-doctor-visits-due-to-cost/#5feab6ff6f57.

because of fear of discrimination.[70] The combination of cost and the fear of discrimination will ultimately fall hardest on people of color, AAPI women living with low incomes, and the LGBTQ communities.

The proposed rule will cause confusion for hospitals, providers, insurance companies, and patients. Section 1557 is the law of the land. The proposed rule conflicts with the statute in various ways, increasing confusion about what the law requires and who is protected under it.

For the reasons detailed above, HHS and CMS should not finalize the proposed rule and redirect their efforts to advancing health care access and equity for all.

Thank you for the opportunity to submit comments on the proposed rule. Please do not hesitate to contact **Phoebe Suva, Policy Associate, at psuva@napawf.org** to provide further information.

Sincerely,

National Asian Pacific American Women's Forum
1225 New York Ave. NW
Suite 800
Washington, DC 20005

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

EXHIBIT D-9

movement advancement project

July 16, 2019

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

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

Dear Secretary Azar,

Thank you for the opportunity to submit comments on the proposed regulations entitled "Nondiscrimination in Health and Health Education Programs or Activities."

The Movement Advancement Project (MAP) works to provide independent and rigorous research, insight and communications that help speed equality and opportunity for all. MAP works to ensure that all people have a fair chance to pursue health and happiness, earn a living, take care of the ones they love, be safe in their communities, and participate in civic life.

MAP strongly opposes the proposed rule. This rule would jeopardize the health of millions of people in the United States, including women and lesbian, gay, bisexual, and transgender people as well as people with limited English proficiency. It would create confusion among patients, providers, and insurance companies about their rights and obligations and promote discrimination, including harmful denials of care by hospitals and insurance companies. We urge the Department of Health and Human Services (HHS) to withdraw the proposed rule.

The proposed rule will threaten patients' access to health care and coverage.
Allowing healthcare providers to decide which procedures to perform and which patients to serve based on personal beliefs rather than medical standards can make it much harder for people to get medically necessary care. It also leaves patients in a terrible position of having to spend their energy on finding a doctor who will treat them, rather than spending their energy on getting better. For communities such as LGBT people, people of color, low-income people, or individuals with disabilities, finding competent and qualified healthcare providers is already difficult, and this added burden could result in them not receiving care at all, or avoiding treatment for fear of discrimination. This is especially true in low-income or rural areas, where

many fewer healthcare providers exist in the first place: if one doctor refuses treatment, there may be no alternative source of care available.

Transgender people are already experiencing significant levels of healthcare discrimination: a recent Center for American Progress survey found that, in 2016, 29% of transgender people said a doctor or health care provider refused to see them because of their gender identity, and a further 12% said they saw a doctor but that doctor refused to give them needed health care related to their gender transition.[1]

Take, for example, the story of Evan Minton, a transgender man. In September 2016, Evan was scheduled to receive a hysterectomy related to his diagnosis with gender dysphoria. The hospital where the procedure was to be performed was Mercy San Juan Medical Center, a hospital in the Dignity Health chain, which is the fifth largest healthcare system in the United States and operates 29 hospitals in California. Two days prior to the appointment, a nurse called to discuss the surgery and Minton mentioned that he is transgender. The next day, the hospital canceled the procedure over his doctor's objections—even though they allowed his doctor to perform a hysterectomy for a non-transgender patient on the same day that Evan's surgery was supposed to take place. As Evan's doctor explained, "I routinely perform hysterectomies at Mercy San Juan... This is the first time the hospital has prevented me from doing this surgery. It's very clear to me that the surgery was canceled because Evan is transgender.[2]

Nondiscrimination protections like the ones in the Health Care Rights Law (Section 1557) do not prevent the use of professional medical judgment–they simply ensure that patients can access the same care provided to other patients, no matter who they are. These protections are fundamental for LGBT patients to be able to access the care that they need.

By proposing to eliminate protections against discrimination based on transgender status and sex stereotyping, HHS is contradicting over 20 years of federal case law[3] and clear Supreme

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

[2] Adapted from "ACLU Sues Dignity Health for Discrimination Against Transgender Patient," ACLU, April 19, 2017. https://www.aclunc.org/news/aclu-sues-dignity-health-discrimination-against-transgender-patient.

[3] *See, e.g., Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015); *Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. 2016); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090 (S.D. Cal. Sept. 27, 2017); *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018); *Boyden v. Conlin,* No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018); *Whitaker v. Kenosha Unified School District*, No. 16-3522 (7th Cir. 2017) (Title IX and Equal Protection Clause); *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal

Court precedent.[4] The overwhelming majority of courts that have been presented with the question of whether federally sex discrimination laws such as Section 1557 specifically cover anti-transgender discrimination have firmly ruled that they do."[5]
Our organization is also opposed to the proposed changes to roll back other, long-standing rules that prohibit discrimination on the basis of gender identity and sexual orientation.[6] These changes are outside of the Office for Civil Rights' jurisdiction and are unrelated to Section 1557 of the ACA.

The proposed rule will impede health care access for people with HIV/AIDS and other serious or chronic conditions.

Section 1557 and the 2016 implementing regulations prohibit health insurance companies from discriminating through marketing practices and benefit design. These protections are especially important for people with HIV/AIDS or other serious/chronic condition. The proposed rule seeks to exempt most health insurance plans from Section 1557's nondiscrimination protections and eliminate the regulation prohibiting discriminatory benefit design and marketing, which could result in health insurers excluding benefits or designing their prescription drug formularies in a way that limits access to medically necessary care for those living with HIV and other chronic conditions.

Protection Clause); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011) (Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004) (Title VII); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); Grimm v. Gloucester County School Board, No. 4:15-cv-54 (E.D. Va. May 22, 2018); M.A.B. v. Board of Education of Talbot County, 286 F. Supp. 3d 704 (D. Md. March 12, 2018).

[4] *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989)

[5] *See, e.g., Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (holding that discrimination against hospital patient based on his transgender status constitutes sex discrimination under Section 1557 of the Affordable Care Act); *Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018) (holding that a Medicaid program's refusal to cover treatments related to gender transition is "text-book discrimination based on sex" in violation of the Affordable Care Act and the Equal Protection Clause of the Constitution); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. 2016) (holding exclusion invalid under the Medicaid Act and the Affordable Care Act); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090 (S.D. Cal. Sept. 27, 2017) (holding that discrimination against transgender patients violates the Affordable Care Act); *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018) (holding that Section 1557 of the Affordable Care Act prohibits discrimination on the basis of gender identity); *Boyden v. Conlin,* No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018) (holding that a state employee health plan refusal to cover transition-related care constitutes sex discrimination in violation of Title VII, Section 1557 of the ACA, and the Equal Protection Clause).

[6] These are: 45 CFR 155.120(c)(1)(ii) and 155.220(j)(2), 45 CFR 147.104(e), 45 CFR 156.200(e) and 156.1230(b)(3), 42 CFR 460.98(b)(3) and 460.112(a), 42 CFR 438.3(d)(4), 438.206(c)(2), and 440.262.

The proposed rule will make it much harder for people to understand their legal rights and will disproportionately harm LGBT people who are limited English proficient (LEP), or who need access to reproductive care.

The proposed rule will make it more challenging for LGBT patients—including LGBT, people who are also limited English proficient (LEP) or have LEP family members—to understand their health care rights under federal law. Many individuals may not know about their rights, how to request language services, or how to file a complaint if they face discrimination. By eliminating tagline requirements and notice standards, the proposed rule will undermine access to health care, health insurance, and legal redress for vulnerable communities.

The proposed rule threatens access to reproductive health care. By attempting to eliminate protections against discrimination on the basis of termination of pregnancy, the proposed rule seeks to allow health care providers to discriminate against individuals who have had an abortion and could result in patients being denied critical care including miscarriage management. In addition, by narrowing the scope of covered entities, the proposed rule would allow more insurance plans to refuse to cover reproductive health services, such as pregnancy care or fertility coverage. LGBTQ people, including transgender, nonbinary, and gender nonconforming people, need access to reproductive health care and coverage, including abortion, contraception, pregnancy care, and fertility services, free from discrimination.

The proposed rule attempts to unlawfully incorporate a broad religious exemption to 1557's protections against discrimination on the basis of sex. The Department's attempts to add a religious exemption are contrary to the express purpose of Section 1557 and violate the plain language of the statute. Adding a religious exemption opens the door for discrimination and emboldens health care providers to deny patients care, threatening the health and well-being of LGBTQ patients and patients seeking reproductive health care.

In summary, we are very concerned about the proposed rule and its impact on millions of people, including women, people with limited English proficiency, and LGBT people. We urge you to withdraw this proposed rule.

Thank you for your time,

Naomi Goldberg
Director of Policy Research

EXHIBIT D-10

NASTAD

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August 13, 2019

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

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

Dear Secretary Azar,

On behalf of the National Alliance of State & Territorial AIDS Directors (NASTAD), which represents public health officials who administer state, local, and territorial HIV and hepatitis prevention and care programs, I appreciate the opportunity to provide comments to the proposed rule, rule entitled "Nondiscrimination in Health and Health Education Programs or Activities."

The Affordable Care Act (ACA) has expanded access to care for tens of thousands of people living with HIV who were previously uninsured or underinsured, in part, by prohibiting insurance practices that have limited access to care for people living with chronic and complex conditions or excluded them from coverage altogether. We are concerned that the proposed rule eliminates the very protections that have ensured access to lifesaving services for people living with and at high risk for HIV and hepatitis and will hamper our nation's efforts to end the HIV epidemic by 2030.

NASTAD strongly opposes the proposed elimination of critical protections guaranteed by Section 1557 of the ACA and the 2016 Nondiscrimination in Health Programs and Activities final rule ("2016 final rule"). We write to urge the Department of Health and Human Services (HHS) to rescind this notice of proposed rulemaking in its entirety.

No one should suffer from discrimination when they are seeking medical attention. Section 1557 is a civil rights law that protects people from being discriminated against and, like every other civil rights law, it should be upheld and enforced. The opportunity to access quality health care and live the healthiest possible life must be equally available to all and not selectively reserved for a few. Nobody should be turned away from care, with their health and lives put at risk, because of who they are.

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Acting Executive Director
Terrance Moore (ex officio)

That longstanding principle of health equity and fairness is why Section 1557 was signed into law. The proposed rule, however, will harm the communities Section 1557 was meant to protect, including people of color, women, people living with disabilities, people living with chronic conditions, seniors, people whose primary language is not English, immigrants, and LGBTQ individuals – all people who already experience significant barriers to accessing health care. Critically, Section 1557 specifically protects against intersectional discrimination, or discrimination based on multiple protected characteristics, by allowing people to file complaints of such discrimination in one place. We are deeply concerned that the proposed regulatory changes fail to reflect the broad protections provided by the law, and that the changes would only serve to obfuscate and weaken one of the nation's strongest nondiscrimination protections for vulnerable communities.

Federal protections that prohibit discrimination in health care based on disability, sexual orientation, and gender identity are critical in the fight to end HIV and hepatitis. Stigma continues to be a significant barrier to lifesaving HIV and hepatitis prevention and care, and federal laws and protections are necessary to combat stigma and the disparities in health care access and outcomes that stigma causes. The ACA's protections – including Essential Health Benefits and prohibitions on pre-existing condition exclusions, lifetime and annual benefit limits, and premium rating based on health status – have played a significant role in increasing coverage for individuals with chronic and complex health conditions by eliminating insurance practices that limited access to care or excluded these individuals from coverage altogether. Section 1557 combats subtler discriminatory practices that jeopardize LGBT health, limit access to care for people living with HIV, hepatitis, and other chronic health conditions, and create barriers to access to the most effective clinically recommended HIV and hepatitis treatments. This is particularly true for transgender individuals, for whom Section 1557 and the 2016 implementing regulation explicitly prohibited pervasive insurance discrimination, including arbitrary benefits exclusions.

While Section 1557 is still the law, this proposed rule attempts to change the administrative implementation in a way that is contrary to the plain language of the statute and amounts to an impermissible attempt to change legislation through administrative action. In order to reflect the ACA's clear intent and its overriding purpose of eliminating discrimination in health care, the proposed rule should not be finalized.

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

The Affordable Care Act was passed with the goal of ensuring that more people would have access to quality, affordable health insurance coverage and health care. To that end, Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain federally funded health programs or activities. This means that health insurers, hospitals, clinics, and any other covered entities that receive federal funds cannot deny patients care on these grounds.

The proposed rule dramatically limits the scope of 1557 by applying inappropriate restrictions to the types of health programs and activities that must comply with Section 1557. The 2016 final rule made clear that Section 1557 applies to all health programs and activities that receive federal financial assistance from HHS. In keeping with the statutory language, the 2016 final rule defines health programs and activities to include *all* operations of an entity receiving federal financial assistance that is principally engaged in the provision or administration of health-related services, health-related insurance coverage, or other health-related coverage and assistance to individuals in obtaining these services or coverage. According to prior regulatory analysis, the 2016 final rule

covers about 900,000 physicians;[1] 133,343 facilities, including but limited to hospitals, nursing homes, rural health clinics, and federally qualified health centers; 445,657 clinical laboratories; 1,300 community health centers; 40 health-related schools and other health education entities; Medicaid and public health agencies in each state and the territories; and at least 180 insurers.[2] All of these entities are integral to the provision of essential health services that people living with HIV, hepatitis, and other chronic conditions need.

The proposed rule improperly attempts to narrow the application of Section 1557's protections to only the portions of certain health care programs or activities—specifically, those provided by entities that are not "principally engaged in the business of providing health care"—that receive federal financial assistance from HHS. This proposal therefore amounts to government subsidized discrimination, because entities that receive federal funds would still be permitted to discriminate on the basis of race, color, national origin, sex, age, or disability. Additionally, this proposal introduces a convoluted framework to determine whether an entity is considered a covered entity and thus subject to the Department's enforcement of these civil rights protections. These carve outs and distinctions are not only confusing to health programs and activities (who now must expend resources to clarify the required extent of their own compliance), but people living with HIV and other chronic illnesses as well as LGBT individuals will have difficulty determining when to expect compliance with nondiscrimination protections. People living with significant health needs require access to health programs and affordable health care plans that do not openly discriminate against members due to their race, color, national origin, sex (including gender identity, sexual orientation, and sex stereotypes; and pregnancy, childbirth, and related medical conditions), age, and disability. Additionally, the proposed changes would be unduly burdensome on consumers who would have to follow a vague, illogical scheme to determine when and where they can file complaints with the Office of Civil Rights ("OCR") about discrimination in the health setting.

By carving out entities who are not principally engaged in the business of providing health care services, HHS proposes an illogically narrow understanding of a "health program or activity", unnecessarily distinguishing "health insurance" from "health care." For people living with significant medical conditions, health insurance is often the only way to access the health care needed to manage chronic conditions. We are concerned that this change will dramatically limit the scope of nondiscrimination protections for health insurance products. The 2016 final rule, in keeping with the statutory language, prohibits insurers that receive federal financial assistance through participation in programs such as Marketplaces from discriminating in *any* of its lines of business. However, the proposed regulation would apply 1557 protections only to those products that receive federal financial assistance—such as Marketplace plans, Medicare Advantage Plans, Medicaid managed care plans, and some employee health benefit programs—and exempt all other lines of business, such as non-ACA products or third party administrator services, that are not federally funded or supported.[3] This has significant consequences for consumers who purchase short-term limited duration insurance

[1] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,446 (May 18, 2016) (concluding that "almost all practicing physicians in the United States are reached by Section 1557 because they accept some form of Federal remuneration or reimbursement apart from Medicare Part B").

[2] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,445. See, e.g., Katie Keith, *HHS Proposes to Strip Gender Identity, Language Access Protections From ACA Anti-Discrimination Rule*, HEALTH AFFAIRS BLOG (May 25, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190525.831858/full/.

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

which, as NASTAD expressed in its comments to the proposed rule entitled *Short-Term, Limited Duration* insurance issued by the Departments of Health and Human Services, Labor, and Treasury last year, are already known to engage in discriminatory practices that significantly harm people living with HIV, hepatitis, and other chronic conditions. We are concerned that the proposal to explicitly exempt short-term, limited duration insurance from Section 1557's protections would embolden insurers to refuse to cover services that people living with chronic conditions need, or rescind coverage for higher-cost enrollees.

These changes unlawfully narrow the scope of Section 1557's application and are contrary to the statute, despite HHS' stated desire in revising its regulations to align more closely with the statutory text. Rather, the statute is clear that the law's provisions apply broadly to "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance."[4] The proposal to limit Section 1557's application only to HHS-funded portions of health programs and activities is in direct opposition to Congress' intent that Section 1557 apply to "*any* health program or activity, *any* part of which is receiving Federal financial assistance" from HHS.

The 2016 final rule also made clear that Section 1557 applies to all health programs and activities administered by the Department, in addition to health programs and activities administered by entities established under Title I of the ACA. The proposed rule attempts to impermissibly narrow the scope of Section 1557 by excluding from its protections all programs and activities not administered under Title I of the ACA, including programs administered by the Department itself. This exempts from Section 1557 a number of programs that are essential in our efforts to end the HIV, hepatitis, and opioid epidemics and prevent new infections, including those administered by the Centers for Disease Control and Prevention, the Indian Health Service, and the Substance Abuse and Mental Health Services Administration.[5]

II. The Proposed Rule Impermissibly Attempts to Narrow the Scope of Sex Discrimination

Section 1557 is key to ensuring that everyone can access the care they need, free of discriminatory barriers, and enjoy the full benefits and protections of the ACA. It builds on longstanding federal civil rights laws – and is the first broad federal protection against discrimination based on sex in health care, designed to correct a pervasive history of sex discrimination. The 2016 final rule clarified that Section 1557 prohibits sex discrimination; protects transgender people based on gender identity; and protects LGBTQ people from discrimination on the basis of sex stereotypes.

Section 1557 has been essential to increase healthcare coverage and choices for millions of consumers who have historically been discriminated against in the healthcare system. Sex discrimination in health care has a disproportionate impact on LGBTQ people, women of color, and individuals living at the intersections of multiple identities – resulting in these individuals paying more for health care, receiving improper diagnoses at higher rates, being provided less effective treatments, and sometimes being denied care altogether. As the first broad prohibition against sex-based discrimination in health care, Section 1557 is crucial to ending gender-based discrimination in the health care industry. In addition to personal stories and lived experience, advocacy groups have submitted surveys, studies, and reports documenting discrimination in health care against these

[4] 42 U.S.C. § 18116(a).
[5] Keith, *supra* note 2.

communities and their families.[6] Although the uninsured rate among LGBTQ individuals has dropped dramatically since 2013, institutional discrimination on the basis of LGBTQ identity persists across the health care sector and acts as a deterrent to seeking care.[7] Repealing or weakening Section 1557's protections would increase costs for individuals who have serious medical needs, jeopardize the health and well-being of LGBTQ individuals, and set back the progress we have made in HIV and HCV prevention.

A. Sex Discrimination Based on Gender Identity and Sex Stereotyping

The 2016 final rule currently provides an accurate definition of sex and appropriately acknowledges that discrimination on the basis of sex includes discrimination on the basis of gender identity, including transgender and/or nonbinary status, and sex stereotyping. The 2016 final rule clarified that healthcare providers cannot refuse to treat someone because of their gender identity, and also prohibited discrimination based on association – for example, discrimination based on the fact that someone is in a relationship with a person of a certain gender identity.[8] The 2016 final rule also reiterated that sex stereotyping is a prohibited form of discrimination on the basis of sex, consistent with longstanding Supreme Court case law. The proposed rule illegally attempts to erase all reference to the ACA's protections against discrimination on the basis of gender identity and sex stereotyping. The proposal also exceeds the authority of OCR by impermissibly seeking to erase references to gender identity and sexual orientation across *all* HHS healthcare regulations, including longstanding regulations that are unrelated to Section 1557 and issued by other agencies within HHS.[9] If finalized, the proposal would only exacerbate existing disparities in transgender, nonbinary, and gender nonconforming individuals' ability to access HIV prevention and care services by providing legal cover to providers and issuers that refuse to provide or cover necessary medical care for all individuals on equal terms.

Although the proposed rule retains the general prohibition against sex-based discrimination in the provision or coverage of healthcare services, it would remove the current definition of discrimination "on the basis of sex," thus eliminating explicit protections against discrimination based on a person's gender identity and potentially allowing health programs and insurance plans to deny access to care or benefits to transgender individuals. This proposed change fails to consider the totality of case law regarding the interpretation of sex and fails to give proper weight to longstanding Supreme Court case law[10] and Circuit Court decisions[11] that have embraced a broad understanding of sex discrimination that includes discrimination on the basis of gender identity and sex stereotyping.

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[6] See, e.g., Public comments submitted in response to proposed rulemaking, Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172 (proposed Sept. 8, 2015).

[7] *Discrimination in America: Experiences and Views of LGBTQ Americans*, NAT'L PUB. RADIO, ROBERT WOOD JOHNSON FOUND. AND HARVARD T.H. CHAN SCH. OF PUB. HEALTH (Nov. 2017), https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2017/rwjf441734. Roughly 1 in 6 LGBTQ individuals surveyed reported being personally discriminated against when visiting a doctor or health clinic, and 18% said they have avoided going to a doctor or seeking health care out of fear that they would be discriminated against or treated poorly because of their LGBTQ identity. Among transgender respondents, 10% reported being personally discriminated against when they visited a doctor or health clinic, 22% said they avoid health care due to fear of discrimination, and 31% have no regular doctor or form of health care.

[8] Keith, *supra* note 2.

[9] *Id*.

[10] Price Waterhouse v. Hopkins, 490 U.S. 228 (1989) (finding that discrimination on the basis of sex, as prohibited in Title VII, included behavior based on expectations about how one should act or behave based on their sex).

[11] See, e.g., Zarda v. Altitude Express, Inc., 883 F.3d 100 (2nd Cir. 2018); Franchina v. Providence, No. 16-2401 (1st Cir. Jan. 25, 2018); Hively v. Ivy Tech, 853 F.3d 339 (7th Cir. 2017).

The proposal, if finalized, would eliminate the requirement that healthcare providers and other entities treat individuals consistent with their gender identity and allow such entities to deny access to health services and facilities based on gender identity.[12] In doing so, HHS would significantly set back our efforts to end the HIV epidemic by reducing transgender, nonbinary, and gender nonconforming individuals' access to HIV care and prevention services. Among the three million HIV testing events reported to CDC in 2017, the percentage of transgender people who received a new HIV diagnoses was three times the national average.[13] Despite the high prevalence of HIV among transgender individuals, nearly two-thirds of transgender individuals surveyed in 2014 and 2015 from 28 jurisdictions reported never testing for HIV.[14] This finding is consistent with other research showing that transgender, nonbinary, and gender nonconforming people often avoid care out of fear of discrimination due to experiencing high rates of discrimination and harassment in healthcare settings. According to the 2015 U.S. Transgender Survey, 33 percent had at least one negative experience in a health care setting relating to their gender identity in the previous year.[15] According to a 2018 study from the Center for American Progress, 23 percent had a provider intentionally misgender or use the wrong name for them, 21 percent had a provider use harsh or abusive language when treating them,[16] and 29 percent experienced unwanted physical contact, such as fondling, sexual assault, or rape, from a provider.[17] The 2015 U.S. Transgender Survey also found that 23 percent of transgender, nonbinary, and gender nonconforming people did not seek health care when they needed it due to fear of being disrespected or mistreated on the basis of their gender identity.[18] Research shows that such negative experiences with providers leads to avoidance of health care settings altogether, which leads to decreased engagement with and retention in HIV care.[19] Rather than exacerbating these disparities by giving medical providers legal cover when they discriminate against individuals on the basis of gender identity, we urge HHS to continue monitoring compliance with Section 1557 and working to strengthen these protections.

The 2016 final rule further clarified that insurance companies cannot categorically exclude or deny coverage for gender-affirming care. The proposed rule illegally attempts to open the door to insurance companies categorically excluding coverage of gender-affirming care from their plans, denying individuals coverage of procedures used for gender affirmation, imposing higher costs for services related to gender-affirming care, or imposing higher costs for services ordinarily available to individuals of one sex or gender based on the fact that the individual's recorded sex in medical or insurance records differs from the one to which such health services are ordinarily provided. Insurance companies have historically used such practices to deny transgender people coverage for

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[12] Keith, *supra* note 2.
[13] *HIV and Transgender People*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/hiv/group/gender/transgender/index.html (last visited July 31, 2019).
[14] *Id*.
[15] S.E. James et al., *Report Of The 2015 U.S. Transgender Survey*, NAT'L CTR. FOR TRANSGENDER EQUALITY 96-97 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf. Rates were higher for Native respondents (50 percent), Middle Eastern respondents (40 percent), multiracial respondents (38 percent), and respondents with disabilities (42 percent).
[16] Shabab Ahmed Mirza and Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, CTR. FOR AM. PROGRESS (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.
[17] *Id*.
[18] James et al., *supra* note 15.
[19] Jae M. Sevelius, PhD et al., *Barriers and Facilitators to Engagement and Retention in Care Among Transgender Women Living with Human Immunodeficiency Virus*, 47 ANNALS BEHAV. MED. 5 (2014).

medically necessary care, including hormone therapy, mental health counseling, and surgeries. As a result, gender-affirming care was financially out of reach for most transgender individuals, since transgender individuals are disproportionately living with lower incomes and therefore cannot afford the care they need without comprehensive, affordable coverage. However, as a result of Section 1557 and the 2016 final rule, many insurers removed categorical coverage exclusions harming transgender people and began to cover gender-affirming services,[20] increasing access to care. HHS asserts that consumers could not have developed a reliance interest on these protections because these provisions of the 2016 final rule did not go into effect until January 2017 and were enjoined by a federal court on December 31, 2016.[21] This assertion is unfounded. Insurers filed their 2017 products well in advance of the court's injunction, and analyses of individual market plans for 2017, 2018, and 2019 shows that the vast majority—at least 90%—of individual market insurers in the federal Marketplace complied with Section 1557 and did not include transgender-specific exclusions in their plans, likely as a result of federal protections.[22] Research shows that access to gender affirming health care, including access to transition-related healthcare such as hormones and surgery, is associated with higher rates of engagement with and retention in HIV care.[23] Retaining Section 1557's protections against discrimination on the basis of gender identity is therefore crucial to our country's efforts to eliminate HIV.

By permitting discrimination on the basis of sex stereotyping, the proposal would have a disproportionate impact on LGBTQ individuals' ability to access essential medical care, including HIV care. LGBTQ people already experience significant discrimination in health care. For example, seven percent had a provider refuse to recognize their family, including a child or a same-sex spouse/partner, and nine percent had a provider use harsh or abusive language when treating them.[24] Further, seven percent experienced unwanted physical contact from provider, including fondling, sexual assault, or rape.[25] However, discrimination based on sex stereotypes can affect *anyone* who does not conform to traditional societal expectations of their sex, regardless of their actual gender identity, sexual orientation, or sex. For example, the proposed rule illegally purports to allow a health care provider to refuse to provide maternity care to an unmarried woman—including HIV care necessary to prevent transmission to her baby and ensure optimal health outcomes for the mother—or to refuse to provide HIV care to a man whom the provider believes is "too feminine," regardless of the patient's gender identity. As such, Section 1557's protections against discrimination on the basis of sex do not only benefit a certain subset of people, but rather address the broad impact that discrimination can have on all individuals, families, and communities. The proposed rule impermissibly attempts to open the door to further discrimination against *all* individuals that do not conform to sex-based stereotypes.

B. Sex Discrimination Based on Pregnancy

Sex discrimination takes many forms and has the potential to occur at every step in the health care system—from obtaining insurance coverage, to receiving proper diagnosis and treatment, to

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[20] *Summary of Findings: 2019 Marketplace Plan Compliance with Section 1557*, OUT2ENROLL, https://out2enroll.org/out2enroll/wp-content/uploads/2018/11/Report-on-Trans-Exclusions-in-2019-Marketplace-Plans.pdf (last visited July 17, 2019).
[21] Keith, *supra* note 2.
[22] *Id*.
[23] Sevelius et al., *supra* note 19, at 5.
[24] Mirza and Rooney, *supra* note 16.
[25] *Id*.

harassment by a provider. Such discrimination has serious adverse impacts on the lives of women, especially pregnant women and pregnant or non-pregnant women living with HIV, hepatitis, and other chronic conditions, causing them to pay more for health care and to risk receiving improper diagnoses and less effective treatments. The effects of sex discrimination for women of color may be compounded by other forms of discrimination they face, including racial discrimination and discrimination based on language proficiency.

The 2016 final rule made clear that sex discrimination under Section 1557 includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy or recovery therefrom, childbirth, or related conditions. The proposed rule attempts to roll back these protections, creating a system where pregnant women living with HIV, hepatitis, and other chronic conditions may not be able to access the care they need. Although HHS acknowledges in the preamble to this proposed rule that the prohibition against sex discrimination includes termination of pregnancy, it refuses to state whether the Department would enforce those protections and proposes to delete the 2016 final rule's clarification that the ban on sex discrimination includes all pregnancy-related care. In doing so, the Department illegally attempts to eliminate the express protections that apply to someone who has had an abortion or has experienced a miscarriage or ectopic pregnancy and needs care for those or other conditions. While the scope of protection under Section 1557 is clear, without unambiguous implementing regulations and enforcement, illegal discrimination is likely to flourish.

Pregnant women living with HIV need a number of medical services to ensure optimal health outcomes for themselves and their babies. The CDC's *Preconception Care Work Group's Recommendations to Improve Preconception Health and Health Care* include a number of recommendations for providers treating pregnant women living with HIV, including but not limited to counseling women about risk factors for perinatal transmission of HIV and strategies to reduce those risks, making referrals to experts in HIV and women's health, evaluating treatment options for potential teratogenicity or other adverse outcomes for mother and baby, optimizing viral suppression while minimizing adverse effects of antiretroviral therapies, and postpartum care for both mother and child.[26] The CDC's recommendations also address providing care to women living with HIV who may experience interactions between hormonal contraceptives and antiretroviral therapy, as well as preconception care and counseling for women living with HIV who are considering pregnancy. By removing discrimination on the basis of pregnancy from the definition of discrimination on the basis of sex under Section 1557, the proposal would allow providers to refuse to provide these and other critical medical services to pregnant women living with HIV and women of child-bearing age living with HIV. Absent access to non-discriminatory health care, women living with HIV may not know they are pregnant, how to prevent or safely plan pregnancy, or what they can do to prevent transmission to their babies.

Retaining Section 1557's protections against discrimination on the basis of pregnancy is also critical for HIV prevention. Many women in the United States do not get tested for HIV during pregnancy, and women living with HIV who do not get tested often transmit HIV to their infants. A pregnant women living with HIV who is not in care has a one in four chance of transmitting HIV to her child; however, 99 percent of pregnant women living with HIV who receive appropriate medical treatment

[26] Kay Johnson, MPH et al., *Recommendations to Improve Preconception Health and Health Care: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care*, CTRS. FOR DISEASE CONTROL & PREVENTION (Apr. 21, 2006), https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm.

will not transmit HIV to their babies.[27] The earlier HIV is diagnosed and treated, the more effective HIV treatment will be at preventing transmission and improving the health outcomes of both mother and child.[28] The proposed rule would also jeopardize access to pre-exposure prophylaxis (PrEP) for HIV-negative women who have a partner living with HIV, limiting women's ability to protect themselves and their babies during pregnancy and while breastfeeding. Rather than allowing providers to discriminate against pregnant women living with HIV and refuse to provide them with necessary care, HHS should promote policies that expand access to HIV testing and care for pregnant women and women of child-bearing age.

For women who already experience discrimination in health care on the basis of their race, color, or national origin, the consequences of HHS' proposal would be especially severe. For example:

- The proposed rule could place Black women at greater risk of pregnancy-related complications. Black women already experience significant disparities in the care they receive during pregnancy and childbirth, and are three-to-four times more likely to die from pregnancy related complications than white women.[29] Pregnancy-related complications are among the ten leading causes of death for Black women aged 15-34 years.[30] Additionally, Black women accounted for 64 percent of diagnosed perinatal HIV transmissions in 2017.[31] Given the disproportionate negative impact of racism on the quality of care women receive during pregnancy and childbirth, HHS' proposal to essentially legitimize discrimination on the basis of pregnancy would disproportionately lead to adverse health outcomes for Black women, including and especially women living with or at risk of HIV, hepatitis, and other chronic conditions, and their children.
- The proposed rule could also be used to deny Asian American and Pacific Islander ("AAPI") communities access to crucial services such as emergency contraceptives and prenatal care. Language and cultural barriers already prevent AAPI women from accessing culturally and linguistically appropriate care. AAPI women use less effective contraceptive methods at much higher rates compared to women of other races and ethnicities, placing AAPI women at greater risk of unintended pregnancy.[32] AAPI mothers are less likely than others to receive early and adequate prenatal care, especially Laotian and Cambodian women.[33] One study found that AAPI women are twice as likely to die from pregnancy-related causes, including embolism and pregnancy-related hypertension.[34] AAPIs are also the fastest growing

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[27] *HIV and Other Important Pregnancy Tests*, AM. COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS (2011), https://www.acog.org/-/media/Departments/HIV/HIV--OtherPregnTsts-tear-pad1.pdf.

[28] *HIV and Pregnant Women, Infants, and Children*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/hiv/group/gender/pregnantwomen/index.html (last updated June 12, 2019).

[29] See, e.g., Miquel Davies, *Racism in Health Care – For Black Women Who Become Pregnant, It's A Matter of Life and Death*, NAT'L WOMEN'S LAW CTR. (Apr. 13, 2018), https://nwlc.org/blog/racism-in-health-care-for-black-women-who-become-pregnant-its-a-matter-of-life-and-death/ (discussing the negative impact of racism in health care on the quality of care Black women receive during pregnancy and childbirth, including disproportionate maternal death rates among Black women).

[30] Cynthia Prather et al., *The Impact of Racism on the Sexual and Reproductive Health of African American Women*, 25(7) J. WOMEN'S HEALTH 664, 664-671 (2016).

[31] *HIV and Pregnant Women, Infants, and Children*, supra note 28.

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

[33] LORA JO FOO, ASIAN AMERICAN WOMEN: ISSUES, CONCERNS, AND RESPONSIVE HUMAN AND CIVIL RIGHTS ADVOCACY 106 (Ford Foundation 2002).

[34] Marcus T. Smith, *Fact Sheet: The State of Asian American Women in the United States*, CTR. FOR AM. PROGRESS (Nov. 7, 2013), https://www.americanprogress.org/issues/race/reports/2013/11/07/79182/fact-sheet-the-state-of-asian-american-women-in-the-united-states/.

population in the United States with documented increases in HIV rates[35] and have lower diagnosis rates compared with other racial and ethnic groups;[36] HHS' proposal would exacerbate these existing disparities and lead to worse health outcomes for AAPI pregnant women living with or at risk of HIV, hepatitis, and other chronic conditions.

- Additionally, HHS' proposal would disproportionately impact Latina and Latinx populations, for whom lack of access to comprehensive, affordable insurance coverage already means sporadic, if not non-existent, access to desperately needed treatment and services. Due to this and other factors, Latinas experience disproportionately high rates of unintended pregnancy, as well as HIV and other chronic conditions. Hispanic women are four times as likely to be diagnosed with HIV compared to non-Hispanic White women, and are four times as likely to have AIDS.[37] Hispanic women are also four times as likely as non-Hispanic White men to die from HIV infection.[38] By impermissibly allowing healthcare providers to discriminate against individuals seeking care on the basis of pregnancy, HHS' proposal would exacerbate these existing disparities and lead to worse health outcomes for Latina pregnant women living with or at risk of HIV, hepatitis, and other chronic conditions.

C. Religious Exemptions

We also oppose any attempts to add new religious or moral exemptions to existing federal non-discrimination protections. The proposed rule attempts to impermissibly apply Title IX's religious exemption to Section 1557's prohibition on sex discrimination, which would affect overall access to care for women and others because a religious provider could say they do not have to comply with sex discrimination protections.[39] The Department's attempt to incorporate a religious exemption violates the plain language of the statute and is contrary to the express purpose of Section 1557. If implemented, this could allow for religiously-affiliated hospitals and other health care entities to discriminate against patients based on sex, disproportionately harming LGBTQ people, people seeking reproductive health services, people who use drugs, people living with chronic conditions such as HIV and hepatitis, and those living at the intersection of protected identities.

Allowing a religious exemption to Section 1557's protection against sex discrimination could have far reaching consequences. Incorporating Title IX's religious exemption could create new instances in which healthcare providers and insurance companies can allow their beliefs to determine patient care, opening the door to illegal discrimination. This could impact a broad range of health care services, including birth control, sterilization, certain fertility treatments, abortion, gender-affirming care, end-of-life care, and care for HIV, hepatitis, and other chronic conditions. Moreover, there is already a proliferation in the types of entities that are now emboldened to use religious beliefs to discriminate against patients, as well as in the number of religiously-affiliated entities that provide

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[35] Soma Sen at al., *HIV Knowledge, Risk Behavior, Stigma, and Their Impact on HIV Testing among Asian American and Pacific Islanders: A Review of Literature*, 32 SOC. WORK PUB. HEALTH 11 (2016).

[36] *HIV and Asians*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/hiv/group/racialethnic/asians/index.html (last visited July 31, 2019).

[37] *HIV/AIDS and Hispanic Americans*, OFFICE OF MINORITY HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVS., https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=66 (last visited July 31, 2019).

[38] *Id.*

[39] Candace Gibson & Wayne Turner, *Questions and Answers On the Proposed Rollback of Nondiscrimination Protections Under the ACA's Section 1557*, NAT'L HEALTH LAW PROGRAM 6-7 (June 14, 2019), https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/06/1557-Reg-Revision-QA-updated-6.14.2019.pdf.

health care and related services that refuse to provide care based on religious beliefs.[40] The proposed rule could encourage these entities to further engage in illegal discrimination.

Section 1557 already includes a range of religious exemptions excepting covered entities from requirements that conflict with their religious or moral beliefs in a wide variety of circumstances. The 2016 final rule explicitly did *not* override other federal statutory protections for religious freedom and conscience, providing health care providers and other covered entities with the ability to claim religious exemptions under The Religious Freedom Restoration Act and other laws.[41] Adding additional exemptions from requirements related to discrimination on the basis of sex or any other grounds is unnecessary and would harm the very populations that Section 1557 is designed to protect. More expansive religious exemptions would permit providers to refuse to provide medically necessary treatment to individuals simply on the basis of religion, gender, drug use, HIV status, sexual orientation, or gender identity. For example, a pharmacist could illegally refuse to fill prescriptions for HIV medications for patients who are LGBTQ or unmarried. This could cause delays in medically necessary treatment, leading to adverse individual and public health consequences. Expanding religious exemptions could be especially harmful in situations where individuals have limited choice of providers, such as in rural areas, or in emergency situations where there is limited opportunity to shop for providers.[42] There are already numerous barriers to accessing HIV prevention and care services in many rural communities, such as limited resources, lack of awareness about HIV prevalence, and lack of services and providers;[43] HHS should advance policies that reduce those barriers rather than compound them. The proposal to allow for additional religious exemptions would exacerbate the negative consequences of other portions of HHS' proposal discussed throughout this comment and will disproportionately impact communities of color and other underserved populations—particularly those in need of HIV prevention and care services.

III. The Proposed Rule Impermissibly Would Eliminate Language Access Protections

Discrimination on the basis of national origin includes, but is not limited to, discrimination on the basis of language and language proficiency. Language assistance is necessary for limited English proficient (LEP) persons to access federally funded programs and activities in the health care system. The 2016 final rule therefore included protections for LEP individuals, which the Department now proposes to eliminate. The proposed repeal of notices, taglines, and language access plans threatens the civil rights of LEP persons. The impact of this proposal is further compounded by other proposed changes, including narrowing the scope of Section 1557's applicability to healthcare entities and erasing references to the ACA's protections against discrimination on the basis of sex.

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[40] See, e.g., Lois Uttley et al., *Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, AM. CIVIL LIBERTIES UNION & MERGER WATCH (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.

[41] Keith, *supra* note 2.

[42] Mirza and Rooney, *supra* note 16. For example, a 2018 study found that 18 percent of LGBTQ people said that, if they were turned away from receiving care, it would be difficult or impossible to find the same type of service at a different hospital, while 17 percent said it would be difficult or impossible to find the same type of service at another clinic. These rates were higher for LGBTQ people living outside of metropolitan areas—41 percent said it would be difficult or impossible to find the same type of service at a different hospital and 31 percent said it would be difficult or impossible to find the same type of service at a different clinic.

[43] *Barriers to HIV/AIDS Care in Rural Communities*, RURAL HEALTH INFORMATION HUB, https://www.ruralhealthinfo.org/toolkits/hiv-aids/1/rural-barriers (last visited July 31, 2019).

Over 21 percent of the U.S. population, or 66 million people, speak a language other than English at home, with 25 million of them speaking English less than "very well" and thus considered LEP.[44] Additionally, 19 million LEP adults are uninsured.[45] For LEP individuals, language differences often compound existing barriers to accessing and receiving appropriate care. Limited English proficiency often makes it difficult to navigate an already complicated healthcare system, especially when it comes to medical or insurance terminology. Moreover, these barriers are often compounded by discrimination based on national origin, immigration status, race, ethnicity, sexual orientation, and gender/gender identity.

We strongly disagree that the 2016 final rule's requirement to include nondiscrimination language in notices, taglines, and language access plans were not justified by need, were overly burdensome, and created inconsistent requirements. The notice requirement is consistent with the long history of civil rights regulations requiring the posting of notice of rights. These notices are not redundant because HHS created the option of using one consolidated civil rights notice to minimize burden on covered entities. Without the notice, members of the public will have limited means of knowing that language services and auxiliary aids and services are available and how to request them, what to do if they face discrimination, and their right to file a complaint. Taglines are well supported by existing federal and state regulations, guidance, and practice, and are a cost-effective approach to ensure that covered entities are not overly burdened. In the absence of translated documents, taglines are necessary to ensure that individuals are aware of their protections under the law.[46]

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

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[44] *2017 American Community Survey 1-Year Estimates: Table S1603 Characteristics of People by Language Spoken at Home*, U.S. CENSUS BUREAU, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_S1603&prodType=table (last visited Jul. 31, 2019); *2017 American Community Survey 1-Year Estimates: Table S1601 Language Spoken at Home*, U.S. CENSUS BUREAU, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_S1601&prodType=table (last visited Jul. 17, 2019).

[45] Asian & Pacific Islander American Health Forum Analysis of 2017 American Community Survey Public Use Microdata Sample Files.

[46] See, e.g., Public comments submitted in response to proposed rulemaking, Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172 (proposed Sept. 8, 2015).

IV. The Proposed Rule Would Eliminate Prohibitions on Discrimination in Insurance Plan Benefit Design and Marketing

Over 133 million people in the United States live with at least one chronic condition,[47] and over 61 million people are living with a disability.[48] Approximately 1.1 million people are living with HIV,[49] and anywhere from 2.5 to 4.7 million people are estimated to be living with hepatitis C.[50] Additionally, since 2012, there have been more deaths due to hepatitis C than all 60 of the other reportable diseases combined.[51] Section 1557's protections ensuring affordable, comprehensive access to coverage and health services to all on equal terms, regardless of health status, are therefore crucial to ensuring the health and well-being of millions of people.

Before the ACA, health insurers routinely discriminated against people living with HIV and other chronic conditions by charging them exorbitant premiums, excluding coverage for their conditions, or refusing to provide health coverage at all. The ACA addressed these issues by prohibiting insurers from charging higher premiums or denying coverage for people with pre-existing conditions. Section 1557 also prohibits covered entities from using discriminatory marketing practices, such as those "designed to encourage or discourage particular individuals from enrolling in certain health plans."[52] Despite these protections, insurers still sought ways to discourage people with significant health conditions from enrolling in their plans. One such tactic is adverse tiering—placing treatments for certain chronic conditions, including HIV and hepatitis, on high cost-sharing tiers.[53] Adverse tiering puts these medications financially out of reach for most people, despite the fact that they have insurance coverage. Although people living with other chronic conditions could no longer be denied coverage or charged higher premiums following the passage of the ACA, they were often still unable to afford the health care they needed.

The National Health Law Program and The AIDS Institute filed a complaint with HHS OCR charging that four issuers in Florida discriminated against persons living with HIV by placing all HIV treatments, including generics, on the highest cost-sharing tiers.[54] Researchers at the Harvard School of Public Health found that the practice of placing HIV drugs in the highest cost sharing tiers was widespread.[55] The Pharmaceutical Research and Manufacturers Association (PhRMA) conducted an analysis of 123

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[47] *The Growing Crisis of Chronic Disease in the United States*, P'SHIP TO FIGHT CHRONIC DISEASE, https://www.fightchronicdisease.org/sites/default/files/docs/GrowingCrisisofChronicDiseaseintheUSfactsheet_81009.pdf (last visited Jul. 17, 2019).

[48] *1 in 4 US Adults Live with a Disability*, Press Release, CTRS. FOR DISEASE CONTROL & PREVENTION (Aug. 16, 2018), https://www.cdc.gov/media/releases/2018/p0816-disability.html.

[49] *U.S. Statistics: Fast Facts*, HIV.GOV, http://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics (last visited Aug. 2, 2019).

[50] *Viral Hepatitis in the United States: Data and Trends*, DEP'T OF HEALTH & HUMAN SERVS., http://www. https://www.hhs.gov/hepatitis/learn-about-viral-hepatitis/data-and-trends/index.html (last visited Aug. 2, 2019).

[51] *Id*.

[52] Musumeci et al., *supra* note 3.

[53] National Health Law Program & The AIDS Institute, Re: Discriminatory Pharmacy Benefits Design in Select Qualified Health Plans Offered in Florida, Administrative Complaint filed with the HHS Office for Civil Rights (May 28, 2014), https://healthlaw.org/resource/nhelp-and-the-aids-institute-complaint-to-hhs-re-hiv-aids-discrimination-by-fl/. See also, *Coverage of Hepatitis B & C Drugs Difficult to Access in Florida's Health Plans*, Press Release, THE AIDS INST. (Oct. 5, 2015), http://www.theaidsinstitute.org/sites/default/files/attachments/10-05-15%20TAI%20Release%20-%20FL%20QHPs%20(1).pdf (describing discriminatory insurer practices placing hepatitis B, hepatitis C, and HIV treatments on high cost-sharing tiers, with coinsurance as high as 30 to 50 percent).

[54] Gibson & Turner, *supra* note 39, at 6-7.

[55] *Id*.

Marketplace plans and similarly concluded that insurance companies routinely applied adverse tiering to treatments for other chronic conditions, including cancer and multiple sclerosis.[56] PhRMA concluded that there was a "lack of adequate formulary scrutiny on the part of state and federal regulators" because "[r]equiring high cost-sharing for all medicines in a class is exactly the type of practice the ACA was designed to prevent."[57]

HHS agreed with PhRMA's conclusions, and therefore expressly prohibited insurers from designing benefits that discourage enrollment by persons with significant health needs in the 2016 final rule. This includes discriminatory health insurance plan designs that impose burdensome prior authorization requirements on HIV and HCV medications, or use adverse tiering to place these medications on high cost-sharing tiers.[58] The 2016 final rule specifically cited to the practice of placing all drugs used to treat a certain condition, such as HIV, as an example of discriminatory plan design prohibited under Section 1557.[59] The proposed rule would remove the current prohibition on discriminatory plan design, which essentially functions as a pre-existing condition exclusion because people with pre-existing conditions would be unable to access the care they need.

Despite these protections, we continue to see discriminatory benefit designs that bar people living with complex and chronic conditions from access to care. Instead of weakening or eliminating this important protection, we urge HHS to better enforce the provisions articulated in Section 1557 and the 2016 final rule, including assessing the presence of the specific examples of discriminatory plan designs described above. Additionally, limitations to curative HCV treatment that are not based on clinical recommendations, including fibrosis score and sobriety/abstinence requirements, should be included as examples of discriminatory plan designs based on disability.

V. Conclusion

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

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

[56] *Id*.
[57] *Id*.
[58] See, e.g., Musumeci et al., *supra* note 3.
[59] Gibson & Turner, *supra* note 39, at 6-7.

to eliminate protections against discrimination based on gender identity, and completely disregards Supreme Court precedent on discrimination based on sex stereotyping. The proposed rule also opens the door for insurance companies to use tactics such as adverse tiering to discourage enrollment by people living with chronic conditions, and amounts to a pre-existing exclusion because people living with chronic conditions would be unable to access the care and treatment they need.

The NPRM's proposed changes pose significant risks to those the law is intended to protect, including LGBTQ people, people who need reproductive health care, including abortion, women of color, people living with disabilities and/or chronic conditions, and people whose primary language is not English–all people who already experience significant barriers to accessing health care. The proposed changes could create additional barriers and potentially lead to worse health outcomes, disproportionately impacting those living at the intersections of these identities. For example, a woman who is transgender and living with HIV could experience compounded discrimination based on her being a woman, being transgender, and living with HIV.

Without strong, clear rules prohibiting discrimination, there will be unequal access to health coverage and health care. Rather than being distributed equally, the burdens of a lack of healthcare coverage and healthcare denials fall disproportionately on communities of color and other underserved populations, which are more likely to experience higher rates of unemployment, to have jobs that do not provide health insurance, and to have lower incomes that put higher insurance premiums out of their financial reach.

We are opposed to reopening, repealing, or weakening the 2016 final rule implementing Section 1557 and its crucial protections against discrimination in health care. We urge HHS to instead uphold federal law and the intent of Section 1557 by preserving and strengthening these important protections.

If you have questions or need additional information, please contact me at 202-434-8000, or tmoore@nastad.org.

Sincerely,

Terrance E. Moore

Terrance E. Moore
Acting Executive Director

EXHIBIT D-11

August 12, 2019

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

RE: Public Comment in Response to the Notice of Proposed Rulemaking Addressing Nondiscrimination in Health and Health Education Programs or Activities
RIN 094-AA11

To Whom It May Concern:

On behalf of the Human Rights Campaign's more than 3 million members and supporters nationwide, I write in response to the request for public comment on the notice of proposed rulemaking, Nondiscrimination in Health and Health Education Programs and Activities published June 14, 2019. As the nation's largest civil rights organization working to achieve lesbian, gay, bisexual, transgender, and queer (LGBTQ) equality, we strongly oppose the proposed changes to the regulatory implementation of the Patient Protection and Affordable Care Act's nondiscrimination policy.

At its core, the Patient Protection and Affordable Care Act's purpose was exactly that: to protect patients and ensure access to affordable care. This purpose is clearly embodied the nondiscrimination policy espoused in Section 1557 that protects patients from discrimination in accordance with multiple different Civil Rights laws dating back decades including protections on the basis of race, sex, age, and disability status. The statute went so far as to create an administrative remedy through the Office of Civil Rights for patients who felt they had faced an adverse action as a result of discrimination. As a result, HHS promulgated regulations ("the Final Rule") interpreting and implementing this nondiscrimination policy to clarify and ensure uniform application of the promise of the Patient Protection and Affordable Care Act.

The proposed rule does not uphold that promise. Rather, this proposal attempts to undermine Section 1557 by mis-stating the law, and creating confusion on a question that has been consistently decided by courts for over two decades. While the Department claims that the change would prevent confusion by removing the definitions and clarifying regulations for the coverage of gender identity, the wholesale removal of definitions and clarifications will in fact have the opposite effect and impact on implementation and access. This vague rule will foster deep uncertainty and confusion among patients and providers. This will undoubtedly undermine

the core mission of nondiscrimination provisions generally – which is to create a universal threshold of security for vulnerable populations so that they will have access to the care they need free from harassment, intimidation, or unwarranted refusal. In the absence of these explicit protections, many patients are likely to avoid seeking care altogether. If the proposed rule is finalized as written, prospective confusion will become realized harm. Moreover, the Department has provided grossly insufficient evidence to support the changes as required under Executive Order 12,866. This action is arbitrary, capricious, inconsistent with the law, and a stark misapplication of the purpose of rulemaking.

For all of these reasons, we strongly oppose this proposed change to the regulatory framework.

I. The Law Supports Protection from Sex Discrimination on the Basis of Gender Identity and Sexual Orientation

We strongly stand in opposition to the repeal of Sections 92.4 and 92.206 of the current regulation. The Final Rule gave clear affirmation of what has already been recognized across the federal government and by many federal courts: discrimination based on gender identity, gender expression, gender transition, transgender status, or sex-based stereotypes is a form of sex discrimination. By removing clarifying definitions and protections, HHS fosters divergence between Federal Regulations and Federal case law--an action that does not remove any protections, but creates the very confusion the proposed regulation is purported to avoid.

a. Definitions of Gender Identity and Sex Stereotype

Numerous federal courts have found that federal sex discrimination statutes reach these forms of gender-based discrimination.[1] In 2012, the Equal Employment Opportunity Commission (EEOC) likewise held that "intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination based on sex and such discrimination therefore violates Title VII."[2] The Department of Labor has taken the same position in internal guidance and proposed regulations, as has the Office of Personnel Management in its regulations.[3]

To date, the vast majority of courts to rule on the issue in the context of Section 1557 have reached the same conclusion: the ACA's sex discrimination prohibition "necessarily" encompasses bias based on gender identity or transgender status.[4] This is obviously the correct

[1] *See, e.g.*, Smith v. City of Salem, 378 F.3d 566, 572-75 (6th Cir. 2004); Rosa v. Park West Bank & Trust Co., 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); Schwenk v. Hartford, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act); see also Statement of Interest of the United States at 14, Jamal v. Saks, No. 4:14-cv-02782 (S.D. Tex. Jan. 26, 2015).
[2] Macy v. Holder, EEOC App. No. 0120120821, 2012 WL 1435995, at *12 (Apr. 20, 2012).
[3] *See* 5 C.F.R. §§ 300.102-300.103, 335.103, 410.302, 537.105.
[4] *Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415, at *2 (D. Minn. Mar. 16, 2015), *Fabian v. Hosp. of Cent. Conn.*, 172 F. Supp. 3d 509 (D. Conn. Mar. 18, 2016) *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. Jul. 5, 2016)*Prescott v. Rady Children's Hospital San Diego*, 265 F. Supp. 3d 1090 (S.D. Cal. Sept. 27,

application of the law's plain words. By explicitly articulating Section 1557's application to discrimination based on gender identity and sex stereotypes, the proposed rule's definition of sex discrimination will provide needed clarity and address a widespread and urgent problem.

We oppose the repeal of the Final Rule's definitions of gender identity and sex stereotypes. Read together, these definitions recognize that protections against sex discrimination should extend to people of all gender identities—including transgender and non-transgender men and women as well as people of non-binary genders. The necessity of recognizing non-binary identities in the provision of health care is widely accepted among medical organizations.[5] Further, federal agencies such as the Department of Labor have recognized that sex discrimination protections extend to non-binary individuals as well as to transgender and non-transgender men and women.[6]

b. Sex Discrimination and Sexual Orientation

The absence of explicit protections from discrimination on the basis of sexual orientation in the proposed regulation not only ignores the health crisis facing lesbian, gay, and bisexual people, but also fails to reflect and reinforce important steps that HHS has already taken under the ACA to explicitly protect people from discrimination on the basis of their sexual orientation. Moreover, the exclusion of sexual orientation from the proposed rule is out of step with current legal doctrine concerning sexual orientation discrimination that has been adopted by other federal agencies and federal courts.

HHS has already used its regulatory authority under the ACA to take steps to address discrimination against lesbian, gay, and bisexual people by clarifying that the ACA prohibits insurance carrier practices that discriminate on the basis of sexual orientation.[7] In 2014, for example, the Centers for Medicare and Medicaid Services (CMS) issued guidance under regulations interpreting Section 2702 of the Public Health Service Act (PHSA), as amended by the ACA, to require health insurance carriers offering non-grandfathered group or individual health coverage in all states to offer legally married same-sex couples the same spousal or family

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2017)*Tovarv. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. Sept. 20, 2018) and *Boyden v. Conlin*, No. 17-cv-264-wmc (W.D. Wis. Sept. 18, 2018).

[5] Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* 6 (2015); World Prof. Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender and Gender-Nonconforming People* 171, 175 (2012) (requiring physicians to provide affirming care for both binary and non-binary transgender and gender non-conforming patients); Am. College of Obstetricians and Gynecologists, *Committee Opinion No. 512: Health Care for Transgender Individuals*, Obstetrics & Gynecology 118(6): 1454 (2011) (same); *see also* Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders, Version 5* 451-53 (2013) (defining gender identity to include identities other than male or female, and specifying diagnostic criteria for gender dysphoria to include such identities); Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, 25-26 (2011) (same).

[6] *See, e.g.*, Department of Labor, Job Corps Program Instruction Notice No. 14-31, Ensuring Equal Access for Transgender Applicants and Students to the Job Corps Program (May 1, 2015).

[7] Kellan Baker, "Open Doors for All: Sexual Orientation and Gender Identity Protections in Health Care," Center for American Progress (Apr. 30, 2015), available at https://www.americanprogress.org/issues/lgbt/report/2015/04/30/112169/open-doors-for-all/.

benefits available to different-sex couples.[8] The plain language of PHSA § 2702 simply requires insurance carriers to guarantee the availability of coverage unless certain exceptions (for example open enrollment periods) apply. The regulations promulgated under this section, at 45 C.F.R. 147.104(e), clarify that this requirement means carriers cannot employ marketing practices or benefit designs that discriminate on the basis of factors that include sexual orientation. To ensure that the protections of Section 1557 reinforce and harmonize with existing nondiscrimination protections under the ACA—and to protect people not only in gaining access to health insurance coverage but also in successfully accessing health care—the final rule should include explicit protection from sexual orientation discrimination. Below we discuss in more detail why discrimination on the basis of sexual orientation falls squarely within the scope of prohibited sex discrimination under Section 1557.

Moreover, Federal courts and the EEOC have determined that discrimination based on sexual orientation is a form of sex discrimination prohibited by Title VII. Explicitly incorporating sexual orientation within the definition of sex in Section 1557 in the final rule is both consistent with this current legal doctrine and essential to ensuring that ALL individuals and families have access to the health care they need.

In *Baldwin v. Foxx*, the EEOC ruled in favor of a Department of Transportation employee who alleged that he did not receive a promotion because of his sexual orientation.[9] The EEOC found that Title VII prohibits employers from relying on "sex-based considerations" when making personnel decisions and that these protections apply equally to lesbian, gay, and bisexual individuals under Title VII.[10] The agency concluded that the Department of Transportation wrongfully relied on sex-based considerations when his supervisors declined to promote the complainant because he is gay. The EEOC held that discrimination on the basis of sexual orientation constitutes sex discrimination under Title VII because sexual orientation is inseparably linked to sex-based considerations. The Commission clearly stated that "sexual orientation is inherently a 'sex-based consideration,' and an allegation of discrimination based on sexual orientation is necessarily an allegation of sex discrimination under Title VII."[11] The EEOC further clarified that "[a] complainant alleging that an agency took his or her sexual

[8] Ctr. for Consumer Info. and Ins. Oversight, "Frequently Asked Questions on Coverage of Same-Sex Spouses," U.S. Dep't of Health and Human Servs. (Mar. 14, 2015), available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/frequently-asked-questions-oncoverage-of-same-sex-spouses.pdf.

[9] EEOC Appeal No. 0120133080, 2015 WL 4397641, at *5 (July 16, 2015). The Commission has developed this interpretation in a long series of decisions prior to Baldwin. See, e.g., Complainant v. Johnson, EEOC Appeal No. 0120110576 (Aug. 20, 2014); Complainant v. Cordray, EEOC Appeal No. 0120141108 (Dec. 18, 2014); Complainant v. Donahoe, EEOC Appeal No. 0120132452 (Nov. 18, 2014); Complainant v. Sec'y, Dep't of Veterans Affairs, EEOC Appeal No. 0120110145 (Oct. 23, 2014); Couch v. Dep't of Energy, EEOC Appeal No. 0120131136 (Aug. 13, 2013); Brooker v. U.S. Postal Serv., EEOC Appeal No. 0120112085 (May 20, 2013); Culp v. Dep't of Homeland Security, EEOC Appeal No. 0720130012 (May 7, 2013); Castello v. U.S. Postal Serv., Appeal No. 0120111795 (Dec. 20, 2011); Veretto v. U.S. Postal Serv., EEOC Appeal No. 0120110873 (July 1, 2011).

[10] Id. at *4; see also Price Waterhouse v. Hopkins, 490 U.S. 228, 240-42 (1989); Macy v. Dep't of Justice, EEOC Appeal No. 0120120821, 2012 WL 1435995, at *5 (Apr. 20, 2012).

[11] Baldwin, supra note 15, at *5.

orientation into account in an employment action necessarily alleges that the agency took his or her sex into account."[12]

This decision is not a novel outlier. Rather, it reflects a steady, consistent development of case law that reaffirms that discrimination on the basis of sexual orientation is a form of sex discrimination. For example, in the recent case *Isaacs v. Felder Services, LLC*, a federal judge incorporated this reasoning from Baldwin stating that "[t]o the extent that sexual discrimination occurs not because of the targeted individual's romantic or sexual attraction to or involvement with people of the same sex, but rather based on her or his perceived deviations from heterosexually defined gender norms, this, too is sex discrimination, of the gender-stereotyping variety."[13] Additionally, in 2002 in *Heller v. Columbia Edgewater Country Club*, the court clearly stated that an employer is engaged in unlawful discrimination if the employee would have been treated differently if she were a man dating a woman, instead of a woman dating a woman.[14]

A 2014 Seventh Circuit decision, *Muhammad v. Caterpillar, Inc.*, is also instructive.[15] In this case, the plaintiff alleged that his co-workers subjected him to both racial and sexual harassment, including references and slurs related to his sexual orientation.[16] When the plaintiff informed his supervisor of the hostile work environment, he was suspended.[17] The district court granted summary judgment for Caterpillar, relying on precedent that Title VII's protections from harassment only apply to gender and not sexual orientation.[18] A Seventh Circuit panel upheld the decision and affirmed the lower court's interpretation that Title VII protections do not extend to sexual orientation discrimination. Although the Seventh Circuit later denied the plaintiff's motion for a panel rehearing, the panel, significantly, amended its original opinion by removing the explicit language stating that Title VII did not extend to discrimination based on sexual orientation.[19] The ruling was affirmed on other grounds and no longer relies on Title VII's supposedly limited scope. This significant deletion illustrates an important shift in judicial reasoning and signals the increased viability of future claims based on sexual orientation in the context of Title VII.

In January 2015, the EEOC published a final determination reflecting this interpretation of Title VII in the health care context in *Cote v. Wal-Mart*.[20] In this case, the EEOC found that Wal-Mart had discriminated against an employee when it denied the employee the opportunity to enroll her same-sex spouse in company provided health care benefits. The EEOC explicitly stated in the determination that the employee had experienced discrimination on the basis of sex

[12] Id.
[13] 2015 U.S. Dist. LEXIS 146663, at *10 (M.D. Ala. Oct. 29, 2015) (internal quotation marks omitted).
[14] 195 F. Supp. 2d 1212, 1223-24 (D. Or. 2002).
[15] 767 F.3d 694 (7th Cir. 2014).
[16] Id. at 696.
[17] Id. at 697.
[18] Id.
[19] Muhammad v. Caterpillar, Appeal No. 12-173 (7th Cir. 2014).
[20] EEOC Charge No. 523-2014-00916 (Jan. 29, 2015).

under Title VII.[21] A federal judge reached a similar conclusion in *Hall v. BNSF Railway Co.*, when an employee was denied coverage for a same-sex spouse under the company health plan.[22] In this case, the judge allowed a plaintiff's claim of sex discrimination under Title VII and the Equal Pay Act to proceed to the next step of litigation. The judge explicitly provided that the plaintiff "experienced adverse employment action in the denial of spousal health benefit due to sex, where similarly situated females [married to males] were treated more favorably by getting the benefit."[23]

II. The Proposed Change Converts Imagined Confusion Into Quantifiable Harm

We additionally oppose this misguided attempt at rulemaking because it asserts to implement the *Patient Protection* and Affordable Care Act without sufficient consideration of how such changes would affect patients. The removal of crucial definitions of gender identity and sex stereotyping claims to decrease confusion, by simply assuming it will no longer exist. Further, by removing the administrative remedies created by Section 1557, such changes force patients to redress discrimination in the court system--a financially untenable remedy for many patients across the country.

a. Removal of Definitions with Insufficient Qualitative Justification

The Department rests its argument for removal of the definition primarily on the implementation of a stay in *Franciscan Alliance*.[24] It claims that "[t]he existence of lawsuits and court orders blocking enforcement of significant parts of the Final Rule for over two years indicates that changes in the proposed rule may minimize litigation risk."[25] This ignores the case law that entrenches the inclusion of such explicit definitions and protections provided by the Final Rule. Moreover, it was made clear in the Final Rule that the definition was included as a means to decrease litigation costs.[26] Removing the definitions, which were expressly included to decrease litigation costs, under the guise of decreasing litigation costs is shortsighted and unfounded in both logic and the administrative record.

As a means of justifying this and other repeals within the proposed rule, the Department claims that the qualitative benefits of "appropriate respect for the roles of Federal courts and Congress"[27] and "increased freedom" for covered healthcare entities "to adapt their Section 1557 compliance programs to most efficiently address their particular needs"[28] far outweigh any costs

[21] Id.
[22] 2014 WL 4719007 (W.D. Wash. Sept. 22, 2014).
[23] Id. at *2; see also Deneffe v. Skywest, Inc., No. 14–cv–00348–MEH, 2015 WL 2265373 (D. Colo. May 11, 2015) (alleged discrimination based on use of domestic partner benefits for same-sex partner and failure to participate in colleagues' anti-gay jokes and bragging about heterosexual sexual activity stated Title VII claim).
[24] 2017 U.S. Dist. LEXIS 145416 (N.D. Tex. July 10, 2017).
[25] 84 Fed. Reg. 27,849.
[26] 81 Fed. Reg. 31,459.
[27] 84 Fed. Reg. 27,849.
[28] 84 Fed. Reg. 27,876.

or burdens. Unfortunately, it is difficult (if not impossible) to quantify the amount of medical care that is sacrificed at the cost of respect and freedom—making the future of this implementation less clear on both the protection of patients and their access to medical care.

b. Resulting Avoidance of Medical Access

LGBTQ individuals have been shown to avoid seeking medical care as a result of discrimination.[29] Such avoidance can decrease access to preventive care and as a result shorten the quality and length of life for LGBTQ individuals. This medical hesitation is the ultimate result behind this proposed change: where a rule abjectly denying protections based on sexual orientation and gender identity would not be permissible by the courts, creating a perception that LGBTQ individuals are not protected in their healthcare and medical needs will cause them to stop seeking services.

Such actions fly in the face of the spirit and intent of the *Patient Protection* and Affordable Care Act, and specifically Section 1557: "[A]n individual shall not, on the ground prohibited under [various Civil Rights laws], be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity."[30] This protection is granted, without equivocation, by the statute itself and cannot be undone by a change in the agency interpretation and federal rulemaking. We oppose this proposed rule as a warping of the spirit and intent of Section 1557 to elicit confusion and reluctance for LGBTQ residents to seek the health care that they need.

III. The Proposed Rule Undermines the Law by Impermissibly Creating a Religious Exemption

Section 1557 contains no exceptions to its nondiscrimination language, religious or otherwise. The 2016 final rule likewise omits any reference to any religious exemption. The attempt to impermissibly apply Title IX's religious exemption warps the plain language of the statute and goes against the express purpose of Section 1557. Under this proposed rule, religiously-affiliated hospitals and other healthcare entities could interpret the regulation, contrary to the spirit and text of Section 1557, to allow the discrimination against patients based on sex—discrimination which would disproportionately harm LGBTQ people and people of color.

The exclusion of the LGBTQ community from adequate healthcare is unfortunately common and should not be further exacerbated by your agency.[31] According to a 2018 study, 18 percent of

[29] *See* Shabab Ahmen Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (January 18, 2018, 9:00 AM) https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[30] 111 P.L. 148, Sec. 1557.

[31] *See Standards for Credit on the MEI*, HRC. ORG, https://www.hrc.org/resources/standards-for-credit-on-the-mei (last visited August 2, 2019); *see also*, NAT'L LATINA INST. FOR REPROD. HEALTH & PERRYUNDEM, *Latina/o*

LGBTQ people said that if they were turned away, it would be very difficult or impossible to find the same type of service at a different hospital, and 17 percent said it would be very difficult or impossible to find the same type of service at a different clinic.[32] Twenty-nine percent of transgender people were refused health care because of their gender identity, and twelve percent were refused gender affirming healthcare.[33] This would have an especially negative impact on people of color who are disproportionately impacted by Catholic hospitals. Such institutions are "governed by strict guidelines that prohibit health care providers from providing contraceptives, sterilization, some treatments for ectopic pregnancy, abortion, and fertility services regardless of their patients' wishes, the urgency of a patient's medical condition, the provider's own medical judgment, or the standard of care in the medical profession."[34] When considering the various barriers for both LGBTQ individuals and people of color accessing healthcare, the proposed rule would serve to slam the door in the faces of LGBTQ people of color whose only access to healthcare is via religiously-affiliated facilities.

Permitting anything less than express inclusion of these nondiscrimination protections inappropriately signals for healthcare professionals at any level—from an individual's insurance provider to their emergency room nurse—to hold out this proposed rule as a defense for their discrimination. At its core, the *Patient Protection* and Affordable Care Act sought, by inclusion of the nondiscrimination policy espoused in Section 1557, to protect *all* patients access to life saving healthcare; a protection that would be severely undermined if not entirely negated by adding such a religious exemption.

IV. The Proposed Rule Does Not Comport with Adequate Administrative Rulemaking and Misapplies the Purpose of the Rule

We further oppose this proposed rule as inconsistent with the tenets of agency rulemaking. The action is arbitrary, capricious and an affront to the law. The proposed rule is lacking in evidentiary support that a lack of due consideration was given when the Patient Protection and Affordable Care Act was passed. Moreover, the Department suggests that the necessary consideration should be ignored in favor of the belief that discrimination will fix itself if it is just not talked about.

The Supreme Court has overturned rescission of agency rules when the rulemaking was "arbitrary and capricious" when the agency has "entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before

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Voters' Views and Experiences Around Reproductive Health: Results from a National Survey of Latina/o Voters (Oct. 4, 2018), https://latinainstitute.org/sites/default/files/NLIRH%20Survey%20Report_F_0.pdf.

[32] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, CTR. FOR AM. PROGRESS (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[33] *Id.*

[34] *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, Columbia Law Sch. (Jan. 19, 2018), https://www.law.columbia.edu/events/bearing-faith-limits-catholic-health-care-women-color.

the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise."[35] Courts are careful not to "substitute [their] judgment for that of the agency,"[36] but have taken a hard look when agencies have rescinded regulations without adequate support for the change. The Second Circuit has included this hard look approach to rulemaking when the agency has failed to make a "rational connection between the facts found and the choice made."[37]

In this regard, the Department has given no data about the impact such a change would have on the patients the Final Rule was intended to protect, nor even the estimated cost in litigation expenses incurred while applying the regulation. The Department seeks to solve a problem it has not shown exists. Moreover, the problem it is proposing to solve has could potentially be exacerbated by the decision to repeal the guiding regulations that gave the courts information to interpret.

Moreover, the regulatory paradigm embodied in the proposed change does not accord with the law in this area. Numerous federal courts have found that federal sex discrimination statutes necessarily include discrimination against a person based on transgender status,[38] as well including sex stereotyping against individuals based on sexual orientation.[39] Such changes are misleading when absent any evidentiary support, causing individual patients to question whether or not they will have access to health care--such questioning is designed to have the same effect as denying them care outright.

Ultimately, this is a misapplication of the purpose of rulemaking. Rules are intended to facilitate the implementation of statutes by agencies--up to and including being responsive to litigation. The case law does not support this proposed change in agency rulemaking, and there is no evidence to support it. For these reasons, we strongly oppose the enactment of the proposed change.

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[35] Motor Vehicle Man. Ass'n v. State Farm Mutual Automobile Insurance Co., 463 U.S. 29, 43 (1983) (citation omitted).
[36] *Id.*
[37] Pub. Citizen, Inc. v. Mineta, 340 F.3d 39, 56 (2nd Cir. 2003).
[38] *See, e.g.*, Smith v. City of Salem, 378 F.3d 566, 572-75 (6th Cir. 2004); Rosa v. Park West Bank & Trust Co., 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); Schwenk v. Hartford, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act); see also Statement of Interest of the United States at 14, Jamal v. Saks, No. 4:14-cv-02782 (S.D. Tex. Jan. 26, 2015).
[39] *See, e.g.*, Complainant v. Johnson, EEOC Appeal No. 0120110576 (Aug. 20, 2014); Complainant v. Cordray, EEOC Appeal No. 0120141108 (Dec. 18, 2014); Complainant v. Donahoe, EEOC Appeal No. 0120132452 (Nov. 18, 2014); Complainant v. Sec'y, Dep't of Veterans Affairs, EEOC Appeal No. 0120110145 (Oct. 23, 2014); Couch v. Dep't of Energy, EEOC Appeal No. 0120131136 (Aug. 13, 2013); Brooker v. U.S. Postal Serv., EEOC Appeal No. 0120112085 (May 20, 2013); Culp v. Dep't of Homeland Security, EEOC Appeal No. 0720130012 (May 7, 2013); Castello v. U.S. Postal Serv., Appeal No. 0120111795 (Dec. 20, 2011); Veretto v. U.S. Postal Serv., EEOC Appeal No. 0120110873 (July 1, 2011).

We stand firm and strong in opposition to this rule change. The proposed rule is wholly insufficient to address the needs of LGBTQ Americans across the country. The change does not comport with the current state of current case law surrounding nondiscrimination in health care and it does nothing to adequately protect patients or their access to necessary health care. We request that you retract it and cease any steps to implement it.

Sincerely,

Alphonso B. David
President, Human Rights Campaign

EXHIBIT D-12

AMERICA'S ESSENTIAL HOSPITALS

August 9, 2019

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

Ref: Nondiscrimination in Health and Health Education Programs or Activities

Thank you for the opportunity to comment on the above-captioned proposed rule. America's Essential Hospitals is concerned this rule fails to account for existing barriers certain patients face when seeking care, including members of the lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) community and individuals with limited English proficiency (LEP).

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all, including vulnerable populations. Filling a vital role in their communities, our more than 300 member hospitals provide a disproportionate share of the nation's uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Our members provide state-of-the-art, patient-centered care while operating on margins one-fifth that of other hospitals—1.6 percent on average compared with 7.8 percent for all hospitals nationwide.[1] Essential hospitals' commitment to serving all people, regardless of income or insurance status, and their diverse patient mix pose unique challenges. A disproportionate number of their patients face sociodemographic challenges to accessing health care, including poverty, homelessness, language barriers, and low health literacy. Ten million people in communities served by essential hospitals have limited access to healthy food, and nearly 24 million live below the poverty line.[2]

Essential hospitals are uniquely situated to address these social determinants of health and are committed to serving all patients. Given essential hospitals' commitment to providing high-quality, patient-centered care to all patients, we urge the Department of Health and Human Services (HHS) to consider the following comments before it finalizes this policy, which could have a disproportionate and negative effect on vulnerable patient populations.

1. **HHS should not finalize changes that remove crucial nondiscrimination protections for patients based on sex, including gender identity.**

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[1] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2017 Annual Member Characteristics Survey*. America's Essential Hospitals. April 2019. https://essentialdata.info. Accessed July 22, 2019.
[2] Ibid.

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Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability under any health program or activity that receives federal financial assistance or under any program or activity administered by an executive agency under Title I of the ACA. In 2016, HHS finalized definitions for key terms and groups protected by Section 1557. HHS defined discrimination "on the basis of sex" to include, among other things, discrimination on the basis of gender identity. At the time, America's Essential Hospitals expressed strong support for the nondiscrimination requirements and their inclusion in Medicare and Medicaid conditions of participation, citing the importance of equity of care in improving outcomes and reducing disparities. As a country, we must remain committed to eliminating disparities in health and health care. Federal policies must reinforce equity of care for all patients, regardless of the patients' socioeconomic and sociodemographic characteristics or other defining factors.

HHS' proposal would narrow the scope of Section 1557 by removing the specific definition of discrimination on the basis of sex, thus eliminating protections based on gender identity. Specifically, this change would eliminate federal protection against discrimination in health care settings for transgender individuals and others who do not identify as the sex assigned to them at birth. As proposed, the HHS Office of Civil Rights (OCR) will continue to enforce protections against discrimination on the basis of sex, but gender identity will no longer be included in those protections.

Essential hospitals take pride in providing high-quality care to all, including members of the LGBTQ community. In 2018, more than 80 essential hospitals took part in the Human Rights Campaign's Healthcare Equality Index (HEI), an annual report measuring policies and practices designed to support LGBTQ inclusion in health care settings.[3] The voluntary survey evaluates facilities' current policies and practices and identifies gaps where there is room for improvement. Several essential hospitals were designated as LGBTQ Healthcare Equality Leaders, earning the highest possible score on the HEI and demonstrating their dedication to equity. Essential hospitals respond to the needs of their communities, developing specialized services for LGBTQ patients. For example, one essential hospital in Ohio runs a clinic to respond to the unique needs of transgender youth, who face an extremely high risk of attempting suicide and other self-harm.[4]

Research has shown that discrimination against individuals seeking health care can lead to lower care quality and worse health outcomes. Equitable access to health services is crucial to better care, healthier individuals and populations, and lower health care costs. Transgender individuals, like others in the LGBTQ community, often face challenges and barriers to accessing necessary care. They experience stigma, violence, substandard care, and outright denial of care by some providers. Transgender individuals also are more likely to face social risk factors, including poverty and interpersonal violence.[5] As proposed, the rollback of federal protection from discrimination will exacerbate the challenges transgender individuals face in health care settings. Without these protections, transgender patients are less likely to receive high-quality, equitable care. HHS provides no rational policy justification for these changes. **America's Essential Hospitals urges HHS not to finalize these changes, as they will harm LGBTQ**

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[3] Healthcare Equality Index 2018. Human Rights Campaign. https://assets2.hrc.org/files/assets/resources/HEI-2018-FinalReport.pdf. Accessed July 16, 2019.

[4] Toomey R, Syversten A, Shramko, M. Transgender Adolescent Suicide Behavior. *Pediatrics*. 142: 4. October 2018. https://pediatrics.aappublications.org/content/142/4/e20174218. Accessed July 16, 2019.

[5] Kates J, Ranji U, Beamesderfer A, Salganicoff A, Dawson L. Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S. Kaiser Family Foundation. May 2018. http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US. Accessed July 16, 2019.

patients through less-equitable care, increased disparities, and worse health outcomes for transgender patients.

2. HHS should uphold all protections for individuals with LEP in health care settings.

Essential hospitals' commitment to caring for all people, including the vulnerable, has made them providers of choice for patients of virtually every ethnicity and language. In 2017, racial and ethnic minorities accounted for more than half of discharges at essential hospitals. To best serve these patients, essential hospitals work to identify the linguistic needs and preferences of their patient population and provide appropriate interpretation services to improve patient experience and overall outcomes. Research shows what essential hospitals already know: Access to appropriate interpreter services improves patient experience and clinical outcomes, while also decreasing readmission rates and costs.[6,7] LEP patients are less likely than their English-speaking counterparts to have access to preventive care.[8] It is vital that hospitals and other health care entities continue to provide interpreter services for LEP patients to ensure they have access to high-quality care and to reduce disparities. Further, it is the federal government's responsibility to promote and protect these LEP services.

a. HHS should continue to ensure LEP individuals have meaningful access to language assistance.

The proposed rule modifies requirements for language assistance for LEP individuals established in the 2016 final rule. Hospitals and other covered entities are required to take reasonable steps to provide meaningful access to individuals with LEP "eligible to be served or likely to be encountered." To make this determination, OCR focuses on the nature and importance of the health program or activity and the particular communication for the LEP individual. OCR also considers whether a covered entity has developed and implemented an effective and appropriate language access plan, although these plans are not required.

The proposed rule alters how OCR will determine whether an entity has met its LEP requirements. As proposed, OCR would eliminate consideration of language access plans when evaluating compliance. Rather, the extent of an entity's obligation to provide language assistance services would be determined by a four-factor test that considers:

- the number or proportion of individuals with LEP eligible to be served or likely to be encountered in the eligible service population;
- the frequency with which individuals with LEP come in contact with the entity's health program, activity, or service;
- the nature and importance of the entity's health program, activity, or service; and
- the resources available to the entity and costs.

America's Essential Hospitals is concerned that the proposed changes to these standards would increase disparities across the health care system at large for LEP individuals. Even if

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[6] Karliner LS, Jacobs EA, Chen AH, Mutha S. Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature. *Health Services Research.* 2007;42(2):727-754. https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1475-6773.2006.00629.x. Accessed July 22, 2019.

[7] Karliner LS, Perez-Stable EJ, Gregorich SE. Convenient Access to Professional Interpreters in the Hospital Decreases Readmission Rates and Estimated Hospital Expenditures for Patients with Limited English Proficiency. *Medical Care.* 2017:55(3):199-206. https://journals.lww.com/lww-medicalcare/fulltext/2017/03000/Convenient_Access_to_Professional_Interpreters_in.1.aspx. Accessed July 22, 2019.

[8] Smith DL. Health Care Disparities for Persons with limited English Proficiency: Relationships from the 2006 Medical Expenditure Panel Survey (MEPS). *Journal of Health Disparities Research and Practice. 2010;*3(3):57-67. https://digitalscholarship.unlv.edu/cgi/viewcontent.cgi?referer=https://scholar.google.com/&httpsredir=1&article=1043&context=jhdrp. Accessed July 22, 2019.

compliance standards are altered as proposed, essential hospitals will continue to provide necessary services to their patients, a disproportionate share of whom are LEP individuals. But essential hospitals cannot do this alone. HHS should continue its role in ensuring all providers promote and protect LEP services. **America's Essential Hospitals urges HHS not to finalize any changes to requirements for LEP patients that will jeopardize access to appropriate interpreter services.**

b. HHS should continue to promote the availability of interpreter services through notice and tagline requirements.

The 2016 final rule also established requirements that covered entities post and provide patients with notices of the covered entity's nondiscrimination policies and the availability of language assistance and interpreter services at no cost. Taglines must be provided in at least the top 15 languages spoken by LEP individuals in the entity's state. The proposed rule would remove these notice and tagline requirements.

OCR acknowledges that repealing these notice and tagline requirements will result in lower utilization by LEP individuals who are unaware of available interpreter services. It is vital that LEP individuals are provided with all necessary information to make decisions about their care. America's Essential Hospitals is concerned that removing notice and tagline requirements will reduce utilization by LEP individuals not otherwise informed of their right to interpreter services. Interpreter services are only of use if patients are adequately informed of their availability. **HHS should not remove notice and tagline requirements that promote access to and usage of interpreter services.**

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO

EXHIBIT D-13

August 13, 2019

VIA ELECTRONIC SUBMISSION

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

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

Dear Secretary Azar:

The National Council of Jewish Women ("NCJW") is pleased to provide comments in response to Nondiscrimination in Health and Health Education Programs or Activities, a proposed rule published by the Department of Health and Human Services ("HHS") in the Federal Register on June 14, 2019 at 84 Fed. Reg. 27,846 ("Proposed Rule").

Founded in 1893, NCJW is the oldest Jewish women's volunteer organization in the United States. Our 90,000 grassroots volunteers and advocates turn progressive ideals into action and make change happen. Inspired by Jewish values, NCJW strives for social justice by improving the quality of life for women, children, and families and by safeguarding individual rights and freedoms. NCJW members carry out the organization's long tradition of progressive action through a powerful combination of community organizing, education, direct service, and advocacy. Through 60 sections and action teams across the country as well as a strong State Policy Advocacy network in 16 states, NCJW works on local, state, and federal issues.

Our organizational principles state that equal rights and equal opportunities for all people must be guaranteed and that all forms of discrimination must be eliminated. NCJW champions the enactment, enforcement, and preservation of laws and regulations that protect civil rights and individual liberties for all — especially for the most marginalized in our society who face structural barriers to exercising their human rights. By encouraging discrimination in health care, HHS takes steps that are directly contrary to these principles.

For the reasons detailed below, we ask HHS to withdraw the Proposed Rule and leave current regulations unchanged. The Proposed Rule, if finalized, would egregiously remove protections and increase the burdens on people of color, women, the LGBTQI community, persons with disabilities, and people of limited English proficiency, violating their civil rights and imposing damage far greater than the monetary effects on the regulated community. In addition, this rulemaking violates the United States Constitution and the Administrative Procedure Act ("APA").

As an organization and community member, NCJW is committed to the belief that every individual has an equal right to access health care.[1] Our Jewish values teach us to respect the dignity and decisions of all people and, as such, we aim to create a world where everyone — regardless of race, class, gender, sexuality, ability, or immigration status — is able to control their body, sexuality, and future. Individuals have the right to follow their own conscience on matters of their own health care, irrespective of their faith or that

[1] *E.g.*, Interfaith Statement Opposing Restrictions on Women's Health Care Options, Jan. 2014; Nat'l Council of Jewish Women, *Vision for America*, https://www.ncjw.org/wp-content/uploads/2018/11/Vision-for-America_ONLINE.pdf (Nov. 2018).

of their providers and the institutions they serve. To that end, NCJW works to ensure that all people have full and equal health coverage consistent with Federal law, including all services and nondiscrimination provisions guaranteed by the Patient Protection and Affordable Care Act ("ACA"). We oppose any regulation that impinges on anyone's ability to access the care best-suited for their own beliefs and conscience.

NCJW believes the Proposed Rule violates the religious freedom and moral autonomy of the individual; jeopardizes the lives and health of people seeking reproductive health care (including abortion), LGBTQ individuals, individuals with LEP (including immigrants), those living with disabilities, and people of color; and would embolden compounding levels of discrimination against those who live at the intersection of these identities.

As such, NCJW strongly believes that HHS should not finalize the Proposed Rule.

I. NCJW, and Communities of Faith in General, Believe that All People Deserve Equal Access to Care.

A common thread running through different faiths is that all strive for social justice and equal rights, including equal access to care. People of faith believe in the dignity of all — and that means *all*. As each of us is made in the image of the divine — *b'tselem Elohim* (Genesis 1:26) — every single person's health is paramount and unassailable. We have an obligation to care for and protect our bodies and to ensure all others can do the same. This means that every human being deserves fair treatment and respect when accessing health care, free from political interference or economic coercion.

As Jews, we value every individual as a moral decision-maker, free to make personal decisions about their lives and care based on their own religious beliefs and consciences without interference from others. Irrespective of their faith or moral opinions, the personal "beliefs" of any provider or institution should never jeopardize patient health and safety or impede the care the patient is able to receive and the services they may access.

Respect for individual conscience must necessarily extend to choices about one's own health care. Individuals have consciences. Non-person entities do not. The proper role of government is to guarantee fair treatment and to protect the freedom of conscience for all patients. By sanctioning discriminatory activity in health care, the government promotes inequality and obstructs patients' decision-making, compromising their moral autonomy and human rights.

As part of our faith-based mission of *tzedek* (justice) for all, NCJW is dedicated to lifting up those disadvantaged economically, those with limited access to services, and those who face structural barriers to exercising their human rights. Our founder Hannah G. Solomon asserted, "We must add our voices to those who cry out that there is a standard below which we will not allow human beings to live, and that standard is not at the freezing or starving point." Since she spoke those words, NCJW has championed policies that improve the lives of marginalized and vulnerable communities including women, children, LGBTQ individuals, individuals with disabilities, and people of color. It is profoundly unjust to even propose reducing health care options for individuals based on their gender identity or any other arbitrary factor.

In sum, health care is a human right, and NCJW overwhelmingly respects the moral autonomy of the individual to make choices about the care they receive.

II. The Impact of the ACA

NCJW was proud to play a role in the enactment of the ACA,[2] landmark legislation that had a transformative impact on all aspects of health care by increasing the scope of benefits and improving access to coverage for millions of Americans. The ACA has reduced health care costs for individuals and employers while at the same time reducing uncompensated care by more than $7.4 billion.[3] In addition, the ACA included critical provisions ensuring full and equitable access to essential services without discrimination.

Indeed, the ACA is a critical source of health care coverage for America's traditionally underserved communities including individuals and families living in poverty, people of color, women, immigrants, LGBTQI individuals, individuals with disabilities, seniors, and individuals with limited English proficiency. Moreover, the ACA reduced the number of individuals without insurance to historic lows, including a reduction of 39 percent of the lowest income individuals.[4] These gains are particularly noteworthy for Latinos, African Americans, and Native Americans. What's more, with the enactment of the ACA, 9.5 million uninsured women gained affordable, comprehensive coverage. Between 2013 and 2015, the first two full years of ACA implementation, the proportion of uninsured women of reproductive age (15-44) declined by 36%. The nation and our communities cannot afford to go back to a time when they did not have access to comprehensive, affordable coverage.

Furthermore, the ACA has been instrumental in covering a wide range of preventive services, ensuring that individuals have access to life-saving cancer screenings and treatment as well as effective contraception and reproductive health care services (well visits, mammograms, lactation counselling and supplies) at no cost to the patient. Similarly, plans are sharply limited in their ability to impose formularies, prior authorization requirements, and other administrative barriers to preventive care services or to benefit designs that may discriminate against persons with specific disease states.

Significantly, absent the financial assistance offered by the ACA, many marginalized groups (including low-income people, people of color, immigrants, young people, and LGBTQ individuals) faced the impossible choice of going without health insurance or straining their resources to pay for services out-of-pocket. By introducing provisions to help low- and moderate-income individuals and families buy health insurance, over 9 million women who would have gone without affordable coverage became eligible for ACA premium tax credits and cost-sharing reductions as of 2014. The ACA also provided states with the option to expand Medicaid, resulting in 3.3 million more women holding Medicaid coverage in 2014 compared to the previous year. Augmented Medicaid coverage promotes women's economic security because those covered by this program are less likely to disregard other bills or to borrow money to pay medical expenses than individuals without health insurance.

Notably, the ACA was the first federal program to prohibit gender discrimination (including gender identity discrimination) in health care. The law specifically bars discriminatory gender-rating, the practice of routinely charging women significantly higher premiums than men (costing American women $1 billion annually prior to the ACA's implementation). ACA Section 1557, in particular, is an essential mechanism to ensure meaningful access to health care by all Americans. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability by any programs or activities that receive Federal financial assistance, such as credits and subsidies (monetary and nonmonetary).

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[2] Pub. L. No. 111-148, 124 Stat. 119–1025 (2010).
[3] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, New Report Details Impact of the Affordable Care Act (Dec. 13, 2016), https://www.hhs.gov/about/news/2016/12/13/new-report-details-impact-affordable-careact.html available at http://wayback.archive-it.org/3926/20170127135924/https://www.hhs.gov/about/ news/2016/12/13/new-report-details-impact-affordable-care-act.html.
[4] Kelsey Avery, Kenneth Finegold and Amelia Whitman, *Affordable Care Act Has Led to Historic, Widespread Increase in Health Insurance Coverage*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES ASPE ISSUE BRIEF, (Sep. 29, 2016) https://aspe.hhs.gov/system/files/pdf/207946/ACAHistoricIncrease Coverage.pdf.

Section 1557 bars hospitals, doctors, and insurers from discriminating against persons seeking health care services or health care coverage. The Proposed Rule, however, would erode the scope of those protections and, correspondingly, impair access to critical services by communities who most need critical care.

III. Summary of the Proposed Rule

Elimination of Nondiscrimination on the Basis of Gender Identity and Sex Stereotyping — The Proposed Rule would remove the inclusion of gender identity[5] and sex stereotyping[6] from discrimination "on the basis of sex." Currently, health insurers are prohibited from excluding coverage of health care services for persons seeking gender transition or limiting coverage on the basis of a person's gender identity. The Proposed Rule would embolden institutions and providers to discriminate.

Elimination of Nondiscrimination on the Basis of Termination of Pregnancy — The Proposed Rule would not include termination of pregnancy as a prohibited basis of discrimination on the basis of sex. The Proposed Rule also "does not adopt a position" as to whether termination of pregnancy constitutes discrimination on the basis of sex based on miscarriage or medical complications.

Narrowing Scope of Nondiscrimination Protections by Eliminating Definition of "Covered Entity" — The Proposed Rule would abandon the definition of "covered entity" and the corresponding extension of nondiscrimination protections. Instead, the Proposed Rule would narrow Section 1557's application to the following programs or activities:

- Health programs or activities any part of which receive Federal financial assistance from the Department of Health and Human Services ("HHS");
- Any program or activity administered by HHS under Title I of the ACA; and
- Any program or activity administered by an entity established by Title I of the ACA.

Thus, Section 1557's protections would no longer extend to all of a health insurer's operations. Instead, under the Proposed Rule, Section 1557 would apply only to the subset of an insurer's operations that receive Federal financial assistance from HHS such as qualified health plans offered on an exchange.

Elimination of Notice Requirements and Narrowing of Language Access Requirements — The Proposed Rule would eliminate the requirement that a covered entity notify beneficiaries, applicants, and the public that the entity does not discriminate on the bases protected by Section 1557, that timely language assistance and other aid is available without charge upon request, and how to contact OCR to file a complaint. The Proposed Rule also would eliminate the requirement that covered entities include taglines in the top 15 languages spoken by Limited English Proficiency ("LEP") persons in the relevant state.

IV. The Proposed Rule Tramples Individuals' Religious Liberty and Would Harm Patients by Encouraging Providers to Deny Care Based on Their Personal Beliefs.

[5] The current regulation defines "gender identity" as ''an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth.'' 81 Fed. Reg. 31,375, 31,467 (May 18, 2016) (codified at 45 CFR § 92.4). The current regulation The regulation requires covered entities to treat individuals ''consistent with their gender identity'' except that covered entities ''may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.'' 45 C.F.R. §§ 92.206 and 92.207(b)(3).

[6] The Section 1557 Final Rule defines ''sex stereotypes'' as ''stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics. These stereotypes can include the expectation that individuals will consistently identify with only one gender and that they will act in conformity with the gender-related expressions stereotypically associated with that gender. Sex stereotypes also include gender expectations related to the appropriate roles of a certain sex.'' 81 Fed. Reg. at 31,468 (codified at 45 C.F.R. § 92.4).

True religious liberty, cemented as one of our nation's founding principles in the First Amendment's Establishment Clause, signifies both freedom of and freedom from religion. The Proposed Rule turns that principle on its head, expressly allowing businesses and individuals to impose their disingenuously claimed "beliefs" upon individuals seeking care.

Being forced to live by another person's beliefs — not to mention the disingenuously claimed "beliefs" of a corporate entity — eviscerates religious freedom. Religious refusals of care do not protect conscience; but instead trample individual religious liberty by granting entire institutions the moral decision-making powers that should be left to patients and ignoring the deeply held convictions of those called to provide patients with abortions or transition-related care. The Proposed Rule is an affront to our Jewish values and to the values of all people of faith who seek to eliminate all forms of discrimination, who rightfully view health care as a basic human right, and who respect the moral autonomy of the individual to make their own choices about the care they receive.

The Proposed Rule fails not only as a matter of policy but also under the Constitution. The First Amendment to the Constitution protects each individual's right to exercise their religious beliefs. By enabling institutions and individuals to prevent others from obtaining their chosen health care services using religious- or conscience-based justifications, the Proposed Rule places an unconstitutional thumb on the scales in favor of one set of beliefs over another.

A. More Important Even Than Constitutional Protections, the Proposed Rule Would Violate the Inherent Dignity of Each Individual.

The Section 1557 Final Rule (presently in effect) provides: "Insofar as the application of any requirement of this part would violate applicable Federal statutory provisions for religious freedom and conscience, such application shall not be required." 45 C.F.R. § 92.2. Nothing more is necessary to adequately protect the religious- and conscience-related beliefs as required by current law. By explicitly incorporating federal refusal of care laws, the Proposed Rule places undue emphasis on the exceptions to the rules that could encourage an unwarranted expansion of claims of such beliefs. Combined with the removal of protections against discrimination, not to mention the narrowing of the application of the rule with regard to certain federal health care programs, the incorporation of the refusals provisions have a compounding negative effect on the people most needing civil rights protections.

Our Jewish tradition calls on us to celebrate religious liberty, which honors individuals' rights to both freedom of and freedom from religion. We depend on religious liberty to be a protective shield, not a weapon used to harm others. Those who invoke "religious liberty" to discriminate and block access to health care grossly violate this principle and our nation's Constitution.

Indeed, discrimination or other violations of an individual's civil rights should not be permissible based on religious or conscience exemptions.[7] Yet the Proposed Rule encourages that result by expressly enabling individual providers to impose their beliefs on their patients. Patients are moral agents who have the capacity, right, and responsibility to make their own decisions about their bodies and health care without interference. Regulations that authorize discrimination and thereby limit access to needed health care

[7] *Cf. Miller v. Davis*, 123 F. Supp. 3d 924, 941 (E.D. Ky. 2015) (finding it unlikely that clerk refusing to issue marriage licenses to same-sex couples would succeed in establishing a violation of her constitutional rights if required to do so, and instead that allowing her to refuse to issue such licenses would likely violate others' constitutional rights); *see also Obergefell v. Hodges*, 135 S.Ct. 2584, 2607 (2015); *Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm'n*, 138 S. Ct. 1719,1727 (2018) ("Nevertheless, while those religious and philosophical objections are protected, it is a general rule that such objections do not allow business owners and other actors in the economy and in society to deny protected persons equal access to goods and services under a neutral and generally applicable public accommodations law.").

severely constrain patients' ability to make choices guided by their own consciences, personal circumstances, and moral or faith traditions.

Perversely, the Proposed Rule would also encourage institutions to instruct their providers regarding what care they may or may not provide, ignoring many with deeply held moral convictions that affirmatively motivate them to provide patients with health care, including abortion, transition-related care, and end-of-life care. For instance, Jewish providers believe that the existing life and health of the pregnant individual is paramount at any and all stages of pregnancy. What's more, unlike some faith traditions, Jewish law does not consider abortion to be murder because the fetus is not considered a 'life' or a 'person' with independent rights. These beliefs would motivate Jewish providers to, for instance, provide an abortion to a patient in an acute medical crisis regardless of hospital policy. Allowing an employer to dictate the type of care Jewish providers can or cannot provide directly impedes their religious liberty.

The institution's violation of civil rights is thus two-fold: both on the provider *and* the patient. Moreover, the provider prohibited from providing necessary care could also face negative repercussions if such denials would result in violations of professional and ethical duties separately required of the provider.

Furthermore, the combination of exemptions incorporated in the Proposed Rule and the removal of definitions related to discrimination leaves a gaping hole in protections for individuals' right to equal treatment. For example, one provision of the Church Amendments allows individuals who work for or with entities receiving grants or contracts for biomedical or behavioral research entities to refuse to participate in "any lawful health services or research activity" based on religious beliefs or moral convictions *specifically related to the service or research activity to which they object*.[8] But the Proposed Rule contains no such limitations, implying that the exemptions are broader than existing law allows. This is a real concern because individuals are at serious risk of experiencing discrimination based on who they are, not based on what care they seek.[9]

Finally, in May 2019, HHS promulgated a Denial of Care Rule (described by some as the "Conscience Rule")[10] that broadens the application of at least 25 federal laws related to the application of religious- or conscience-based beliefs to health care. Immediately challenged in court, HHS has agreed to delay implementation of the Denial of Care Rule pending the outcome of these cases.[11] At the core of those legal challenges are issues that are also implicated in the Proposed Rule. At the very least, HHS should delay finalizing any rule, such as this Proposed Rule, that could fall on the same grounds.

Ultimately, the Trump administration's manipulation of religious liberty in the name of "conscience" has one overarching theme: a push to make policy and to interpret the law based on a narrow understanding of evangelical Christianity. This view leaves no room for minority religions or atheists and completely disregards the separation of religion and state. The administration threatens the religious liberty of all people when it enacts policy to align with one interpretation of one religion, and when it allows employers, health care providers, and government officials to use their individual beliefs to thwart our nation's civil rights laws.

B. Regulations Authorizing Religious Refusals of Care, including Those Incorporated in the Proposed Rule, Harm Patients.

[8] The Church Amendments, 42 U.S.C. § 300a-7 (2018).
[9] *See infra* note 38.
[10] U.S. Dep't of Health and Human Servs., "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," 84 Fed. Reg. 23,170 (May 21, 2019).
[11] Katie Keith, "Provider Conscience Rule Delayed Due to Lawsuits," HealthAffairs (July 2, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190702.497856/full/.

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

Allowing a religious exemption to Section 1557's protection against sex discrimination could have far-reaching consequences. This could create new instances in which health care providers, including insurance companies, hospital, doctor, or nurses, can allow their beliefs to determine patient care, opening the door to illegal discrimination. This could impact a broad range of health care services, including birth control, sterilization, certain fertility treatments, abortion, gender-affirming care, and end of life care. Moreover, there is already a proliferation in the types of entities that are now emboldened to use religious beliefs to discriminate against patients and the number of religiously-affiliated entities that provide health care and related services and refuse to provide care based on religious beliefs.[12] The proposed rule could encourage these entities to engage in illegal discrimination.

For instance, refusals of care based on personal beliefs have been invoked in countless ways across the country to deny patients the care they need. One woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously affiliated facility, where she was denied the miscarriage management she needed because the hospital objected to this care.[13] Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.[14] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[15] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[16] Another woman was sent home by a religiously affiliated hospital with two Tylenol after her water broke at 18 weeks of pregnancy. Although she returned to the hospital twice in the following days, the hospital did not give her full information about her condition and treatment options.[17]

Religious exemptions disproportionately harm LGBTQ people, especially those who are transgender, nonbinary, or gender nonconforming. LGBTQ people are often refused health care services because of their sexual orientation and/or gender identity.[18] For example, 8 percent of LGBQ people were refused health care because of their sexual orientation, and 6 percent were refused care related to their sexual orientation. Similarly, 29 percent of transgender people were refused health care because of their gender identity,[19] and 12 percent were refused gender-affirming health care.[20] The proposed rule purports to allow further illegal refusals of care for LGBTQ people.

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

[13] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

[14] *See* Julia Kaye, et al., *Health Care* Denied, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

[15] *See* Shepherd, et al., *supra* note 13.

[16] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.

[17] *See* Shepherd, et al., *supra* note 13.

[18] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[19] *Id.*

[20] *Id.*

When LGBTQ people are refused treatment, it becomes difficult or impossible to find another provider, especially for those living in rural areas and for transgender people.[21] According to a 2018 study, 18 percent of LGBTQ people said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 17 percent said it would be very difficult or not possible to find the same type of service at a different clinic. Rates are higher for LGBTQ people living outside of a metropolitan area: 41 percent said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 31 percent said it would be very difficult or not possible to find the same type of service at a different clinic. Rates are also higher for transgender people: 31 percent said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 30 percent said it would be very difficult or not possible to find the same type of service at a different clinic. The proposed rule would make it harder for LGBTQ people to access the health services they need.

Additionally, NCJW works for comprehensive, affordable, accessible, and equitable family planning, reproductive, sexual health, and maternal health services — including abortion; people seeking access to these services are also harmed by religious refusals. Geography is already a barrier for people needing abortion care. If people are refused care because of a provider's religious beliefs, it would make it difficult or impossible to receive the care they need. People often must travel between 10-79 miles to reach their nearest abortion clinic, with 20 percent having to travel 42-54 miles or more.[22] "[T]hose living in rural areas typically have to travel greater distances who live in urban areas."[23] "As of 2014, 90 percent of U.S. counties lacked an abortion clinic. . . . Many states have only one clinic."[24] NCJW opposes all measures, including the Proposed Rule, that restrict access to safe abortion and prevent patients from receiving the services they need.

Religious exemptions have a particularly negative impact on people of color. Women and people of color are disproportionately served by Catholic hospitals. These institutions are "governed by strict guidelines that prohibit health care providers from providing contraceptives, sterilization, some treatments for ectopic pregnancy, abortion, and fertility services regardless of their patients' wishes, the urgency of a patient's medical condition, the provider's own medical judgment, or the standard of care in the medical profession."[25] The Proposed Rule would make it harder for people of color, especially those that are LGBTQ and/or needing reproductive care, to access the health services they need.

Over the past several decades, religious refusals have helped systematically chip away at abortion access across the country. This limiting of abortion care has meant that individuals have been denied the care they need. Being denied an abortion has long-term negative impacts on an individual and reduces financial security and safety for themselves and their families. For example, women denied an abortion had almost 4 times greater odds of a household income below the federal poverty level and 3 times greater odds of being unemployed.[26] Additionally, women who were denied an abortion were more likely to not have enough money to pay for basic family necessities like food, housing and transportation.[27] A recent study found that continuing an unwanted pregnancy and giving birth is associated with more serious health

[21] *Id.*
[22] Jonathan M. Bearak, et al., *Disparities and Change Over Time in Distance Women Would Need to Travel to Have an Abortion in the USA: A Spatial Analysis*, 2 The Lancet e493, e493-e500 (2017), https://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(17)30158-5.pdf.
[23] *Id.*
[24] Anna North, *Abortion is Still Legal in America*, Vox (May 16, 2019, 12:19 PM), https://www.vox.com/2019/5/16/18626744/alabama-abortion-law-legal-50-states-roe.
[25] *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, Columbia Law Sch. (Jan. 19, 2018), https://www.law.columbia.edu/events/bearing-faith-limits-catholic-health-care-women-color.
[26] Bixby Ctr. for Global Reprod. Health, University of Cal. S.F., *Turnaway Study*, https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf (last visited Jul. 23, 2019).
[27] *Id.*

problems than abortion.[28] Critically, lacking access to abortion care can also undermine the safety and security of the individual seeking services. For example, one study found that women who were unable to terminate unwanted pregnancies were more likely to stay in contact with their violent partners, putting them and their children at greater risk than if they had received the abortion.[29]

At base, allowing the personal beliefs of health care entities and providers to override patient care jeopardizes public health and lives. For many patients, refusals of care do not merely represent an inconvenience, but can result in delay or outright denial of vital care. These refusals are particularly dangerous in situations where individuals have limited options, such as in emergencies, when needing specialized services, in rural areas, or in areas where religiously-affiliated hospitals are the primary or sole institution serving a community. Based on the Jewish value of *kavod ha bri'ot*, NCJW believes that refusals of care and discrimination simply have no place in health care, where all are entitled to fair treatment and respect.

C. The Proposed Rule Unconstitutionally Prioritizes the Religious Beliefs of the Few over Those of the Many.

The First Amendment to the Constitution reads, "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press . . . ."[30] The Proposed Rule violates the Free Exercise and Establishment of Religion Clauses of the First Amendment because it enables an individual or institution receiving government funds to discriminate against a patient due to the patient's beliefs or very being. Both clauses regulate how government policy interacts with moral and religious belief.

In interpreting these clauses, the Supreme Court has held that both prevent the government from shifting the cost of religious and moral accommodation from those who practice to third parties.[31] The Proposed Rule would do just that by shifting the cost of religious and moral accommodations for health insurers and health care providers onto patients by denying them access to services and forcing them to delay or forgo care, which can come with a cost to both their health and their pocketbook. The government's ability to accommodate the free exercise of religion does not relieve its burden of ensuring that they do not compel others to subsidize religious practices that they do not support.[32]

V. The Proposed Rule Would Have Serious Negative Implications for the Health of Women and LGBTQI Individuals.

One of the main benefits of the ACA is its guarantee of certain basic minimum requirements for health care policies *for everyone*. Although only one step towards truly seamless health care, the ACA nevertheless was supposed to make it easier, not more difficult, for people to live their lives without worrying about what services may or may not be covered.

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[28] *Id.*
[29] *Id.*
[30] US CONST. amend. I.
[31] *See Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 710 (1985) (stating, "The First Amendment. . . gives no one the right to insist that in pursuit of their own interest others must conform their conduct to his own religious necessities."); *United States v. Lee*, 455 U.S. 252 (1982) ("When followers of a particular sect enter into commercial activity as a matter of choice, the limits they accept on their own conduct as a matter of conscience and faith are not to be superimposed on the statutory schemes which are binding on others in that activity. Granting an exemption from social security taxes to an employer operates to impose the employer's religious faith on the employees."); *see e.g. Cutter v. Wilkinson*, 544 U.S. 709, 720, 722 (2005) (to comply with the Establishment Clause, courts "must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries" and must ensure that the accommodation is "measured so that it does not override other significant interests") (citing *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985)); *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).
[32] *United States v. Lee*, 455 U.S. 252 (1982).

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

This Proposed Rule is a giant step backward in the quest for adequate health care for all. By repealing the definition of "on the basis of sex," the Proposed Rule improperly encourages discrimination against people that lawfully exercise their rights or that present in a way that some may oppose and thereby violates the Constitution. Although the Constitution, through the Fifth and Fourteenth Amendments, guarantees equal protection for all, the Proposed Rule would enable government-subsidized discrimination by allowing denial of care to particular groups of people.

A. Women and LGBTQI Individuals Have Long Endured Discrimination in Health Care, Leading Patients to Delay or Forego Care.

Patients who endure discrimination based on religious or moral beliefs of providers or the disingenuously claimed "beliefs" of hospitals and clinics may suffer devastating health consequences.[33] These consequences extend far beyond those services most associated with reproduction or gender identity that providers may believe they are allowed to deny to individuals under rules such as the Proposed Rule. For example, nearly 60% of women use contraception to help treat several medical conditions specific to women, not necessarily for contraceptive purposes.[34]

Women have long been the subject of discrimination in health care. Despite the historic achievements of the ACA, women are still more likely to forego care because of cost, and women — particularly Black women — are far more likely to be harassed by a provider. These barriers mean women are more likely not to receive routine and preventive care than men. Moreover, when women are able to see a provider, women's pain is routinely undertreated and often dismissed. And due to gender biases and disparities in research, doctors offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.

Women who have exercised their rights to services such as abortion also face a real, harmful stigma that can affect their ability to seek and access care.[35] These effects can extend to not "seeking or receiving social support," or experiencing "economic costs" when women "feel they must conceal their abortions.[36] Additionally, this stigma could result in providers being less likely or able to be trained to provide abortion procedures,[37] leading to even fewer avenues for women to access safe abortion services.

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[33] For documented instances where religious health care providers denied care to patients on the basis of religious beliefs, *see* Compl. 2, *ACLU of Mich. v. Trinity Health Corp*., 2016 U.S. Dist. LEXIS 30690 (E.D. Mich. Mar. 10, 2016); Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUBLIC HEALTH 1774 (2008), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/; National Women's Law Center, *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/ (last visited Oct. 20, 2017).

[34] Jones, R.K. (2011). Beyond Birth Control: The Overlooked Benefits of Oral Contraceptive Pills. Retrieved from http://www.guttmacher.org/pubs/Beyond-Birth-Control.pdf. Over 99% of sexually-active women using at least one method of contraception at some point during their lifetime. Guttmacher Institute, *Contraceptive Use in the United States*, (September 2016) https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states.

[35] Alison Norris et. al., WOMEN'S HEALTH ISSUES, "Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences" (2011), https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/Abortion-Stigma.pdf.

[36] *Id.* at 4.

[37] *Id.* at 8.

Similarly, transgender, nonbinary, and gender nonconforming people already experience high rates of discrimination and harassment in health care. In fact, "the data show that health care providers most often discriminate against transgender people *simply for being who they are* –not based on the care they need."[38] According to the 2015 U.S. Transgender Survey, 33 percent had at least one negative experience in a health care setting relating to their gender identity in the past year. Rates were higher for Native respondents (50 percent), Middle Eastern respondents (40 percent), multiracial respondents (38 percent), and respondents with disabilities (42 percent). Moreover, a 2018 study from the Center for American Progress indicated that 23 percent of transgender, nonbinary, and gender nonconforming patients had a provider intentionally misgender or use the wrong name for them, 21 percent had a provider use harsh or abusive language when treating them, and 29 percent experienced unwanted physical contact, such as fondling, sexual assault, or rape, from a provider. The Proposed Rule could impermissibly open the door to further discrimination.

LGBTQ people, and especially transgender, nonbinary, and gender nonconforming people, also face unique barriers to accessing reproductive health care. Under the proposed rule, those barriers would only increase. For example, transgender, nonbinary, and gender nonconforming people assigned female at birth whose gender marker is male or nonbinary could be denied coverage for necessary care such as a pap smear or mammogram. Likewise, transgender nonbinary, and gender nonconforming people assigned male at birth whose gender marker is female or nonbinary could be denied coverage for necessary care, such as a prostate exam.

Together, systemic barriers to care and fear of discrimination lead transgender, nonbinary, and gender nonconforming people to avoid care. According to the 2015 U.S. Transgender Survey, 23 percent did not seek health care when they needed it due to fear of being disrespected or mistreated as a transgender person. Again, rates were higher for Native American respondents (37 percent) and Middle Eastern respondents (34 percent). By emboldening discrimination, the Proposed Rule would only further discourage people from seeking necessary medical care.

B. The Proposed Rule Would Sow Confusion Regarding Provider Duties Under the Emergency Medical Treatment and Active Labor Act.

The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires all hospitals receiving Medicare funds — including those that are private, public, and religiously affiliated — to provide appropriate medical screening to any patient who presents to an emergency room. If the patient is suffering from a medical emergency, the hospital is required to either stabilize the condition or to transfer the patient to another facility that is more equipped to handle the condition.[39] Repealing the Section 1557 Final Rule's definition of "on the basis of sex" would create confusion in the provision of care because, in conjunction with the Denial of Care rule, the Proposed Rule could be interpreted so as to allow providers to violate EMTALA by refusing to provide care to, for example, transgender men or women with emergency complications that require an abortion.

The question whether EMTALA overrules the Denial of Care Rule and/or the Proposed Rule is particularly concerning considering the number of religiously-affiliated hospitals with emergency departments that are the only available providers for miles in certain rural areas. By one count, "Catholic hospitals hold 1 in 6 hospital beds in the United States."[40] While we anticipate that HHS, based on its response to comments in

[38] Sharita Gruberg & Frank J. Bewkes, CENTER FOR AMERICAN PROGRESS, "The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial" (Mar. 7, 2018), https://cdn.americanprogress.org/content/uploads/2018/03/06122027/ACAnondiscrimination-brief2.pdf (emphasis added).
[39] *See* 42 U.S.C. §1395d(e)(3)(A); 42 U.S.C. §1395dd(b).
[40] Emily London & Maggie Siddiqi, CENTER FOR AMERICAN PROGRESS, "Religious Liberty Should Do No Harm" 9 (Apr. 11, 2019), https://www.americanprogress.org/issues/religion/reports/2019/04/11/468041/religious-liberty-no-harm/.

the preamble to the Denial of Care Rule issued in May 2019, will claim that EMTALA and religious exemption will be applied "harmoniously,"[41] their inevitable conflict could lead to violations of this guarantee for emergency care.

C. Repealing the Section 1557 Final Rule's Definition of "On the Basis of Sex" Will Encourage Unlawful Discrimination Against LGBTQI People and Women in Direct Conflict with Constitutional and Statutory Protections.

The Section 1557 Final Rule defines "on the basis of sex" to "include[], but is not limited to, discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity."[42] In the Proposed Rule, HHS would remove this definition from the regulatory text.[43] HHS provides essentially three justifications: (1) one federal district court issued a preliminary injunction against implementation of the definition; (2) HHS should be consistent among definitions within HHS and across federal agencies; and (3) the decision regarding how to implement "on the basis of sex" should be left to the States. None persuades that the Proposed Rule satisfies the Constitution.

The Fifth and Fourteenth Amendments explicitly prohibit the federal government and the states from depriving individuals of their "life, liberty, or property" without due process of law.[44] The Fourteenth Amendment, applicable to the states, expressly extends "equal protection of the laws" to "any person," and although the Fifth Amendment does not contain such a clause, it has been interpreted as embodying principles of equality and anti-discrimination as against the federal government.[45] By rescinding protections from groups courts have already ruled are deserving of them, such as women[46] and gender non-conforming individuals,[47] the Proposed Rule violates the equality principles embodied in the Fifth Amendment, expressly applicable to the federal government, and encourages states to violate the Equal Protection Clause of the Fourteenth Amendment.

The Proposed Rule would allow certain health insurers and health care providers to discriminate against many of the groups that are currently covered by Section 1557, and the opportunity to cut costs would likely encourage them to do so. The Proposed Rule has not set forth an "exceedingly persuasive justification" to allow such disparate treatment, under the "heighted scrutiny" such treatment receives in court.[48] To justify enabling discrimination, HHS asserts that the Section 1557 Final Rule is the only federal regulation defining "sex," and that since other agencies have not supported that definition, rescission is warranted.[49] A purported need for consistency with other definitions is not a remotely, much less "exceedingly" persuasive rationale to allow discrimination. To the contrary, context is important, and any presumption that the phrase "on the basis of sex," and in particular, the term "sex," must mean the same thing regardless of context "readily yields whenever there is such variation in the connection in which the words are used as reasonably to warrant the conclusion that they were employed in different parts of the act with different intent."[50] To

[41] 84 Fed. Reg. 23,170, 23,188 (May 21, 2019).
[42] 81 Fed. Reg. at 31,467/3.
[43] 84 Fed. Reg. at 27,852.
[44] U.S. CONST. amend. V; U.S. CONST. amend. XIV; *see also Frontiero v. Richardson*, 411 U.S. 677 (1973) (applying Fifth Amendment as barring discrimination between men and women in context of military benefits and explaining that "classifications based upon sex, like classifications based upon race, alienage, and national origin, are inherently suspect and must therefore be subjected to close judicial scrutiny"); *United States v. Virginia*, 518 U.S. 515 (1996) (prohibiting state of Virginia from treating women differently in context of military education).
[45] *E.g.*, *Frontiero*, 411 U.S. at 680 n.5.
[46] *Virginia*, 518 U.S. at 531–33.
[47] *E.g.*, *Smith v. City of Salem, Ohio*, 378 F.3d 566, 575 (6th Cir. 2004) (ruling that "[s]ex stereotyping based on a person's gender non-conforming behavior is impermissible discrimination, irrespective of the cause of that behavior").
[48] *Virginia*, 518 U.S. at 531–33.
[49] 84 Fed. Reg. at 27,856.
[50] *Gen. Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581, 595 (2004) (quoting *Atl. Cleaners & Dyers, Inc. v. United States*, 286 U.S. 427, 433 (1932)) (ruling that "age" means "old age" when coupled with the term "discrimination").

be sure, just as "age" is a word that "has several commonly understood meanings among which a speaker can alternate in the course of an ordinary conversation, without being confused,"[51] so too with "sex." In the context of a statutory provision expressly incorporating protections against discrimination in a range of statutes, giving the term its broadest possible meaning is more important than any claimed consistency rationale.

HHS claims that removing the definition of "on the basis of sex" would "significantly restore the ability of States to establish policies in this area, based on their weighing the competing interests at stake."[52] HHS expresses the concern that retaining the Section 1557 Final Rule's definition of "sex" "may stifle the ability of States, local governments, and covered entities to set their own policies and balance multiple competing interests on questions related to gender dysphoria."[53] HHS nowhere explains what "competing interests on questions related to gender dysphoria" could possibly exist, or what "questions" could lead to such competing interests, much less counsel in favor of allowing discriminating against individuals seeking care.

What this rule really would do is to allow states to decide that some groups are not deserving of civil rights protections. HHS' rationale that states are "heavily reliant on the continued receipt of Federal funds subject to Title IX requirements,"[54] and therefore they cannot be expected to extend civil rights protections, could be used to justify rolling back all progress since states first accepted federal funds. In the case of "on the basis of sex," states cannot reasonably argue that they could not have been "cognizant" of the consequences of their participation. Again, then, HHS has failed to demonstrate that an "exceedingly persuasive justification" exists to enable the discrimination inherent in the Proposed Rule.

In sum, by removing civil rights protections from certain groups of people based on specious and unsupported rationales, HHS would enable the discrimination of those groups, in violation of the Constitution.

VI. The Proposed Rule's Narrow Interpretation of the Scope of Covered Entities under Section 1557 Would Further Disadvantage Individuals Seeking Care in Derogation of the Fundamental Right to Health Care.

The Proposed Rule would significantly narrow the scope of entities impacted by this rule and would increase the likelihood that now-exempted entities could engage in discriminatory practices that will negatively impact health and well-being of communities that are currently protected under the 2016 rule. The proposed changes frustrate the original intent of Congress to prevent discrimination under "any health program or activity, any part of which is receiving Federal financial assistance." Organizations that are already inclined towards discrimination will be all the more emboldened by HHS writing them out of their existing anti-discrimination requirements.

The Proposed Rule draws a distinction between "health insurance" and "health care,"[55] unlike the Section 1557 Final Rule which applied to "all of the operations of an entity principally engaged in providing or administering health services or health insurance coverage."[56] OCR justifies this change in interpretation by citing the Civil Rights Restoration Act of 1987 ("CRRA"): "The CRRA… defined "program or

[51] *Id.* at 596.
[52] 84 Fed. Reg. at 27,857.
[53] 84 Fed. Reg. at 27,857.
[54] *Id.*
[55] *See* 84 Fed. Reg. at 27,862.
[56] *See* 81 Fed. Reg. at 31,385.

activity"…to cover all the operations of entities only when they are 'principally engaged in the business of providing education, *health care*, housing, social services, or parks and recreation.'"[57]

The Proposed Rule argues that an entity principally or otherwise engaged in the business of providing health insurance shall not be considered to be principally engaged in the business of providing health care.[58] This means the proposed rule would not apply to Medicare Part B, self-funded health plans under ERISA, the Federal Employees Health Benefits Program, or STLDI plans because those programs do not receive Federal financial assistance from HHS, and the entities operating them would not be considered to be principally engaged in the business of providing health care.

The text of Section 1557 of the ACA is much more expansive and was interpreted accordingly in the Section 1557 Final Rule. The legislative text states that that this title will apply to "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title [1] (or amendments)."[59]

In the Section 1557 Final Rule, HHS stated that including issuers of health insurance coverage was appropriate because "[t]his interpretation serves the central purposes of the ACA, and effectuates Congressional intent, by ensuring that entities principally engaged in health services, health insurance coverage, or other health coverage do not discriminate in any of their programs and activities, thereby enhancing access to services and coverage."[60] This rationale is still true today. The Proposed Rule ignores the fact that health insurance programs are vital to the provision of health care in the United States. In controlling how health care is paid for, how benefits are designed and which providers are within their networks, health insurance programs have vast influence over access to and the provision of health care to Americans.

Indeed, HHS even cites a definition of health insurance coverage at 42 U.S.C. § 300gg-91 that includes "benefits consisting of *medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care)* under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer." (emphasis added) This very definition makes it clear that the provision of health insurance coverage is inextricably linked to the provision of health care itself.

Further, Section 1557 applies to "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or *contracts of insurance*…" (emphasis added). This strongly suggests that Congress intended for the law to apply to entities receiving a contract of insurance from the Federal government, such as a Federal Employees Health Benefits Program plan. Excluding health insurance programs from the scope of Section 1557 would fundamentally frustrate the objective of Congress, which was to avoid discrimination in the provision of health care, including denial of benefits. This change will encourage unlawful discrimination against specific communities, including LGBTQI people and women as discussed above, in direct conflict with existing constitutional and statutory protections.

Differing insurance products determine not only what will be covered but also drive access to care with provider networks designing them to include or exclude persons. As explained above, there is no distinction between health care and health insurance. Insurance companies will use benefit design and coverage decision-making to limit and exclude treatment for patients and discriminate against them. For example,

[57] *See* 84 Fed. Reg. at 27,862.
[58] *See* 84 Fed. Reg. at 27,863.
[59] 42 U.S.C. § 18116.
[60] *See* 81 Fed. Reg. at 31,386.

insurers could put therapies or medications specific to LGBTQI or women's health in the highest cost-sharing tier, while not doing so for other conditions. Insurers could use provider networks to exclude particular providers based on the scope of their practice including women's reproductive health care or health care for LGBTQI individuals.

VII. The Proposed Rule Would Make Access to Care More Difficult for People with Limited English Proficiency.

Section 1557 of the Affordable Care Act , along with other non-discrimination laws that are incorporated into Section 1557, provide necessary protections to ensure every person has access to health care on a non-discriminatory basis. Equal access to health care is a fundamental human right — regardless of one's national origin or language. Central to respecting the dignity of all, a core Jewish value, is ensuring that all people receive information that can affect their rights in a way they can understand. People cannot understand what they cannot read, much less what they hear in a language they do not speak. Indeed, the principle of informed consent underlying modern medical practice cannot possibly be met when individuals do not know what they are being asked to consent to. Nevertheless, the proposed revisions to Section 1557 of the ACA seek to repeal certain provisions that provide individuals with limited English proficiency ("LEP") with necessary language services.

In underserved communities, laws like Section 1557 can make all the difference in patients receiving the care they are entitled to. The proposed revisions would open the door to national origin discrimination in health care, and the existing protections of Section 1557 should remain in place.

Ensuring language access touches the lives of millions of Americans, 25 million of whom are LEP.[61] As discussed more below, research has shown that language barriers negatively impact the quality of care and ability of a person to access care and maintain coverage. Existing protections ensure LEP persons understand their rights and help limit the barriers they have to accessing quality health care. The revisions to Section 1557, on the other hand, would raise language barriers. While OCR claims that this might save money, this justification does not outweigh the pernicious impact the rule change will have on individuals with LEP and does not account for the increased costs the health care system will ultimately bear when LEP individuals are placed at higher risk by reduced access to and impaired understanding of medical care.

Research has proven that health care quality and outcomes improve for LEP patients and families when professional interpreters are used or language-concordant providers are available. Although professional interpretation can present logistical and financial challenges for health care providers, many LEP patients do not have access to quality health care without such services. And given that such institutions are receiving federal funding, they must comply with the federal requirement not to discriminate based on individuals with a different national origin. Part of this obligation is to provide individuals with LEP adequate translation services.[62] Providing such services is particularly essential in the health care sphere as

[61] Migration Policy Institute (MPI) tabulations from the U.S. Census Bureau's 1990 and 2000 Decennial Censuses and 2010 and 2013 American Community Surveys (ACS), available at: https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states.

[62] *See, e.g.*, U.S. Dep't of Health and Human Services Office for Civil Rights, Settlement Agreement with AL Dep't of Human Resources (Oct. 25, 2017) ("OCR's investigation found that the father's LEP was a significant factor in ADHR's failure to provide timely language assistance and other services essential for reunification. Additionally, OCR's investigation found that ADHR consistently failed to take reasonable steps to ensure meaningful access to its programs by Latino persons with LEP. Thus, OCR determined that ADHR administered its programs in a manner that had the effect of delaying or denying access to its programs and services on the basis of national origin in violation of Title VI," *available at* https://www.hhs.gov/sites/default/files/alabama-child-welfare-agreement.pdf; U.S. Dep't of Health and Human Services Office for Civil Rights, Resolution Agreement with MI Dep't of Human Services Division of Family & Children's Services, Transaction Numbers 09-099895/10-109106 (Apr. 15, 2014), ("The compliance review was initiated in response to information received from the U.S. Department of Justice that indicated MDHS-DFCS may be discriminating against persons based on their national origin (Hispanic) in violation of Title VI of the Civil Rights Act of 1964 (Title VI) in the operation of its programs by failing to ensure that limited English proficient (LEP) persons have meaningful access to its

that LEP patients might otherwise avoid or postpone seeking the medical care they require out of fear of discrimination or mistreatment due to their national origin or the language they speak.

HHS should not prioritize lowering costs for providers at the expense of these patients. LEP has been shown as a risk factor for health disparities including access and medical errors that may have disastrous effects on patient safety. Although translation services may lead to a marginal increase in operating costs for health care providers, these costs are far outweighed by the costs associated with "medical errors, greater malpractice risk, poor quality of care, and disparities in morbidity and mortality between English-speaking patients and those with limited English proficiency."[63] Providers have a number of options to minimize costs, including the use of pooled resources and remote translators. In fact, HHS' own breakdown of the costs demonstrates that, per party insured, the costs are minimal. Surely providers have passed along larger costs to their patients and insureds. The minimal cost per patient is the relevant benchmark, not the total.

It is important to note that individuals with limited English proficiency are also more likely to be individuals with difficulty accessing other resources, including transportation, making it even more important for those individuals to know their rights. What's more, these individuals may also fall within a category now allowed to be subject to discrimination by the Proposed Rule, further compromising their access to care.

Disadvantaging an individual on the basis of his or her English proficiency is inextricably linked to discrimination on the basis of national origin. Those who are seeking health care cannot be assumed to be aware of their rights. Making people aware of their rights is integral to the values of justice and dignity for all central to faith communities. Created in the image of the divine, Jews believe that *every person* has the right to be understood and to understand. The different languages we speak are but one manifestation of the wonderful abundance of creation. To respect this creation, OCR should retain the existing requirements of Section 1557 as they pertain to LEP individuals.

VIII. The Proposed Rule Violates the Rulemaking Requirements of the Administrative Procedure Act.

The discussion above demonstrates that the Proposed Rule is unconstitutional and, simply put, bad policy. In addition, the Proposed Rule violates basic principles of law applicable to agency decisionmaking, further demonstrating why it should not be finalized and why the Section 1557 Final Rule should remain in place.

As a rulemaking exercise of an executive branch agency, the Administrative Procedure Act ("APA") applies to the Proposed Rule. The APA imposes important procedural requirements on the actions of executive branch agencies, including when agencies are "formulating, amending or repealing" a rule.[64] The APA requires courts to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,"[65] "contrary to a constitutional right,"[66] or "in excess of statutory jurisdiction."[67]

Here, the Proposed Rule fails in a number of respects, but two are of particular note: First, the Proposed Rule violates Section 1557 by enabling individuals and institutions to deny care that Section 1557 requires they provide. As such, HHS lacks the statutory authority to promulgate the Proposed Rule. Second, HHS' rationale for the Proposed Rule is arbitrary and capricious. HHS has failed to provide a reasoned explanation

programs and services." As a result, MDHS-DFCS agreed to expand language services to resolve the complaints), *available at* https://www.hhs.gov/sites/default/files/ocr/civilrights/activities/agreements/miss_dhs_vra.pdf; *see also* 42 U.S.C. § 2000d; 45 C.F.R. Part 80.

[63] Elizabeth A. Jacobs, et. al., Shared Networks of Interpreter Services, At Relatively Low Cost, Can Help Providers Serve Patients With Limited English Skills, Health Affairs, Vol. 30, No. 10, (Oct. 2011), *available at* https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0667.

[64] 5 U.S.C. § 551(5).

[65] 5 U.S.C. § 706(2)(A).

[66] 5 U.S.C. § 706(2)(B).

[67] 5 U.S.C. § 706(2)(C).

for why the facts and rationale it relied upon just three years ago when promulgating the Section 1557 Final Rule are no longer persuasive, and why such an opposite result should prevail today. Additionally, HHS has justified the Proposed Rule based on cost considerations, but has analyzed only one side of the equation, completely ignoring costs to patients.

A. Section 1557 Prohibits the Discrimination the Proposed Rule Would Enable.

The APA requires courts to set aside rules that run contrary to the statute they purport to interpret.[68] Section 1557 of the ACA, by its own terms, prohibits sex discrimination in certain health programs and activities.[69] By permitting objecting institutions to deny coverage for contraceptives, transition-related services, and numerous other services; and by improperly narrowing the scope of beneficiary protections to only health care programs and activities and to programs and activities administered by executive agencies, the Proposed Rule enables violations of the statute it intends to interpret and must be set aside on that basis.

The Proposed Rule also arbitrarily fails to recognize the large amount of case law contrary to HHS' view. Instead of examining this case law in determining the ability of HHS to promulgate the Proposed Rule, HHS relies on the preliminary injunction issued in *Franciscan Alliance Inc. v. Burwell* to justify the change in policy. But a preliminary injunction in a district court case does not require a change in HHS policy and, in any event, is contrary to the weight of case law. Over twenty years ago, a court recognized that discrimination based on the fact that a woman had had an abortion was sex discrimination, *i.e.*, discrimination "on the basis of sex."[70] Moreover, being prohibited from discriminating against someone because they had an abortion is in no way related to any requirement to provide abortions. Indeed, Title IX itself expressly does not permit penalties based on a woman's prior termination of pregnancy.[71] Nor does Title IX exclude gender identity from its protections. For example, the court in *Adams v. School Board of St. Johns Cty.* held that "the meaning of 'sex' in Title IX includes 'gender identity' for the purposes of its application to transgender students."[72] The NPRM correctly notes that the Supreme Court has not settled the matter for purposes of Title IX; however, in a related context — Title VII of the Civil Rights Act — the Court stated:

> [W]e are beyond the day when an employer could evaluate employees by assuming or insisting that they matched the stereotype associated with their group, for in forbidding employers to discriminate against individuals because of their sex, Congress intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes.[73]

The NPRM ignores entirely that the Sixth Circuit has applied this reasoning to extend Title VII's protections, ruling that "[s]ex stereotyping based on a person's gender non-conforming behavior is impermissible discrimination, irrespective of the cause of that behavior."[74] Although Section 1557 does not expressly incorporate Title VII, it does incorporate Title IX, and this Title VII protection has also been applied in the Title IX context.[75]

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[68] 5 U.S.C. § 706.
[69] 42 U.S.C. § 18116.
[70] *Turic v. Holland Hosp., Inc.*, 85 F.3d 1211, 1214 (6th Cir. 1996) (holding an employer who discriminates against an employee who has exercised right to access abortion violates Title VII prohibition on sex discrimination).
[71] 20 U.S.C. § 1688.
[72] 318 F. Supp. 3d 1293, 1325 (M.D. Fla. July 26, 2018); *see also A.H. v. Minersville Area Sch. Dist.*, 290 F. Supp. 3d 321 (M.D. Pa. Nov. 22, 2017) (holding that plaintiff successfully stated a claim where plaintiff alleged discrimination based on gender identity).
[73] *Price Waterhouse v. Hopkins*, 490 U.S. 228, 251 (1989) (internal quotation marks and citation omitted).
[74] *Smith v. City of Salem, Ohio*, 378 F.3d 566, 575 (6th Cir. 2004).
[75] *Johnston v. Univ. of Pittsburgh of Com. Sys. of Higher Educ.*, 97 F. Supp. 3d 657, 680 (W.D. Pa. 2015), *appeal dismissed*, No. 15-2022 (3d Cir. Mar. 30, 2016) (applying Title VII sex-stereotyping rulings to Title IX claims of transgender individual).

Relying instead on litigation positions in unsettled matters as HHS does here by invoking *Franciscan Alliance* offers no support for HHS' policy change and does not provide a sound basis for a reasoned analysis under the APA.[76] Moreover, HHS' wholesale avoidance of *any* contrary case law in the Proposed Rule demonstrates the one-sided nature of the agency's decisionmaking, yet another reason it violates the APA.

B. HHS Has Failed to Justify Its Abrupt About-Face from the Section 1557 Final Rule, or Otherwise Provide a Reasoned Explanation for the Proposed Rule.

When an agency proposes a change in position, it must "display awareness that it is changing position" and "show that there are good reasons for the new policy."[77] The agency must provide a more detailed justification where, as here, "its new policy rests upon factual findings that contradict those which underlay its prior policy; or when its prior policy has engendered serious reliance interests that must be taken into account."[78] Ultimately, "a reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy."[79]

Here, HHS proposes to remove important protections offered by the Section 1557 Final Rule.[80] HHS has failed to provide a reasoned analysis for why it decided to change in position, much less the substance of those changes. HHS fails to account for the extensive history of health care discrimination that LGBTQI individuals and individuals seeking reproductive care have suffered as noted above, and it provides no contrary data to counter the original factual findings in the Section 1557 Final Rule. Furthermore, individuals have reasonably placed their reliance upon the federal government to protect their civil rights as explained in the Section 1557 Final Rule. The Proposed Rule fails entirely to address these concerns, and as such is arbitrary and capricious.

In addition to representing an arbitrary shift from the Section 1557 Final Rule, the Proposed Rule fails on its own merits because HHS has not adequately explained its reasoning. For example, HHS has identified cost[81] and regulatory burdens[82] as primary factors in its proposal to rescind the Section 1557 Final Rule. Setting aside the question of whether factors such as cost are even relevant in a rulemaking interpreting civil rights protections, having put these factors at issue, the APA requires HHS to consider all important aspects of those factors, and adequately explain the agency's conclusions.[83]

The Proposed Rule's cost-benefit and regulatory analyses are woefully deficient, analyzing only costs and impacts to providers, not costs and other impacts to individuals needing care. Focusing on the burdens imposed by the notice and tagline requirements,[84] the NPRM offers six reasons why the costs do not justify the need.[85] Each reason focuses on either the ineffectiveness, lack of evidence of benefit, or burden of implementation.[86] Aside from relying on questionable or attenuated data sets, HHS also fails to provide support for its position because it does not balance the considerations against any need. It overstates the

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[76] *See* 84 Fed. Reg. at 27,853.
[77] *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009).
[78] *Id.*; *see also Perez v. Mortgage Bankers Ass'n*, 135 S.Ct. 1199 (2015) (reaffirming that an agency must provide "more substantial justification" when its previous policy engendered serious reliance interests or its new policy relies on facts contrary to those relied on for the previous policy).
[79] *F.C.C. v. Fox Television Stations*, 556 U.S. at 516.
[80] 45 C.F.R. pt. 92.
[81] *See* 84 Fed. Reg. at 27,857–60.
[82] *Id.* at 27,872–77.
[83] *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co. ("MVMA")*, 463 U.S. 29, 43 (1983).
[84] The Section 1557 Final Rule requires notices of nondiscrimination and taglines be appended to all "significant" publications and communications (larger than a postcard or brochure) sent by covered entities to beneficiaries, enrollees, applicants, or members of the public. 45 C.F.R. § 92.8(f)(1).
[85] 84 Fed. Reg. at 27,859.
[86] *Id.*

import of these regulatory costs of compliance, which alone do not justify the proposed changes. HHS ignores the costs to individuals — financial, health-related, and otherwise — when services are denied, or when providers are allowed to discriminate against them in the provision of services. HHS does not attempt to quantify, for example, the number of women who will suffer irreparable health effects or death should they be refused services due to complications from an abortion, *or even a miscarriage*.[87] Nor does HHS concern itself with the psychological impacts to LGBTQI individuals, much less the health effects, of being provided inadequate care or being denied care entirely due to gender identity or presentation.

Almost two-thirds of Americans face medical debt.[88] Policies that would remove necessary coverage would only result in additional debt, lifelong health implications, or both, without a compelling justification. The federal government should be focusing its resources expanding coverage, not arbitrarily making it easier for plans to discriminate and take coverage away.

By not accounting for *any* cost or other impacts on patients or providers, HHS has "entirely failed to consider an important aspect of the problem," a hallmark of arbitrary and capricious decisionmaking.[89]

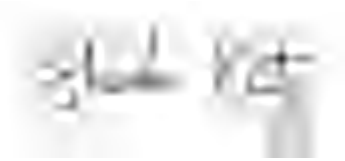
IX. Conclusion

Thank you for the opportunity to provide comments on the Proposed Rule for Nondiscrimination in Health and Health Education Programs or Activities. We trust that these comments, along with the many others we expect the Department will receive, will demonstrate how damaging and unjust the Proposed Rule would be to numerous individuals, whether members of a faith community or not. We hope that HHS will come to understand that this Proposed Rule prioritizes the religious liberty of the few[90] — typically the powerful and wealthy — over the dignity and conscience of the many — often vulnerable and already disadvantaged — and unconstitutionally interferes with the rights of individuals to make decisions regarding their own care based on their own conscience and faith. In discriminating against the religious liberty of the individual, this Proposed Rule upends the protections the Constitution is supposed to provide.

We believe the Department has the duty not to finalize this damaging rule and recognize once more that full access to health care should be available to all.

Please do not hesitate to contact Shannon Russell, Legislative Associate, at srussell@ncjw.org to provide further information.

Respectfully submitted,



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CEO
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[87] Nancy Northrup, HUFFINGTON POST, "New Bill Would Allow Religious Hospitals to Deny Life-Saving Emergency Care" (Feb. 14, 2011), https://www.huffpost.com/entry/new-bill-would-allow-reli_b_822168.
[88] https://www.commonwealthfund.org/publications/newsletter-article/survey-79-million-americans-have-problems-medical-bills-or-debt
[89] *MVMA*, 463 U.S. at 44.
[90] Gruberg *et al.*, CENTER FOR AMERICAN PROGRESS, "Religious Liberty for a Select Few" 2–3 (explaining effect of these types of policies as "protecting the religious liberty of only [a] small segment of Americans"—"conservative Christians"), *available at* https://cdn.americanprogress.org/content/uploads/2018/04/03074429/ReligiousExemptions-report-5.pdf.

EXHIBIT D-14

August 13, 2019

Sent Via Public Comment Online

The Honorable Alex Azar
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Azar,

We are interdisciplinary healthcare professionals whose collective experience spans many decades. As leaders and practitioners from across Johns Hopkins Medicine, we are steadfast in our commitment to ensure that all patients can access medical care. Further, we strive to reduce health disparities and health inequities for those marginalized communities who, historically, have been denied care because of discrimination and prejudice. Accordingly, we oppose the Department's proposed rule that will remove anti-discrimination protections on the bases of sexual orientation and gender identity from Section 1557 of the Affordable Care Act.

In *HealthyPeople 2020*, HHS recognized that societal stigmatization and discrimination targeted at sexual and gender minorities contributes to the health disparities and health inequities faced by these communities. In our practices, we often encounter LGBTQ patients who come to us for care after being rejected by other providers and organizations outright, being harassed by providers or staff elsewhere, being denied insurance coverage for medically necessary care, or after having received substandard care due to ignorance of LGBTQ health issues. Section 1557 was intended to prevent these types of incidents.

A challenge for us is to create an environment that can overcome the fear of discrimination that many in the LGBTQ community rightfully harbor when seeking medical care. This fear, based on a well-documented history, contributes to delay or avoidance of care that, in turn, contributes to exacerbation of chronic health issues, health deterioration, and an increase in the need for more complex medical interventions. All of this results in poorer community health and an increase in medical costs affecting the entire healthcare system.

Evidence, best practices, and medical science underpin academic medicine. The research on minority populations demonstrates that societal discrimination is a major contributor to negative health outcomes. Two major studies, conducted five years apart, reflect the persistent negative impact of discrimination in healthcare for transgender patients. In 2011, the National Transgender Discrimination Survey reported that 28% of respondents postponed seeking medical care due to a fear of discrimination. That fear is understandable; because 19% reported being refused care, 28% reported being harassed by healthcare workers when seeking care and 2% reported being the victims of violence in health care settings. In 2015, in the U.S. Trans Survey, 23% reported delaying care because of fear of anti-transgender bias while 33% of those who has sought care in the year prior to the survey had a negative experience with healthcare providers due to anti-transgender prejudice or a lack of practitioner competence in transgender health issues.

The purpose of Section 1557 was to ensure that medically underserved communities that face barriers to access to care, would have that access to care unencumbered by the prejudice of health care providers and organizations. The proposed rule would remove protections for LGBTQ patients and would serve to perpetuate the health inequities faced by these communities. This proposed rule ignores evidence-based medicine and merely serves to embolden those who seek to harm LGBTQ people by impeding their access to medical care. This proposed rule should not be enacted.

Respectfully,

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EXHIBIT D-15

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August 13, 2019

By Electronic Submission

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Section 1557 NPRM, RIN 0945–AA1
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

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

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

Dear Secretary Azar and Mr. Severino:

The Transgender Legal Defense & Education Fund (TLDEF) is a 501(c)(3) nonprofit whose mission is to end discrimination and achieve equality for transgender and non-binary people, particularly those in our most vulnerable communities. We provide legal representation to transgender individuals who have been subject to discrimination, focusing on the key issues of employment, education, public accommodations, and healthcare. We also provide public education on transgender rights.

TLDEF appreciates the opportunity to comment on the Notice of Proposed Rulemaking Regarding Nondiscrimination in Health Programs and Activities under Section 1557 of the Patient Protection and Affordable Care Act (ACA). Section 1557 contributes to the health equity of the transgender community, promotes equal access to healthcare for all, and increases affordability and accessibility of coverage and care for all individuals.

TLDEF opposes the proposed rule and the rolling back of explicit and necessary protections for transgender individuals.[1] The proposed rule will be detrimental to transgender people by threatening to mislead individuals and institutions into thinking that discrimination against transgender individuals seeking to access medically necessary health care is permissible even though it is still prohibited by statute. It is also inconsistent with existing jurisprudence, other anti-discrimination legislation and general healthcare and insurance trends. This will cause unnecessary confusion and have a chilling effect on transgender people seeking to access healthcare.

TLDEF also opposes the proposed changes to roll back other, long-standing rules that prohibit discrimination on the basis of gender identity and sexual orientation.[2] These changes are outside of the Office for Civil Rights' (OCR) jurisdiction and are unrelated to Section 1557 of the ACA. It is not appropriate for these rulemakings to be combined, and it is arbitrary and capricious for HHS to characterize them as "conforming amendments" without offering any legal, policy or cost-benefit analysis about them and their impacts on various CMS programs. In particular, HHS offers no analysis of the impact these regulations have had during the years—in some cases over a decade—that they have been in effect or the impact of changing them now.

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[1] These are currently codified at 45 C.F.R. pt. 92.

[2] 45 CFR 155.120(c)(1)(ii) and 155.220(j)(2), 45 CFR 147.104(e), 45 CFR 156.200(e) and 156.1230(b)(3), 42 CFR 460.98(b)(3) and 460.112(a), 42 CFR 438.3(d)(4), 438.206(c)(2), and 440.262.

1. The proposed rule threatens transgender patients' access to healthcare.

1.1. Transgender people face pervasive discrimination in healthcare settings.

Transgender people have been subject to pervasive discrimination, particularly with regard to accessing healthcare. While this discrimination has begun to lessen, transgender people still experience much prejudice and violence. In addition to the direct harm to transgender individuals who are denied care or receive substandard care, this also has a chilling effect: 23% of transgender individuals in 2015 reported that they did not see a doctor when they needed to because of fear of being mistreated.[3] Transgender people are also more likely to live with psychological distress, with 40% having attempted suicide in their lifetime, nine times higher than the general population.[4]

In a survey by the Center for American Progress, of transgender people who had visited a doctor or healthcare providers' office in the past year, 29 percent said a doctor or other healthcare provider refused to see them because of their actual or perceived gender identity, 12 percent said a doctor or other healthcare provider refused to give them healthcare related to gender transition; 23 percent said a doctor or other healthcare provider intentionally misgendered them or used the wrong name; 21 percent said a doctor or other healthcare provider used harsh or abusive language when treating them; and 29 percent said that they experienced unwanted physical contact from a doctor or other healthcare provider (such as fondling, sexual assault, or rape).[5]

Many members of the LGBTQ community have a "high degree of

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[3] 2015 U.S. Transgender Survey Report, at 10, available at https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[4] *Id.* at 5.

[5] Center for American Progress, *Discrimination Prevents LGBTQ People from Accessing Healthcare* (January 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care.

anticipation and belief that they w[ill] face discriminatory care" which ultimately causes many people to not seek the essential care that they need.[6] For many transgender and gender-nonconforming people the fear of potential negative treatment from health care professionals is even more exacerbated.

1.1. Eliminating 42 C.F.R. § 92.207(b)(3), the explicit ban denying sex-specific care to transgender individuals, would hinder the enforcement of Section 1557.

Regulations explicitly prohibiting denials of sex-specific care are important to ensuring that transgender individuals receive equal access to basic preventative care including gynecological visits and cancer screenings. Prior to the 2016 regulations, denials of sex-specific care were rampant. For example, in 2012, a transgender woman who was denied coverage for a mammogram because her insurance company had recorded her sex as male required TLDEF's assistance to get this critical preventative procedure.[7] Similarly, OCR investigated the discriminatory exclusion of transgender women from a CDC-funded mammogram program, resulting in the CDC issuing new guidance clarifying that transgender women can participate in the program.[8] Without clear protections for sex-specific care, transgender people risk having to fight for preventative care even though it is covered under Section 1557's nondiscrimination requirements.

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[6] Lambda Legal, W*hen Health Care Isn't Caring, Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV,* at 6 (2010), http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf.

[7] Susan Donaldson James, *Transgender Woman Wins Insurance Coverage for Mammogram*, ABC NEWS, May 1, 2012, https://abcnews.go.com/Health/transgender-woman-wins-health-coverage-mammogram/story?id=16246219.

[8] U.S. Dep't of Health and Human Services, *OCR Enforcement under Section 1557 of the Affordable Care Act Sex Discrimination Cases*, (Sept. 23, 2015), https://web.archive.org/web/20150923030557/http:/www.hhs.gov/ocr/civilrights/understanding/section1557/casesum.html.

1.2. Eliminating 42 C.F.R. § 92.207(b)(4), the explicit ban on categorical exclusions for transgender-related healthcare, would hinder the enforcement of Section 1557.

TLDEF routinely receives requests for assistance with accessing healthcare. We are currently pursuing litigation against the state employee health plan of North Carolina because it contains an explicit exclusion for transgender-related health care.[9] As detailed in the complaint, the state health plan removed an exclusion for coverage for gender-affirming healthcare in 2017 in response to the 2016 Section 1557 regulations, but aided by the confusion created by *Franciscan Alliance, Inc. v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016), reinstated it in 2018. One plaintiff had surgery preauthorized in 2017 that was scheduled for 2018 and thus was no longer covered. Another plaintiff had treatment that was begun in 2017, and in 2019 had to purchase an individual plan on the Marketplace in order to continue to receive care. That this lawsuit's claims rely on Section 1557 and not to the regulations points to the reality that a categorical exclusion for transgender-related health care is prohibited under the statute. Eliminating 45 C.F.R. § 92.207(b)(4), which makes that prohibition explicit, may cause covered entities to continue to be mislead into engaging in unlawful practices for which they will face liability. Repealing the regulations will only lead to further confusion and litigation that hinders the enforcement of Section 1557.

1.3. Eliminating 42 C.F.R. § 92.207(b)(5), the explicit ban on discriminatory denials of insurance coverage for transgender-related healthcare, would hinder the enforcement of Section 1557.

Transgender people face many denials of insurance coverage caused not by categorical exclusions for all transgender-related healthcare, but by the care being deemed not medically necessary. For example, TLDEF currently represents transgender women who have been denied chest reassignment surgery by a major insurance company pursuant to its nationwide clinical policy that states that chest

[9] *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C. filed March 11, 2019).

reassignment surgery for transgender women—but not transgender men—is categorically considered to be not medically necessary and therefore excluded. Such a policy is clearly unlawful under 45 C.F.R. § 92.207(b)(5), which prohibits denying or limiting coverage "for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual." Targeted exclusions for other procedures such as facial gender reassignment surgery or surgery for people who are under age 18 are still commonly maintained by covered entities. TLDEF receives numerous requests for assistance to challenge such denials in public and private insurance, including Medicaid. Retention and enforcement of § 92.207(b)(5) is essential to prohibit these discriminatory denials of healthcare on the grounds of sex.

1.4. Eliminating 42 C.F.R. § 92.206, which requires equal program access on the basis of sex, would hinder the enforcement of Section 1557.

Section 92.206 ensures that transgender people can be placed in sex-specific hospital rooms, inpatient mental health facilities, and substance use treatment programs according to their affirmed sex. Not having access to sex-appropriate facilities has dire consequences for transgender people.

1.4.1. Access to substance use facilities.

Transgender individuals are at a higher risk of substance abuse than the general population.[10] Transgender individuals face high levels of

[10] Sari L. Reisner et al., *Substance Use to Cope with Stigma in Healthcare Among U.S. Female-to-Male Trans Masculine Adults*, 2 LGBT HEALTH 324 (2015); Lisa Miller & Anthony Grollman, *The Social Costs of Gender Nonconformity for Transgender Adults: Implications for Discrimination and Health*, 30 SOC. FORUM 809, 825 (2015); Larry Nuttbrock et al., *Gender Abuse, Depressive Symptoms, and Substance Use Among Transgender Women: A 3-Year Prospective Study*, 104 Am. J. of Public Health, 2199 (2014); Tiffany R. Glynn and Jacob J. van den Berg, *A Systematic Review of Interventions to Reduce Problematic Substance Use Among Transgender Individuals: A Call to Action*, 2.1 Transgender Health, 45 (2017); Eric G. Benotsch et al., *Non-Medical Use of Prescription Drugs, Polysubstance Use, and Mental Health in Transgender Adults,* 132 Drug and Alcohol Dependence 391 (2013); Paul Kobrak and Bali White, *Transgender Women and HIV Prevention in New York City: A Needs Assessment* (2011); National Research Council, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* 218 (2011).

prejudice, discrimination, violence, and other forms of stigma.[11] This results in physical effects including increased cortisol levels, anxiety, depression, suicidality, and using substances to cope.[12] Additionally, when transgender people do not have access to transgender-related health care, it is common for people to use substances to self-medicate and attempt to alleviate the symptoms of gender dysphoria.[13] Appropriate treatment for gender dysphoria is known to resolve substance use problems.[14]

Despite high rates of substance use, transgender individuals often encounter difficulties in accessing substance use treatment including discrimination, provider hostility and insensitivity, being barred from participating in sex-specific programs and facilities, and lack of acceptance in sex-appropriate recovery groups. In addition, transgender people who use substances are much more likely to experience challenges completing an education, obtaining stable housing and obtaining employment. Many find that their substance abuse disqualifies them from participating in programs specifically intended to assist them with these challenges.[15]

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[11] Jaclyn M. White Hughto et al., *Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions*, 147 Social Science and Medicine, 222-231 (2015).

[12] *Id.*; Sari L. Reisner et al., *Gender Minority Social Stress in Adolescence: Disparities in Adolescent Bullying and Substance Use by Gender Identity*, 52 J. of Sex Research 243 (2015).

[13] *E.g.*, Robin M. Mathy, *Transgender Identity and Suicidality in a Nonclinical Sample*, 14 J. of Psychology & Human Sexuality, 47, 61 (2003) ("[T]he significant relation between suicide attempts (but not suicidal ideation) and substance use difficulties suggests some transgender individuals may attempt to cope by 'self-medicating.'"); Beth R. Hoffman, *The Interaction of Drug Use, Sex Work, and HIV Among Transgender Women*, 49 Substance Use & Misuse, 1049 (2014) (noting transgender women experienced high rates of depression and anxiety and "engaged in substance use to cope with mental health problems and stress").

[14] *See* Jamil Rehman et al., *The Reported Sex and Surgery Satisfactions of 28 Postoperative Male-to-Female Transsexual Patients*, 28 Archives of Sexual Behavior 71, 83 (1999).

[15] Nina Kammerer et al., *Transgender Health and Social Service Needs in the Context of HIV Risk*, *in* Transgender and HIV: Risks, Prevention and Care (Walter Bockting & Sheila Kirk ed. 2001); K. Clements et al., *HIV Prevention and*

For example, Sabrina Wilson was a 32-year-old homeless transgender woman who was arrested for a drug offense and given the opportunity to participate in a drug treatment program as an alternative to incarceration. The residential program she was assigned to required her to room with men, to use the men's bathroom, and to dress and wear her hair in ways associated with men. The program also denied her participation in women's support groups and she had to attend all-male counseling sessions. These actions constructively forced her out of the facility, which resulted in her being sentenced to 2 1/2 years in jail. When she was released, she successfully filed discrimination charges against the facility under New York law.[16]

In response to on-going reports of lack of access to substance use treatment programs such as that experienced by Ms. Wilson, in 2016, TLDEF undertook a survey of 53 substance use treatment programs in New York and found that 47% engaged in some form of anti-transgender discrimination and 34% would refuse to allow a transgender person to be housed according to their true sex. We took our findings to the NYC Commission on Human Rights, which brought successful enforcement actions under the NYC Human

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Health Service Needs of the Transgender Community in San Francisco, 3 INT'L J. OF TRANSGENDERISM (1999); J. Sperber et al., *Access to Health Care for Transgendered Persons: Results of a Needs Assessment in Boston*, 8 INT'L J. OF TRANSGENDERISM 74 (2005); T. Nemoto et al., *Health and Social Services for Male-To-Female Transgender Persons of Color in San Francisco*, 8 INT'L J. OF TRANSGENDERISM 5 (2005); Samuel Lurie, *Identifying Training Needs of Health-Care Providers Related to Treatment and Care of Transgendered Patients: A Qualitative Needs Assessment Conducted in New England*, 8 INT'L J. OF TRANSGENDERISM 93 (2004); E.L. Lombardi & G. van Servellen, *Building Culturally Sensitive Substance Use Prevention and Treatment Programs for Transgendered Populations*, 19 J. OF SUBSTANCE ABUSE TREATMENT 291 (2002); U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (2012), https://store.samhsa.gov/system/files/sma12-4104.pdf; A.D. Marcel, *Determining barriers to treatment for transsexuals and transgenders in substance abuse programs.* Transgender Education Network, Boston (1998).

[16] *Wilson v. Phoenix House*, 978 N.Y.S.2d 748 (N.Y. Sup. Ct. Kings County 2013).

Rights Law.[17]

If OCR repeals or continues to refuse to defend or enforce this provision, in jurisdictions without such local laws and administrative agencies to rely on, transgender individuals will continue to be forced to hire a lawyer to enforce their rights under Section 1557 instead of being able to file a complaint with OCR. This will decrease enforcement actions. Section 1557 prohibits such discriminatory treatment on the grounds of sex, and substance use facilities need to be made plainly aware of their obligations to prevent unlawful discrimination and the need for litigation after the harm has already occurred.

1.4.1. Access to hospitals and doctor's offices.

Section 92.206 is also important for placement in hospital rooms. OCR previously enforced these provisions to ensure that transgender people could access care in hospitals.[18] In an enforcement action against a hospital in Brooklyn, OCR entered into an agreement to resolve a discrimination complaint alleging that the hospital housed a transgender woman in a double-occupancy patient room with a male occupant.

But TLDEF continues to receive reports of transgender individuals facing inappropriate treatment and harassment in hospitals and doctor's offices, and there is a need for an administrative complaint process for these claims to be heard by OCR. For example, in 2018, a transgender man who suffers from severe anxiety and depression had

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[17] NYC Commission on Human Rights, *NYC Commission on Human Rights Charges Four Substance Abuse Centers with Discriminatory Intake Policies for Transgender Patients* (July 13, 2017), https://www1.nyc.gov/assets/cchr/downloads/pdf/press-releases/Press%20Release%20-%20Substance%20Abuse%20Centers%20FINAL.pdf.

[18] Voluntary Resolution Agreement Between the U.S. Department of Health and Human Services Office for Civil Rights and the Brooklyn Hospital Center, Transaction Number: 12-147291 (2015), https://www.hhs.gov/sites/default/files/ocr/civilrights/activities/agreements/TBHC/vra.pdf; U.S. Dep't of Health and Human Services Office for Civil Rights, The Brooklyn Hospital Center Implements Non-Discriminatory Practices to Ensure Equal Care for Transgender Patients (July 14, 2015), https://www.hhs.gov/sites/default/files/ocr/civilrights/activities/agreements/TBHC/statement.pdf.

an appointment with a gynecologist in Brooklyn and was to schedule a hysterectomy. The staff member who was told to schedule it laughed in his face as if it were a joke. The doctor did not immediately address this situation, and the patient was severely distressed because of it. The patient was also scheduled for another procedure with the doctor but cancelled it due to his fear and discomfort with seeing the doctor or any other doctor again. Because of situations like these, the regulation ensuring "equal access to its health programs or activities without discrimination on the basis of sex"—and its enforcement by OCR—is vital to ensuring that transgender people can do something as basic as being treated with dignity and respect while being treated or hospitalized for serious health needs.

2. Repealing the 2016 Section 1557 rule is arbitrary and capricious, an abuse of discretion, or otherwise not in accordance with the law.

The 2016 implementing rule is sound, has been crucial for transgender patients to be able to access the care that they need, and promotes equal access to medically necessary health services. The 2016 Section 1557 implementing final rule was the product of a lengthy process of deliberation and public input. The rule was developed over the course of six years of study and following two comment periods, with over 25,000 comments from stakeholders, which were overwhelmingly supportive of inclusion of protections against discrimination based on sex stereotyping and gender identity. HHS engaged stakeholders through listening sessions, participation in conferences, and other outreach prior to taking regulatory action.

2.1. Eliminating 42 C.F.R. § 92.4, the definition section, is not in accordance with widespread court interpretation of discrimination on the basis of "sex" to include transgender status.

Proposing to eliminate nondiscrimination protections for transgender people contradicts longstanding court precedent. Section 92.4 defines "on the basis of sex" and "gender identity" to make it clear to covered entities that discrimination based on transgender status is unlawful. "Sex" in civil rights law has

universally been interpreted to include discrimination based on sex stereotypes and transgender status in multiple areas including employment (Title VII), education (Title IX), Equal Protection, and Section 1557 itself.

It is well-settled law that anti-transgender discrimination is prohibited sex discrimination under Title IX.[19] Cases to the contrary are readily distinguished.[20] Discriminating in insurance on the basis that the care sought is intended to change sex characteristics is inherently sex discrimination.[21]

A robust body of case law similarly holds that discriminatory

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[19] *See, e.g., Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1046-47 (7th Cir. 2017) (distinguishing *Ulane v. Eastern Airlines, Inc.*, 742 F.2d 1081 (7th Cir. 1984) and holding that Title IX prohibits treating transgender students differently from non-transgender students), *petition for cert. dismissed*, No.17-301, 138 S. Ct. 1260 (Mar. 5, 2018); *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217, 221 (6th Cir. 2016) (denying motion to stay preliminary injunction that prevented school district from excluding transgender girl from the girls' restroom); *Adams by Kasper v. Sch. Bd. of St. Johns Cty.*, 318 F. Supp. 3d 1293, 1298 (M.D. Fla. 2018), appeal docketed, No. 18-13592 (11th Cir. Aug. 24, 2018); *Grimm v. Gloucester County School Board*, No. 4:15-cv-54, 2019 WL 3774118 (E.D. Va. Aug. 9, 2019); *M.A.B. v. Bd. of Educ. of Talbot Cty.*, 286 F.Supp.3d 704 (D. Md. 2018); *A.H. v. Minersville Area Sch. Dist.*, 290 F.Supp.3d 321 (M.D. Pa. Nov. 22, 2017); *Bd. of Educ. of the Highland Local Sch. Dist. v. U.S. Dep't. of Educ.*, 208 F. Supp. 3d 850, 856-58 (S.D. Ohio 2016), *stay pending appeal denied sub nom.*, *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217 (6th Cir. 2016). *See also Doe by & through Doe v. Boyertown Area Sch. Dist.*, 897 F.3d 518, 533 (3d Cir. 2018), *cert. denied sub nom. Doe v. Boyertown Area Sch. Dist.*, 139 S. Ct. 2636 (2019) (agreeing that allowing boys and girls who are transgender to use sex-specific restrooms and locker rooms did not raise privacy concerns and "barring transgender students from restrooms that align with their gender identity would itself pose a potential Title IX violation."); *Students & Parents for Privacy v. U.S. Dep't of Educ.*, No. 16-cv-4945, 2016 WL 6134121, at *28-29 (N.D. Ill. Oct. 18, 2016) (report and recommendation) (same), *adopted by* 2017 WL 6629520 (N.D. Ill. Dec. 29, 2017).

[20] *Johnston v. Univ. of Pittsburgh*, 97 F.Supp.3d 657 (W.D. Pa. Mar. 31, 2015) (relying on outdated precedent to hold that Title IX does not prohibit discrimination based on gender identity or transgender status per se); *Texas v. United States*, 201 F.Supp.3d 810 (N.D. Tex. Aug. 21, 2016) (finding in a preliminary injunction that Title IX permitted bathrooms to be separated based on sex in light of specific regulations under Title IX).

[21] *See Franciscan Alliance, Inc. v. Burwell*, 227 F.Supp.3d 660, 688 (N.D. Tex. Dec. 31, 2016) ("[T]he text, structure, and purpose reveal that the definition of sex in Title IX's prohibition of sex discrimination unambiguously prevented discrimination on the basis of the biological differences between males and females.").

treatment of transgender individuals must needs be sex discrimination under Title VII. In 2012, the Equal Employment Opportunity Commission (EEOC) held that "intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination based on sex and such discrimination therefore violates Title VII."[22] As the Sixth Circuit put it, "[b]ecause an employer cannot discriminate against an employee for being transgender without considering that employee's biological sex, discrimination on the basis of transgender status necessarily entails discrimination on the basis of sex."[23] The Supreme Court has recognized sex stereotyping as a component of prohibited sex discrimination.[24] Federal courts, including the First, Sixth, Seventh, Eighth, Ninth, Eleventh and D.C. Circuits explicitly or implicitly agree that discrimination against transgender people is actionable sex discrimination.[25] The Third and Tenth Circuits have

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[22] *Macy v. Dep't. of Justice*, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, at *12 (Apr. 20, 2012). *See also Tamara Lusardi v. John McHugh, Sec'y, Dep't of the Army*, No. 0120133395, 2015 WL 1607756, at *9 (E.E.O.C. Apr. 1, 2015) (finding that "denying transgender individuals access to a restroom consistent with gender identity discriminates on the basis of sex in violation of Title VII.").

[23] *Equal Employment Opportunity Comm'n v. R.G. &. G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 574 (6th Cir. 2018), *cert. granted in part sub nom. R.G. & G.R. Harris Funeral Homes, Inc. v. E.E.O.C.*, No. 18-107, 2019 WL 1756679 (U.S. Apr. 22, 2019).

[24] *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989).

[25] *See Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (recognizing claim for sex discrimination under Equal Credit Opportunity Act, analogizing to Title VII); *Equal Employment Opportunity Comm'n v. R.G. &. G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 574 (6th Cir. 2018), *cert. granted in part sub nom. R.G. & G.R. Harris Funeral Homes, Inc. v. E.E.O.C.*, No. 18-107, 2019 WL 1756679 (U.S. Apr. 22, 2019) (holding "that discrimination on the basis of transgender and transitioning status violates Title VII); *Smith v. City of Salem*, 378 F.3d 566, 574-75 (6th Cir. 2004) ("Price Waterhouse…does not make Title VII protection against sex stereotyping conditional or provide any reason to exclude Title VII coverage for non sex-stereotypical behavior simply because the person is transsexual."); *Hively v. Ivy Tech Cmty. Coll. of Indiana*, 853 F.3d 339, 341 (7th Cir. 2017) (en banc) (upholding a Title VII sexual orientation discrimination claim and implicitly rejecting *Ulane v. Eastern Airlines, Inc.*, 742 F.2d 1081 (7th Cir. 1984)); *Hunter v. United Parcel Serv.*, 697 F.3d 697, 702 (8th Cir. 2012) (evaluating a transgender man's Title VII claim "based on his non-conformity to gender stereotypes or his being perceived as transgendered"); *Schwenk v. Hartford*, 204 F.3d 1187, 1202 (9th Cir. 2000) (relying on Title VII cases to conclude that violence against a transgender woman was violence because of gender under the Gender

assumed that a sex stereotyping claim is available to transgender plaintiffs.[26] Furthermore, dozens of district courts—both within and outside of the circuits that have explicitly recognized sex discrimination claims by transgender people—have found that anti-transgender discrimination is unlawful sex discrimination.[27]

Motivated Violence Act); *Chavez v. Credit Nation Auto Sales*, 641 F. App'x 883, 883 (11th Cir. 2016) ("Sex discrimination includes discrimination against a transgender person for gender nonconformity.") (citing *Glenn v. Brumby*, 663 F.3d 1312, 1316–17 (11th Cir. 2011)); *Evans v. Ga. Reg'l Hosp.*, 850 F.3d 1248, 1265-66 (11th Cir. 2017) (Pryor, J., concurring) (noting that "discrimination against a transsexual because she fails to conform to the employer's view that a birth-assigned male should have male anatomy" constitutes sex discrimination), *cert. denied*, 138 S. Ct. 557 (2017); *Schroer v. Billington*, 577 F. Supp. 2d 293, 306-08 (D.D.C. 2008) (noting that "the Library's refusal to hire Schroer after being advised that she planned to change her anatomical sex by undergoing sex reassignment surgery was literally discrimination 'because of ... sex.'").

[26] *See Stacy v. LSI Corp.*, 544 F. App'x 93, 97-98 (3d Cir. 2013); *Etsitty v. Utah Transit Auth.*, 502 F.3d 1215, 1224 (10th Cir. 2007).

[27] *See, e.g.*, *Fabian v. Hosp. of Cent. Conn.*, 172 F. Supp. 3d 509, 527 (D. Conn. 2016) ("Employment discrimination on the basis of transgender identity is employment discrimination 'because of sex' and constitutes a violation of Title VII of the Civil Rights Act."); *E.E.O.C. v. Rent-a-Center East, Inc.*, 2017 WL 4021130 (C.D. Ill., Sept. 8, 2017) (holding transgender discrimination is actionable under Title VII, relying on 7th Circuit rulings under Title IX (gender identity as sex discrimination) and Title VII (sexual orientation discrimination as sex discrimination) to justify not following an old circuit precedent); *Roberts v. Clark Cnty. Sch. Dist.*, 215 F.Supp.3d 1001, 1014 (D. Nev. 2016) (finding the weight of authority in the 9th Circuit holds discrimination based on transgender status is sex discrimination); *U.S. v. S.E. Okla. State Univ.*, No. 5:15-CV-324, 2015 WL 4606079 at *2 (W.D. Okla. July 10, 2015) (rejecting motion to dismiss premised on *Etsitty v. Utah Transit Auth.*, 502 F.3d 1215 (10th Cir. 2007) and allowing claim based on harassment, health insurance exclusion, and termination based on gender transition to proceed as sex stereotyping discrimination under Title VII); *Finkle v. Howard Cty., Md.*, 12 F. Supp. 3d 780, 789 (D. Md. 2014) (denying motion to dismiss Title VII claim where plaintiff plausibly alleged that she was rejected both "because of her obvious transgendered status" and also her gender nonconformity); *Hughes v. William Beaumont Hosp.,* No. 13-cv-13806, 2014 WL 5511507 (E.D. Mich. Oct. 31, 2014) (transgender woman subjected to disparate treatment where decision maker testified that people would be uncomfortable with "a man acting as a woman"); *Lopez v. River Oaks Imaging & Diagnostic Grp., Inc.*, 542 F. Supp. 2d. 653 (S.D. Tex. 2008) (holding that a transgender woman stated a claim under Title VII where the employer rescinded a job offer because she was transgender); *Tronetti v. TLC HealthNet Lakeshore Hosp.*, No. 03-CV- 0375E(SC), 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003) (finding an actionable claim where employer advised a transgender woman to avoid wearing overtly feminine attire and ultimately fired her because she failed to act

Anti-transgender discrimination has also been widely regarded as an unconstitutional sex-based classification triggering intermediate scrutiny for Equal Protection claims in the context of schools,[28] identity documents,[29] prisons,[30] the military,[31] and

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like a man).

[28] *Whitaker supra* note 19, at 1051 (holding that heightened scrutiny used for sex-based classifications applied to school policy requiring transgender student to use bathroom of sex listed on his birth certificate because it "treat[ed] transgender students . . . who fail to conform to the sex-based stereotypes associated with their assigned sex at birth, differently"); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 288 (W.D. Pa. 2017) (holding that "all of the indicia for the application of the heightened intermediate scrutiny standard are present" for transgender individuals); *M.A.B. v. Bd. of Educ. of Talbot Cty.*, 286 F.Supp.3d 704, 718-19 (D. Md. 2018) (reviewing *Glenn* and *Whitaker* and determining that heightened scrutiny applied in transgender school bathroom case); *Adams by Kasper v. Sch. Bd. of St. Johns Cty.*, 318 F. Supp. 3d 1293, 1298 (M.D. Fla. 2018), *appeal docketed,* No. 18-13592 (11th Cir. Aug. 24, 2018) (same); *A.H. v. Minersville Area Sch. Dist.*, 290 F.Supp.3d 321, 331 (M.D. Pa. 2017) (holding intermediate scrutiny applied in transgender school bathroom case); *Bd. of Educ. of the Highland Local Sch. Dist. supra* note 19, at 872–74 (finding that "transgender status is a quasi-suspect class under the Equal Protection Clause").

[29] *F.V. v. Barron*, 286 F.Supp.3d 1131, 1145 (D. Idaho Mar. 5, 2018) (applying intermediate scrutiny because "transgender people bear all of the characteristics of a quasi-suspect class").

[30] *E.g., Doe v. Mass. Dep't of Correction,* No. 1:17-cv-12255-RGS, 2018 WL 2994403 at *9 (D. Mass. Jun. 14, 2018) ("[W]here a State creates a classification based on transgender status, the classification is tantamount to discrimination based on sex and is therefore subject to heightened judicial scrutiny."); *Adkins v. City of New York*, 143 F. Supp. 3d 134, 140 (S.D.N.Y. 2015) (concluding "that transgender people are a quasi-suspect class"); *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015) (applying intermediate scrutiny where an transgender inmate was denied access to surgery to treat gender dysphoria).

[31] *Stone v. Trump*, 280 F. Supp. 3d 747, 755 (D. Md. 2017), *appeal dismissed*, No. 17-2398, 2018 WL 2717050 (4th Cir. Feb. 2, 2018) (applying intermediate scrutiny to decision to exclude transgender individuals from the military); *Doe 1 v. Trump*, 275 F. Supp. 3d 167, 210 (D.D.C. 2017), *vacated sub nom. Doe 2 v. Shanahan*, 755 F. App'x 19 (D.C. Cir. 2019) (vacated following change in federal policy) (same); *Karnoski v. Trump*, No. C17-1297-MJP, 2017 WL 6311305, at *7 (W.D. Wash. Dec. 11, 2017), *appeal dismissed*, No. 17-36009, 2017 WL 8229552 (9th Cir. Dec. 30, 2017) (applying intermediate scrutiny to a policy of denying transgender-related healthcare to military service members and granting a preliminary injunction); *Karnoski v. Trump*, No. C17-1297-MJP, 2018 WL 1784464, at *1 (W.D. Wash. Apr. 13, 2018), *vacated on other grounds and remanded*, 926 F.3d 1180 (9th Cir. 2019) (applying strict scrutiny to transgender people as a protected class where defendants sought to deny transgender-related healthcare to military

employment.[32]

Finally, courts have and will continue to find that the Section 1557 itself—independent of any regulation—protects transgender individuals from discrimination in health care in general,[33] and that transgender insurance exclusions in particular trigger sex discrimination protections under Section 1557.[34] Repealing the explicit transgender protections does nothing to change the underlying protections of the statute or court precedent but does create confusion about the obligations of covered entities and fosters a misguided license to discriminate. This harms not only transgender people who will need counsel to access health care, but also the covered entities who rely on HHS regulations to guide their practices.

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service members).

[32] *Smith v. City of Salem, Ohio*, 378 F.3d 566, 577 (6th Cir. 2004) (holding that the facts alleged by transgender plaintiff to support claims of gender discrimination on the basis of sex stereotyping "easily constitute a claim of sex discrimination grounded in the Equal Protection Clause of the Constitution"); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011) (recognizing discrimination against transgender people as sex discrimination and applying intermediate scrutiny).

[33] *Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 at *2 (D. Minn. Mar. 16, 2015); *Prescott v. Rady Children's Hospital-San Diego*, 265 F.Supp.3d 1090, 1099 (S.D. Cal. Sept. 27, 2017) ("Because Title VII, and by extension Title IX, recognize that discrimination on the basis of transgender identity is discrimination on the basis of sex, the Court interprets the ACA to afford the same protections.").

[34] *Cruz v. Zucker,* 116 F.Supp.3d 334, 348 (S.D.N.Y. 2015) (entertaining a sex discrimination claim for transgender people under Medicaid); *Flack v. Wis. Dep't of Health Servs.*, 328 F.Supp.3d 931 (W.D. Wis. Jul. 25, 2018) (granting a preliminary injunction barring enforcement of Wisconsin Medicaid's transgender exclusion because such an exclusion denies surgery on the basis of sex in violation of Section 1557); *Flack v. Wisconsin Dep't of Health Servs.,* No. 18-CV-309-WMC, 2019 WL 1772403, at *12 (W.D. Wis. Apr. 23, 2019) (same); *Boyden v. Conlin*, 341 F.Supp.3d 979, 997 (W.D. Wisc. 2018) (applying Section 1557 to Wisconsin state employee health plan); *Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 954 (D. Minn. 2018) (holding that employer and third-party administrator may be held liable for administering a self-funded plan containing an exclusion for "gender reassignment" treatment).

2.2. Eliminating 42 C.F.R. § 92.4, the definition section, is not in accordance with widespread court interpretation of "sex" to include gender identity as a biological component of sex.

The scientific consensus, as recognized by numerous courts, recognizes that "sex" includes myriad physical characteristics that comprise and define one's sex, which can include hormone levels, genital appearance, reproductive organs, and secondary sex characteristics such as facial hair, fat distribution, muscle mass, breasts, and neurological structure and function.[35] One of these components is gender identity: the self-knowledge of one's sex.[36] Everyone—transgender or not—is born with an internal sense of their sex; transgender persons know themselves to be a sex different from that which they were labeled at birth.[37] Courts have thus recognized that a transgender person's sex is not defined by genitalia

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[35] *See, e.g.*, *Schroer v. Billington*, 424 F. Supp. 2d 203, 211-13 (D.D.C. 2006) (scientific observation confirms "sex is not a cut-and-dried matter of chromosomes" but rather consists of "different components of biological sexuality") (citation omitted); *In re Heilig*, 816 A.2d 68, 73 (Md. 2003) (gender is determined by seven factors, including "personal sexual identity"); *Maffei v. Kolaeton Indus., Inc.*, 164 Misc. 2d 547, 551-52 (N.Y. Sup. Ct. 1995) (explaining that at least seven variables . . . interact to determine the ultimate sex of an individual," including gender identity); *F.V. v. Barron*, 286 F. Supp. 3d 1131, 1136 (D. Idaho 2018) ("There is scientific consensus that biological sex is determined by numerous elements"). *See also* Dru M. Levasseur, *Gender Identity Defines Sex: Updating the Law to Reflect Modern Medical Science is Key to Transgender Rights*, 39 Vt. L. Rev. 943, 951-52 (2015).

[36] *See Doe by & through Doe v. Boyertown Area Sch. Dist.*, 897 F.3d 518, 522 (3d Cir. 2018), *cert. denied* 139 S. Ct. 2636 (2019) ("A person's gender identity is their subjective, deep-core sense of self as being a particular gender."); *accord, e.g., Parents for Privacy v. Dallas Sch. Dist. No. 2*, 326 F. Supp. 3d 1075, 1083 (D. Or. 2018) *app. pending*, No. 18-35708 (9th Cir. 2019).

[37] *See, e.g., Karnoski v. Trump*, 926 F.3d 1180, 1188 (9th Cir. 2019) ("Although most people have a gender identity that matches their sex assigned at birth, this is not the case for transgender people, who identify as transgender because their gender identity does not match their birth-assigned sex."); *Boyden supra* note 34, at 986 ("For purposes of medical diagnosis, as well as increasingly for purposes of common usage, 'gender identity' is the internal core sense of one's own sex, such as male or female. All human beings have a gender identity. . . . 'Transgender' means there is an incongruence between a person's sex at birth (also referred to as one's 'natal sex' in medical texts) or the gender assigned at birth and the individual's gender identity").

at birth, but by their gender identity.[38] Courts have also long recognized that an individual's gender identity is immutable[39] and psychotherapy cannot change a person's gender identity.[40] It is largely because of this medical and legal consensus that at the federal level, people can correct the sex on their passports, immigration documents, Social Security cards, and federal employee records based on a letter from a doctor without any requirement of

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[38] *See, e.g.*, *Schroer v. Billington*, 424 F. Supp. 2d 203, 212-213 (D.D.C. 2006) (recognizing "real variations in how the different components of biological sexuality—chromosomal, gonadal, hormonal, and neurological – interact with each other, and in turn, with social, psychological, and legal conceptions of gender"); *Whitaker supra* note 19, at 1053 (acknowledging that in some cases, "it is clear that the marker on the birth certificate would not adequately account for or reflect one's biological sex, which would have to be determined by considering more than what was listed on the paper").

[39] *See, e.g.*, *Bd. of Educ. of the Highland Local Sch. Dist. supra* note 19, at 874 (being transgender is "immutable"); *Adkins supra* note 30, at 139-140 (same); *Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 947 n.20, 953, 953 n.29 (W.D. Wis. 2018) ("Gender identity is innate and generally considered an immutable characteristic."); *Evancho supra* note 28, at 277 n.12 ("[E]xternal sex organs are one (but by no means the only or most accurate) indicia of a person's sex and gender. . . . [B]eing transgender is not a 'preference.' . . . [B]eing transgender has a medically-recognized biological basis . . . it is an innate and non-alterable status.").

[40] *See, e.g.*, *Richards v. U.S. Tennis Ass'n*, 400 N.Y.S. 2d 267, 271 (N.Y. Sup. Ct. 1977) ("Medical Science has not found any organic cause or cure (other than sex reassignment surgery and hormone therapy) for transsexualism, nor has psychotherapy been successful in altering the transsexual's identification with the other sex or his desire for surgical change."); *Doe v. State of Minn., Dep't of Pub. Welfare*, 257 N.W. 2d 816, 819 (Minn. 1977) ("Given the fact that the roots of transsexualism are generally implanted early in life, the consensus of medical literature is that psychoanalysis is not a successful mode of treatment for the adult transsexual."); *Doe v. McConn*, 489 F. Supp. 76, 77 (S.D. Tex. 1980) (making a factual finding that "[t]reatment of this condition in adults by psychotherapy alone has been futile" and that "[a]dministration of hormones of the opposite sex followed by sex-conversion operations has resulted in better emotional and social adjustment by the transsexual individual in the majority of cases." Because transsexualism is not a "choice," "it has been found that attempts to treat the true adult transsexual psychotherapeutically have consistently met with failure."); *Sommers v. Iowa Civil Rights Comm'n*, 337 N.W.2d 470, 473 (Iowa 1983) ("It is generally agreed that transsexualism is irreversible and can only be treated with surgery to remove some of the transsexual feelings of psychological distress; psychotherapy is ineffective."); *In re Heilig*, *supra* note 35, at 78 ("[C]ourts have recognized that psychotherapy is not a 'cure' for transsexualism. Because transsexualism is universally recognized as inherent, rather than chosen, psychotherapy will never succeed in 'curing' the patient.").

undergoing surgery first.[41] In short, it is widely recognized in law and medicine that one's sex cannot be determined solely by reference to physical sex characteristics. Gender identity is an inherent part of the way law and medicine define "sex," and making attempts to eliminate "gender identity" arbitrary and not in accordance with the statute.

2.3. Section 1557 has protected transgender people from discrimination.

Section 1557 has been instrumental in protecting transgender individuals. Since 2016, the implementing final rule has provided an administrative framework for addressing legitimate complaints for individuals who are denied healthcare or receive substandard healthcare as a result of their transgender status.[42] This framework has enabled victims to seek redress without the costs and time associated with litigation.[43]

The 2016 regulations have been an instrumental part of a broader trend in healthcare coverage for transgender people. Since the 2016 regulations were enacted, insurers and employers have continued to expand coverage to include transgender healthcare and have increasingly removed transgender exclusions. At least 20 states now have explicit coverage in their Medicaid plans for gender dysphoria treatments,[44] and many of those policy changes explicitly reference

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[41] *See FAQ About Identity Documents*, Lambda Legal, https://www.lambdalegal.org/know-your-rights/article/trans-identity-document-faq (last visited Aug. 13, 2019).

[42] The Center for American Progress, *The ACA'S LGBTQ Nondiscrimination Regulations Prove Crucial* (March 7, 2018), available at https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial.

[43] *Id.*

[44] *See* National Center for Transgender Equality, Healthcare Action Center (2018), https://transequality.org/health-care-action-center; Department of Health and Human Services, Office of MaineCare Services, 10-144 C.M.R., Chapter 101, MaineCare Benefits Manual, Section 90, Chapter II, Physician Services (Jun. 18, 2019) (eliminating transsexual surgery exclusion to comply with § 1557 and implementing regulations), https://www.mainepublic.org/sites/mpbn/files/201906/mainecare_benefits_manual__se

Section 1557 and the implementing regulations as the basis for removing exclusions. Similarly, nineteen states and the District of Columbia prohibit the exclusion of transgender-related care in private insurance policies, with many citing Section 1557 and the 2016 regulations.[45] But as less than half of the states have explicit Medicaid coverage or explicit transgender insurance protections, the regulations are still very necessary to prevent discrimination.

3. The proposed rule also makes healthcare access for transgender people more difficult in additional ways.

3.1. The proposed rule will impede healthcare access for people with HIV/AIDS and other serious or chronic conditions.

Transgender people are up to five times more likely than the general population to be living with HIV/AIDS.[46] Transgender women of color are particularly likely to be at risk, with nearly one in five black transgender women living with HIV.[47]

Section 1557 and the 2016 implementing regulations prohibit health insurance companies from discriminating through marketing practices and benefit design. These protections are especially important for people with HIV/AIDS or other serious/chronic conditions. The proposed rule seeks to exempt most health insurance plans from Section 1557's nondiscrimination protections and eliminate the regulation prohibiting discriminatory benefit design and marketing, which could result in health insurers excluding benefits or designing their prescription drug formularies in a way that limits access to medically necessary care for those living with HIV and other chronic conditions.

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ction_90__chapter_ii__physician_services_emerg_.pdf.

[45] *See* Transcend Legal, *State Health Insurance Laws & Guidance*, https://transcendlegal.org/state-health-insurance-laws-and-guidance (listing bulletins, regulations and statutes that prohibit exclusions).

[46] 2015 U.S. Transgender Survey Report, *supra* note 3, at 10.

[47] *Id.*

3.2. The proposed rule will make it much harder for people to understand their legal rights and will disproportionately harm people who are limited English proficient.

The proposed rule will make it more challenging for patients—including transgender people who are also limited English proficient—to understand their healthcare rights under federal law. Many individuals may not know about their rights, how to request language services, or how to file a complaint if they face discrimination. By eliminating tagline requirements and notice standards, the proposed rule will undermine access to healthcare, health insurance, and legal redress for vulnerable communities.

3.3. The proposed rule will make it much harder for transgender people who need access to reproductive care.

The proposed rule also threatens access to reproductive healthcare. LGBTQ people, including transgender, non-binary, and gender nonconforming people, need access to reproductive healthcare and coverage, including abortion, contraception, pregnancy care, and fertility services, free from discrimination.

The proposed rule attempts to unlawfully incorporate a broad religious exemption to 1557's protections against discrimination on the basis of sex. The Department's attempts to add a religious exemption are contrary to the express purpose of Section 1557 and violate the plain language of the statute. Adding a religious exemption opens the door for discrimination and emboldens healthcare providers to deny patients care, threatening the health and well-being of LGBTQ patients and patients seeking reproductive healthcare.

4. Conclusion

The proposed rule will harm transgender individuals by engendering confusion about the state of the law and promoting discrimination by providers and insurers. It also contradicts existing jurisprudence and medical consensus, causing inconsistency in access to healthcare and discriminatory denials of medically necessary care. We respectfully

request that the proposed rule be withdrawn in its entirety. If you have any questions, please contact David Brown, Legal Director (646) 862-9396, dbrown@transgenderlegal.org).

Sincerely,

Transgender Legal Defense & Education Fund

EXHIBIT D-16

August 5, 2019

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

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

Dear Mr. Severino:

The National Immigration Law Center (NILC) thanks the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) for the opportunity to comment on the notice of proposed rulemaking (NPRM) on Section 1557 of the Patient Protection and Affordable Care Act (ACA) ("Health Care Rights Law" or "Section 1557").

Founded in 1979, NILC is the leading advocacy organization in the United States exclusively dedicated to defending and advancing the rights and opportunities of low-income immigrants and their families. We focus on issues that affect the well-being and economic security of immigrants and their families: health care and safety net programs; education and training; workers' rights; and federal and state policies affecting immigrants. To advance our mission, we use three integrated strategies: litigation, state and federal policy advocacy, and strategic communications.

For nearly four decades, NILC has been at the forefront of many of the country's greatest challenges in addressing immigration issues. NILC is a leading organization in the immigrant justice movement, playing a central role in shaping policy—including at the state and local level—and in initiating creative litigation strategies that expand opportunities for immigrant families with low-incomes. Since its founding, NILC has been a staunch advocate for nondiscrimination and access to healthcare for immigrants.

NILC expressed strong support for Section 1557 of the ACA, which prohibits discrimination on the basis of race, color, national origin, sex, age, and disability. We also supported the 2016 Nondiscrimination in Health Programs and Activities Final Rule (2016 Final Rule), which implemented the Section 1557 nondiscrimination provisions.

As an organization that is committed to upholding the civil rights of low-income immigrants and their families, we know the population we serve is diverse and intersectional. As such, we strongly oppose the NPRM provisions which seek to eliminate and limit protections for individuals who are limited English proficient, LGBTQ+ persons, persons with disabilities and chronic conditions, and persons needing reproductive health services. Section 1557 addresses not only protections for each protected class covered, but the intersection of those protections. As such, an attack on the civil rights of one group in the NPRM is an attack on the civil rights of all.

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We are concerned that the NPRM strips the protections required to ensure that persons with limited English proficiency (LEP) have the meaningful access required not only by Section 1557 but also by Title VI of the Civil Rights Act of 1964 (Title VI) and its implementing regulations. We oppose eliminating the language access protections as proposed in the NPRM. In addition, we oppose any other efforts to otherwise eliminate or roll back protections and provisions contained in the 2016 Final Rule as they apply to other protected classes, including LGBTQ+ persons, women, and persons with disabilities. Overall, we urge HHS to withdraw and not finalize this rule.

I. DHS Should Consider All Citations to Supporting Evidence and Authority as Part of the Formal Administrative Record for Purposes of the Administrative Procedure Act

Throughout the comments that follow, we have included numerous citations to supporting evidence and authority, including active links. We direct OCR to each citation and corresponding links and we request that the full text of the evidence and authority cited, along with the full text of our comment, be incorporated into the formal administrative record for purposes of the Administrative Procedure Act.

II The Proposed Subpart A General Provisions Run Counter to the 1557 Statutory Text

We oppose the proposed changes in § 92.1 - 92.3 that would narrow the scope of application of Section 1557. The proposed changes would limit the antidiscrimination provisions by removing language in the 2016 Final Rule that enforces nondiscrimination requirements over programs receiving federal financial assistance that the Department of Health and Human Services (HHS) plays a role in administering.[1] The proposed rule would limit the enforcement of these nondiscrimination provisions to programs receiving federal financial assistance from HHS, programs administered by HHS, or by any entity established under Title I of the ACA.[2] The new rule further limits Section 1557 by changing the definition of "health program or activity" in a way that limits the applicability of the nondiscrimination provisions to health insurance companies; it distinguishes health insurance from health care and notes that if "an entity is not principally engaged in the business of health care, the Department proposes to interpret Section 1557 so that only the operation for which it receives Federal financial assistance is part of the 'program or activity'" subject to the nondiscrimination provisions.[3] Section 1557, however, applies to any health program or activity, any part of which is receiving federal financial assistance or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the ACA. Thus, Section 1557 applies to *all* health programs or activities administered by the Department (as well as other federal Departments) *plus* those established under Title I. Further, similar to Title VI, Section 1557 applies to *all* parts of the covered entity, not only the portion receiving federal financial assistance. In addition, given that the majority of individuals access health care through insurance plans, the provision of health insurance is a "health program or activity" and thus Section 1557 applies to it. The proposed changes run counter to the statutory text and intent of Section 1557 and would severely limit its application. We therefore oppose them.

III. The Proposed § 92.5 Enforcement Incorrectly Limits Remedies Available Under Section 1557

We oppose the proposed changes to § 92.301 as newly designated § 92.5. OCR incorrectly limits the remedies available under Section 1557, in part by referencing the regulations implementing the cited statutes. One of the goals of Section 1557 was to build and expand on prior civil rights laws such that individuals seeking to enforce their rights would have access to the full range of available civil rights

[1] Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846, 27861 (proposed June 14, 2019).
[2] *Id.*
[3] *Id.* at 27861-27862.

remedies and not be limited to only the remedies provided to a particular protected group under prior civil rights laws. This is why Section 1557 expressly provides individuals access to any and all of the "enforcement mechanisms provided for and available under" the cited civil rights statutes, regardless of the type of discrimination.[4]

IV. Proposed Subpart B's Specific Applications to Health Programs or Activities Incorrectly Construe Section 1557, Cutting Off Meaningful Access for Individuals with Limited English Proficiency

A. Obligations

The proposed § 92.101 inappropriately switches the emphasis from "each individual with limited English proficiency," as provided in the 2016 Final Rule,[5] to the covered entity's program or activities. In Section 1557, Congress declared "an individual shall not" be subject to discrimination.[6] Section 1557 regulations cannot offer less protection than the statute that authorizes such regulations. Therefore, the correct emphasis in the 1557 regulations must be on individuals. By shifting the focus to programs and activities, this NPRM would weaken meaningful access. Moreover, it runs counter to Congressional intent and the thorough administrative record supporting the 2016 Final Rule, and we oppose it.

B. Specific applications

We appreciate the Department's historical emphasis on ensuring meaningful access for LEP individuals, as required by Title IV and regulations and consistent with over four decades of U.S. Supreme Court precedent and enforcement by HHS and the U.S. Dept. of Justice (DOJ). As advocates for immigrant families, we have strongly supported Title VI and 2003 HHS LEP Guidance and have provided input on how to interpret the 4-factor test to ensure its application results in the meaningful access for LEP persons required by Title VI and its regulations. The four-factor test balances the following issues in assessing compliance: "(i) [t]he number or proportion of limited English proficient individuals eligible to be served or likely to be encountered in the eligible service population; (ii) [t]he frequency with which LEP individuals come in contact with the entity's health program, activity, or service; (iii) [t]he nature and importance of the entity's health program, activity, or service; and (iv) [t]he resources available to the entity and costs."[7]

We oppose the codification of the 4-factor test in the Section 1557 regulation for the following two reasons. First, it is already the interpretation of OCR that the 2-factor test in the 2016 Final Rule is consistent with Title VI, the only statute in Section 1557 that prohibits national origin discrimination against LEP individuals.[8] The two-factor test "(1) [e]valuate[s], and give[s] substantial weight to, the nature and importance of the health program or activity and the particular communication at issue, to the individual with limited English proficiency; and (2) Take[s] into account other relevant factors, including whether a covered entity has developed and implemented an effective written language access plan, that is appropriate to its particular circumstances, to be prepared to meet its obligations in

[4] 42 U.S.C. § 18116(a).
[5] 45 C.F.R. § 92.201(a).
[6] 42 U.S.C. § 18116(a).
[7] Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846, 27892. (proposed June 14, 2019).
[8] *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31453 (May 18, 2016).(". . . the proposed rule adopted recipients' existing obligations under Title VI to take reasonable steps to provide meaningful access to individuals with limited English proficiency and codified the standards consistent with long-standing principles from the HHS LEP Guidance regarding the provision of oral interpretation and written translation services.").

§92.201(a)."[9] The protections in Section 1557 and its regulations cannot be anything less than those already guaranteed by Title VI. This reality negates OCR's claim, in the current NPRM, that it seeks to align Section 1557 with Title VI. They are already in alignment.

Second, in providing the 2-factor test based upon, informed by and consistent with Title VI, OCR was providing a method of articulating how it would engage in its enforcement review in the health activities and programs context, a specific application of Title VI and newly created by Section 1557. The 2-factor test incorporates the principles in the HHS LEP Guidance and allows OCR to better explain how the factors will be considered in the specific 1557 health activities and programs context, which gives substantial weight to the nature and importance of the particular communication at issue.

V. We Oppose the Repeal or Reconsideration of the Current 1557 Provisions that Uphold the Rights of LEP Individuals

Overall, we strongly disagree that the nondiscrimination notice, tagline, and language access plan language in the 2016 Final Rule were overly burdensome and not justified by need, and that they created inconsistent requirements. In focusing most significantly on the costs and burdens to covered entities and devoting minimal discussion and analysis to the costs to LEP individuals, OCR is not acting consistent with the balancing principles identified by it in the 2003 HHS LEP Guidance which states that "[f]irst we must ensure that federally assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English."[10]

A. Proposed Repeal of Nondiscrimination Notice

We oppose the repeal of the requirement that covered entities provide a notice of nondiscrimination that informs the public of their legal rights. The sample notice language in the 2016 Final Rule states that covered entities comply "with applicable Federal civil rights laws and [do] not discriminate on the basis of race, color, national origin, age, disability, or sex" and "[do] not exclude people or treat them differently because of race, color, national origin, age, disability, or sex."[11] The sample notice also includes information about language access services and about the process for filing grievances if an individual believes an entity failed to comply with these nondiscrimination requirements.[12] The notice requirement is consistent with the long history of civil rights regulations requiring the posting of notice of rights, including Title VI, Section 504, Title IX and the Age Discrimination Act, which all require that recipients of federal financial assistance notify recipients that they do not discriminate.

OCR has provided no explanation for how individuals will know of their rights and how elimination of notices will not deny LEP individuals, LGBTQ+ persons, women, and persons with disabilities meaningful access. Without the notice, members of the public will have limited means of knowing that language services and auxiliary aids and services are available, how to request them, what to do if they face discrimination, that they have the right to file a complaint, and how to file such a complaint. In the health insurance context, these notices of language services are extremely important. Survey data comparing the experiences of Spanish-speakers and English-speakers shows that Spanish-speakers "are less likely than English-speakers to say they understand the services covered by their plan and

[9] 45 C.F.R. § 92.201.
[10] U.S. DEP'T. OF HEALTH AND HUMAN SERV., GUIDANCE TO FEDERAL FINANCIAL ASSISTANCE RECIPIENTS REGARDING TITLE VI PROHIBITION AGAINST NATIONAL ORIGIN DISCRIMINATION AFFECTING LIMITED ENGLISH PROFICIENT PERSONS (2013), https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-vi/index.html.
[11] 45 C.F.R. § 92 (Appendix A).
[12] *Id.*

their out-of-pocket costs well" and "more likely to experience gaps in their coverage . . . reporting they need services that are not covered by their plan."[13] Lack of knowledge about language services could further exacerbate these issues, potentially leading to gaps in crucial services for LEP individuals.

OCR incorrectly asserts that the nondiscrimination notice is redundant of existing civil rights notices under other statutes. Rather, the notice recognizes the fact that individuals may face multiple forms of discrimination and in fact eliminates duplication by consolidating the underlying statutes' notice requirements into one.[14]

B. Proposed Repeal of In-Language Taglines

We strongly oppose the repeal of the requirement for covered entities to provide in-language taglines. As defined in the 2016 Rule, taglines are "short statements written in non-English languages that indicate the availability of language assistance services free of charge."[15] The elimination of these tagline requirements, combined with the elimination of the nondiscrimination notice, threatens the civil rights of LEP persons. The inclusion of taglines is well-supported by long-standing federal and state regulations, guidance, and practice.[16] The use of taglines is a cost-effective approach to ensuring that covered entities are not overly burdened while maintaining access for LEP individuals.

In the absence of fully translated documents, taglines are necessary "to ensure that individuals are aware of their protections under the law, and are grounded in OCR's experience that failures of communication based on the absence of auxiliary aids and services and language assistance services raise particularly significant compliance concerns under Section 1557, as well as Section 504 and Title VI."[17] As such, we oppose the proposal to eliminate them.

C. Proposed Repeal of Video Interpretation Standards

We oppose the removal of technical and training requirements for the use of high quality video remote interpreting services for spoken language interpretation. The type of interpreting during a medical visit should depend on the encounter as telephonic communication may be appropriate for scheduling, but not for interpreting information related to the provision of healthcare. Non-verbal cues in the health care setting or prescription writing cannot be observed via telephone. Clinical data demonstrates that video interpretation—as opposed to telephonic interpretation—can lead to greater understanding of diagnoses and, even more importantly, may decrease risks for safety events related to ineffective communication. A 2015 study published in JAMA Pediatrics found that "video interpretation led to improved diagnosis comprehension among parents with LEP of children treated in a pediatric ED" and to decreased likelihood of reporting "frequent lapses in professional interpreter use."[18] Crucially, the study further concluded that increased "parent comprehension . . . may decrease the risk for

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[13] Samantha Artiga, et al., *The Role of Language in Health Care Access and Utilization for Insured Hispanic Adults* at 5, KAISER COMMISSION ON MEDICAID AND THE UNINSURED (Nov. 2015), http://files.kff.org/attachment/issue-brief-the-role-of-language-in-health-care-access-and-utilization-for-insured-hispanic-adults.

[14] To reduce the burden on covered entities, OCR developed a model nondiscrimination notice that treats compliance with § 92.8 as satisfying the notice requirements under the regulations implementing Title VI, Section 504, Title IX, and the Age Act.

[15] 45 C.F.R. § 92.4.

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

[17] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54172, 54193 (proposed Sept. 8, 2015).

[18] K. Casey Lion, et al., *Effect of Telephone vs Video Interpretation on Parent Comprehension, Communication, and Utilization in the Pediatric Emergency Department*, 169 JAMA PEDIATRICS, 1117, 1124 (2015), https://jamanetwork.com/journals/jamapediatrics/fullarticle/2463124.

communication-related safety events."[19] In short, video interpretation may lead to better health outcomes for patients than audio interpretation alone. Despite the documented benefits for patients of video interpretation, the proposed rule only considers the costs to HHS.[20] OCR must consider the more positive health outcomes of Video Remote Interpreting as opposed to audio interpreting and weigh these against the projected financial costs. Even with the higher cost in equipment and training, Video Remote Interpreting has saved costs from in person interpreting as there are no minimums, travel time, or cancellation risks, though we believe in-person interpreting is still best for the patient. Keeping the current standard allows providers to determine which technology is appropriate and when an entity uses video.

D. Language Access Plans

We oppose removing all references to language access plans because under the 2016 Final Rule, they are voluntary, not required by the 2016 rule, and only a factor to be considered. Language access plans are not required by Title VI or its regulations but have long been recognized as a way for a covered entity to ensure it is compliant with Title VI. OCR has required language access plans from covered entities as a key component of Title VI enforcement actions involving LEP individuals since before Executive Order 13166 was issued in 2000. Executive Order 13166 also required that HHS create and implement a language access plan for its federally conducted programs and activities. That Executive Order also required HHS to issue Title VI LEP Guidance which provided multiple factors an entity could take when developing a language access plan. As such, repealing the voluntary language removes a tool that HHS has used for enforcement and that covered entities can use to support their compliance efforts. Covered entities may, as a result, fail to fully plan on how to best meet the needs of LEP patients and customers.

VI. The Regulatory Impact Analysis (RIA) is Flawed and Ignores Costs to LEP Individuals

A. The RIA Fails to Justify the Proposals or Consider Alternatives

The NPRM provides a RIA that is wholly insufficient to justify the extensive scope of the proposed changes to language access and entirely fails to identify and to quantify costs to protected individuals. OCR's estimate of the burden to covered entities for compliance with the nondiscrimination notice and tagline requirements is based on voluntary actions and interpretations by covered entities. OCR based the elimination of the notice and taglines on these estimates, but did not consider whether alternatives, such as further clarification about the requirements, was warranted in the form of FAQs or other guidance. That is, OCR failed to consider alternatives to a complete repeal of notices and taglines that could have appropriately balanced the need to inform individuals of their rights while recognizing there may be a difference in the intentions behind the 2016 Final Rule and covered entities' interpretation of it.

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

[19] *Id.*
[20] Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846, 27866 (proposed June 14, 2019).

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

B. Language Access Requirements in the 2016 Final Rule Are Justified by Need

OCR has provided no tangible analysis of the costs and burdens of repealing the notice and tagline requirement. Instead, OCR provides only acknowledgment that repeal "may impose costs, such as decreasing access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services."[21] OCR perfunctorily labels the impact as "negligible" while providing no evidentiary basis.[22]

The costs are not only reduced awareness of language services by LEP persons, but also reduced awareness by the general public about their rights as protected by 1557, especially regarding the notices which include information about the broader nondiscrimination requirements of Section 1557. OCR's only acknowledgement of this impact is one statement about the "unknown number of persons [that] are likely not aware of their right to file complaints."[23]

We urge OCR to consider data indicating the serious detrimental health impacts resulting from lack of language access. A study on the correlation between language proficiency and adverse health effects in patients in hospitals found that "some degree of detectable physical harm occurred in 49.1% of reported LEP patient adverse events, whereas only 29.5% of reported adverse events for patients who speak English resulted in detectable physical harm."[24] Per the study, over "half (52.4%) of the adverse events experienced by LEP patients were attributable to some failure in communication, compared with 35.9% for English speaking patients."[25] The data underscores the crucial nature of language services for LEP individuals. Without these services, LEP individuals can face severe health consequences.

Additional data reinforces the connections between lack of language access and both detrimental health effects for LEP individuals and higher costs for hospitals and institutions. One study found that LEP individuals without an interpreter on the date of admission and the date of discharge had longer hospital stays as compared to LEP individuals with these interpretation services..[26] Further research concluded that "LEP respondents . . . were more likely to report problems understanding medical situations, confusion about their medications, trouble understanding medication labels, and bad

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[21] *Id.* at 27882.
[22] *Id.*
[23] *Id.* at 27883.
[24] Chandrika Divi et al., *Language proficiency and adverse events in US hospitals: a pilot study*, 19 INT'L J. QUALITY HEALTH CARE 60, 62 (2007), https://academic.oup.com/intqhc/article/19/2/60/1803865.
[25] *Id.*
[26] Mary Lindhom et al., *Professional Language Interpretation and Inpatient Length of Stay and Readmission Rates*, 27 J. GEN. INTERNAL. MED. 1294, 1297-98 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3445680/pdf/11606_2012_Article_2041.pdf.

reactions to medications."[27] In short, LEP individuals face significant barriers to quality care, making language access services crucial to their well-being.

Discrimination on the basis of national origin, which encompasses discrimination on the basis of language, creates unequal access to health care. Language access in health care is just as critical now as when the Civil Rights Act was originally passed in 1964. Over twenty-five million individuals in the United States are LEP. [28] An estimated 19 million LEP adults are insured.[29] Language assistance is necessary for LEP persons to access federally funded programs and activities in the healthcare system. Without meaningful access, the estimated 25 million individuals who are LEP would be excluded from programs and services to which they are legally entitled.

VII. We Further Oppose Changes that Would Negatively Impact Other Marginalized Communities

A. The Proposed Rule would severely impact the rights of LGBTQ+ patients

If finalized, this Proposed rule would severely threaten LGBTQ+ patients' access to all forms of health care, create confusion among patients and providers about their rights and obligations, and promote discrimination. Among other changes, the proposed rule would repeal the definition of sex in the 2016 Final Rule, which includes "gender identity."[30]

The proposed rule would encourage hospitals to deny care to LGBTQ+ people and enable insurance companies to deny transgender people coverage for essential health care services that they cover for non-transgender people. By proposing to eliminate protections against discrimination based on transgender status and sex stereotyping, HHS is contradicting over 20 years of federal case law[31] and clear Supreme Court precedent.[32] The overwhelming majority of courts that have been presented with the question of whether federally sex discrimination laws such as Section 1557 specifically cover anti-transgender discrimination have firmly ruled that they do."[33]

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[27] Elisabeth Wilson et al., *Effects of Limited English Proficiency and Physician Language on Health Care Comprehension*, 20 J. GEN. INTERNAL MED. 800, 802 (2005), https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1525-1497.2005.0174.x.

[28] Asian & Pacific Islander American Health Forum Analysis of 2017 American Community Survey Data.

[29] Asian & Pacific Islander American Health Forum Analysis of 2017 American Community Survey Public Use Microdata Sample Files.

[30] Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846, 27856 (proposed June 14, 2019).

[31] *See*, *e.g.*, *Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015); *Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. 2016); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090 (S.D. Cal. Sept. 27, 2017); *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018); *Boyden v. Conlin,* No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018); *Whitaker v. Kenosha Unified School District*, No. 16-3522 (7th Cir. 2017) (Title IX and Equal Protection Clause); *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal Protection Clause); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011) (Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004) (Title VII); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); *Grimm v. Gloucester County School Board*, No. 4:15-cv-54 (E.D. Va. May 22, 2018); *M.A.B. v. Board of Education of Talbot County*, 286 F. Supp. 3d 704 (D. Md. March 12, 2018).

[32] *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989).

[33] *See*, *e.g.*, *Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (holding that discrimination against hospital patient based on his transgender status constitutes sex discrimination under Section 1557 of the Affordable Care Act); *Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018) (holding that a Medicaid program's refusal to cover treatments related to gender transition is "text-book discrimination *based on sex*" in violation of the Affordable Care Act and the Equal Protection Clause of the Constitution); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. 2016) (holding exclusion invalid under the Medicaid Act and the Affordable Care Act); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090 (S.D. Cal. Sept. 27, 2017) (holding that discrimination against transgender patients violates the Affordable Care Act); *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018)

Such discrimination can lead to severe health outcomes for members of the LGBTQ+ community. Research shows that transgender individuals may be more likely to postpone or avoid care due to past experiences of discrimination,[34] thus potentially compromising their health. A regulation that permits such discrimination would further marginalize members of the transgender community, who may be even less likely to seek crucial care due to fears of discrimination. A published study also found "significant associations between experiencing discrimination in public settings and adverse health outcomes among gender minority adults."[35] The proposed rule could exacerbate obstacles members of the LGBTQ+ community face in receiving crucial healthcare. OCR should consider these severe potential health outcomes for members of the LGBTQ+ community and withdraw the rule.

Our organization is also opposed to the proposed changes to roll back other, long-standing rules that prohibit discrimination on the basis of gender identity and sexual orientation.[36] These changes are outside of the OCR's jurisdiction and are unrelated to Section 1557 of the ACA. It is not appropriate for these rulemakings to be combined, and it is arbitrary and capricious for HHS to characterize them as "conforming amendments"[37] without offering any legal, policy or cost-benefit analysis about them and their impacts on various CMS programs.

The 2016 Final Rule is the product of a lengthy process of deliberation and public input. The rule was developed over the course of six years of study and following two comment periods, with over 25,000 comments from stakeholders, which were overwhelmingly supportive of inclusion of protections against discrimination based on sex stereotyping and gender identity. HHS engaged stakeholders through listening sessions, participation in conferences, and other outreach prior to taking regulatory action.

The provisions in the rule that strip protections for LGBTQ+ people represent a step back that would severely impact the health and wellbeing of members this community. As an organization dedicated to LGBTQ+ equality and inclusion we strongly oppose these changes.

B. Certain Proposed Changes Would Severely Curtail Women's Rights, Amounting to Sex Discrimination Based on Pregnancy

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

(holding that Section 1557 of the Affordable Care Act prohibits discrimination on the basis of gender identity); *Boyden v. Conlin,* No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018) (holding that a state employee health plan refusal to cover transition-related care constitutes sex discrimination in violation of Title VII, Section 1557 of the ACA, and the Equal Protection Clause).

[34] Jennifer Glick et al., *The Role of Discrimination in Care Postponement Among Trans-Feminine Individuals in the U.S. National Transgender Discrimination Survey*, 5 LGBT HEALTH 171, 176 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6425922/pdf/lgbt.2017.0093.pdf; SHARITA GRUBERG AND FRANK J. BEWKES, THE ACA'S LGBTQ NONDISCRIMINATION REGULATIONS PROVE CRUCIAL 7 (CENTER FOR AMERICAN PROGRESS 2018), https://cdn.americanprogress.org/content/uploads/2018/03/06122027/ACAnondiscrimination-brief2.pdf.

[35] Sari L. Reisner et al., *Legal Protections in Public Accommodations Settings: A Critical Public Health Issue for Transgender and Gender-Nonconforming People*, 93 MILBANK Q. 484, 509 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4567851/pdf/milq0093-0484.pdf.

[36] These are: 45 C.F.R. § 155.120(c)(1)(ii) and § 155.220(j)(2), 45 C.F.R. § 147.104(e), 45 C.F.R. § 156.200(e) and § 156.1230(b)(3), 42 C.F.R. § 460.98(b)(3) and § 460.112(a), 42 C.F.R. § 438.3(d)(4), § 438.206(c)(2), and § 440.262.

[37] Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846, 27849 (proposed June 14, 2019).

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

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

The Latina and Latinx population would face disproportionate consequences from these proposed changes. Their lack of access to comprehensive, affordable insurance coverage means sporadic, if not non-existent, access to desperately needed treatment and services. Due to this and other factors, Latinas experience disproportionately high rates of unintended pregnancy, sexually transmitted infections, diabetes, and other health issues.[38] Latinas have the highest incidence of cervical cancer.[39] Immigrant Latinas often experience these inequities because they lack employment opportunities that provide insurance coverage, face extreme poverty, and lack culturally and linguistically appropriate health care providers and services.[40]

We vehemently oppose these changes, which we know would have an immediate negative impact on the low-income immigrant populations we represent.

VIII. We Urge the Trump Administration to Withdraw This Unlawful Rule

NILC urges the administration to adhere to the 2016 Rule's faithful interpretation of Section 1557. The proposed changes would breed discrimination against numerous groups and leave many without necessary protections—including LEP individuals, women, and members of the LGBTQ+ community. As an organization dedicated to advancing the rights of low-income immigrants—whose identities

[38] Mareshah Jackson, *Fact Sheet: The State of Latinas in the United States*, CENTER FOR AMERICAN PROGRESS (Nov. 7, 2013), https://www.americanprogress.org/issues/race/reports/2013/11/07/79167/fact-sheet-the-state-of-latinas-in-the-united-states/; *Cervical Cancer Incidence Rates Remain Higher in Hispanic/Latina Women*, CANCER ACTION NETWORK (last visited Aug. 1, 2019), https://www.fightcancer.org/sites/default/files/FINAL%20-%20Hispanic%20Latinas%20and%20Cervical%20Cancer%2005.09.17.pdf.

[39] *Cervical Cancer Incidence Rates Remain Higher in Hispanic/Latina Women*, CANCER ACTION NETWORK (last visited Aug. 1, 2019), https://www.fightcancer.org/sites/default/files/FINAL%20-%20Hispanic%20Latinas%20and%20Cervical%20Cancer%2005.09.17.pdf.

[40] *The Reproductive Health of Latina Immigrants*, NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH (Dec. 2005), https://latinainstitute.org/sites/default/files/RepoHlthImgrnt-5_0.pdf.

intersect with many of these vulnerable groups—we strongly oppose these changes. For the reasons we outline above, we urge OCR to withdraw this proposed rule.

Respectfully,

Gabrielle Lessard
Senior Policy Attorney
National Immigration Law Center

Mariel Perez-Santiago
Law Clerk
National Immigration Law Center

EXHIBIT D-17

GLMA
Health Professionals
Advancing LGBT Equality

August 13, 2019

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

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

Dear Secretary Azar,

GLMA: Health Professionals Advancing LGBTQ Equality (GLMA) writes today in opposition to Section 1557 NPRM, RIN 0945-AA11, "Nondiscrimination in Health and Health Education Programs or Activities" and strongly urges withdrawal of the proposed rule.

GLMA—previously known as the Gay & Lesbian Medical Association—is a national association of lesbian, gay, bisexual, transgender and queer (LGBTQ) healthcare professionals and their allies whose mission is to ensure health equity for LGBTQ and all sexual and gender minority (SGM) individuals and equality for LGBTQ healthcare professionals. Founded in 1981, GLMA employs the expertise of our medical and health professionals in education, policy and advocacy, patient education and referrals and the promotion of research to improve the health and well-being of LGBTQ people and their families.

Since our founding, GLMA has believed in the critical importance of eliminating health disparities and ensuring that all people, including LGBTQ individuals and their families, do not face discriminatory barriers when seeking quality, affordable healthcare and coverage. We therefore take this opportunity to strongly oppose the changes to the Section 1557 regulation outlined in the proposed rule, in particular the provisions that would eliminate nondiscrimination protections based on gender identity or sex stereotyping in healthcare access and coverage.

As an organization of health professionals who often serve and care for patients from the LGBTQ community, we know that discrimination against LGBTQ individuals in healthcare and coverage remains a pervasive problem. Despite recent advances in legal protections for LGBTQ individuals, LGBTQ people living across the United States continue to regularly encounter discrimination on the basis of sexual orientation and gender identity when seeking health insurance coverage and healthcare. Numerous surveys, studies, and reports have documented the widespread extent of the discrimination experienced by LGBTQ individuals and their families in the health system. *When Health Care Isn't Caring*, a nationwide survey assessing the healthcare experiences of LGBTQ people and people living with HIV, found that the majority of the almost

5,000 respondents reported experiencing at least one of the following types of discrimination when accessing healthcare:[1]

- Health care providers refusing to touch them or using excessive precautions
- Health care providers using harsh or abusive language
- Health care providers being physically rough or abusive
- Health care providers blaming them for their health status

The US Transgender Survey, the largest survey detailing the experiences of transgender people in the United States, further documents the pervasive discrimination faced by transgender and gender nonconforming individuals in healthcare settings. According to the study, "[o]ne-third (33%) of those who saw a health care provider had at least one negative experience related to being transgender, such as being verbally harassed or refused treatment because of their gender identity." [2]

These encounters with discrimination have serious negative consequences for the health and wellbeing of LGBTQ individuals. They also exacerbate the significant health disparities that affect the LGBTQ population at large. Sources such as the National Academy of Medicine[3] (formerly the Institute of Medicine), the Centers for Disease Control and Prevention, and Healthy People 2020 report that discrimination threatens the health of the LGBTQ population in ways that include:[4]

- Increasing risk factors for poor physical and mental health such as smoking and other substance use;[5]
- Driving high rates of HIV among transgender women and gay and bisexual men;[6]
- Barring access to appropriate health insurance coverage, especially for transgender people;[7]
- Obstructing access to preventive screenings;[8] and
- Putting LGBTQ people at risk of poor treatment from health care providers who are unprepared to meet the needs of LGBTQ patients.[9]

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[1] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010), *available at* http://www.lambdalegal.org/publications/when-health-care-isnt-caring (hereinafter "When Health Care Isn't Caring").
[2] Nat'l Ctr. for Transgender Equality, *The Report of the 2015 US Transgender Survey* (2016), *available at* http://www.transequality.org/sites/default/files/docs/usts/USTS%20Full%20Report%20-%20FINAL%201.6.17.pdf.
[3] *See, e.g.*, Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), *available at* http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx.
[4] U.S. Dep't of Health and Human Services, *Healthy People 2020: LGBT Health Topic Area* (2015), *available at* http://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health.
[5] Ctr. for Disease Control and Prevention, "Lesbian, Gay, Bisexual, and Transgender Health" (July 2014), *available at* http://www.cdc.gov/lgbthealth/about.htm.
[6] Office of Nat'l AIDS Policy, "National HIV/AIDS Strategy," (2015).
[7] Laura E. Durso, Kellan E. Baker, and Andrew Cray, *LGBT Communities and the Affordable Care Act: Findings from a National Survey* (2013), *available at* http://www.americanprogress.org/wp-content/uploads/2013/10/LGBT-ACAsurvey-brief1.pdf.
[8] Fenway Institute, *Promoting Cervical Cancer Screening Among Lesbians and Bisexual Women* (2013), *available at* http://www.lgbthealtheducation.org/wp-content/uploads/Cahill_PolicyFocus_cervicalcancer_web.pdf.

GLMA members have reported witnessing numerous instances of discrimination in healthcare against LGBTQ people, and in particular transgender individuals, including members who have recently shared:

- "I see patients nearly every day who have been treated poorly by providers with moral and religious objections… Patients with HIV who have been told they somehow deserved this for not adhering to God's law. Patients who are transgender who have been told that 'we don't treat your kind here'. The psychological and physical damage is pervasive."

- "[Some providers in my clinic] do not wish to have contact with transgender patients, mumbling religious incompatibilities when asked why. These people have made our transgender patients feel very uncomfortable and unwelcome at times, making them more potentially more hesitant to use the health services they may need."

- "The impact on my patients who were directly denied care was both psychological and physical. With regard to their mental wellbeing they clearly felt marginalized and disrespected. With regard to their physical wellbeing, they experienced delay in care, and in some cases disruption of their routine medication dosing or diagnostic assessment."

In this context, the Section 1557 nondiscrimination implementing rule adopted in 2016 has played a key role in addressing health disparities faced by vulnerable Americans—including transgender individuals—by protecting these communities from discriminatory practices that impede their access to care and coverage and ensuring access to medically necessary care. The national consensus about the importance of these protections is reflected in the number of leading medical and mental health associations, including the American Medical Association[10] and the American Psychological Association,[11] among many others, who have spoken out in support of maintaining the Section 1557 rule. In fact, in May 2019, GLMA and the American Psychiatric Association helped organize more than 30 associations who joined a letter to you in support of the 1557 nondiscrimination regulation.[12] (See also Attachment A.)

Conclusion

Reducing discrimination and other barriers to accessing health and human services and the accompanying health disparities faced by marginalized communities is core to HHS' mission to "enhance and protect the health and well-being of all Americans." The 1557 nondiscrimination regulation fosters this commitment and ensures that LGBTQ people have access to healthcare and coverage, including equal access to medically necessary care. GLMA supports Section

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[9] "When Health Care Isn't Caring," *supra* note 2.
[10] Am. Medical Assn., *Letter to Director Roger Severino* (Sept. 1, 2017), https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2017-09-01_Letter-to-Severino-re-Section-1557-Identity-Protection.pdf.
[11] Am. Psychological Assn., *Comment on Department of Health and Human Services Request for Information, Docket No. CMS-9928-NC* (July 12, 2017), https://www.regulations.gov/document?D=CMS-2017-0078-2528.
[12] GLMA, *Letter to Sec'y Azar* (May 23, 2019), http://glma.org/index.cfm?fuseaction=document.viewdocument&ID=CEB9FEE4B8DD8B7F4F7575376BD476C3D4D67E05EEFE579F64358A4E67735C28C0731320B03D2F5E1022F1C15602FBEA

1557's nondiscrimination provisions as an essential tool to ensuring the health and well-being of lesbian, gay, bisexual, transgender and queer people in this country. Therefore, GLMA strongly urges HHS to refrain from any action that would eliminate the 1557 nondiscrimination rule and recommends expeditious withdrawal of the proposed rule.

Sincerely,

Hector Vargas, JD
Executive Director

ATTACHMENT A

May 24, 2019

Sent Via Email and Fax

The Honorable Alex Azar
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Dear Secretary Azar,

The undersigned health professional associations representing providers of all disciplines and patients across the country are deeply concerned with the Department's announcement today of plans to weaken nondiscrimination protections for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) individuals under Section 1557 of the Affordable Care Act. We oppose these efforts and express our strong support for providing the strongest nondiscrimination protections available for LGBTQ people.

Section 1557's nondiscrimination protections assist some of the populations that have been most vulnerable to discrimination, including LGBTQ people, and help provide those populations equal access to healthcare and health coverage.[1] Federal courts, including in the context of Section 1557, have recognized repeatedly over many years that sex discrimination includes discrimination based on gender identity. The subsequent regulations promulgated under Section 1557 further clarify that discrimination based on gender identity and sex stereotyping is prohibited in healthcare coverage and access.

Despite advances in acceptance for LGBTQ people, stigma and discrimination continue to be the greatest problems facing sexual and gender minorities. In fact, many LGBTQ people develop an internalized shame that can contribute to problems with self-acceptance, anxiety, depression, difficulty forming intimate relationships, and being open about their sexual orientation or gender identity. The literature on the "minority stress model" highlights the impact of social prejudice, isolation and invisibility as the primary factors leading to an increased health burden and greater risk of mental health issues, homelessness and unemployment.[2] LGBTQ patients also have higher rates of suicide with 40 percent of transgender people reporting attempting suicide.[3,4] Additionally, the risk of physical conditions is also exacerbated with increased rates of tobacco use, HIV and AIDS, and weight problems.[2]

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[1] 81 Fed. Reg. 31435 (May 18, 2016).
[2] Hatzenbuehler, M. L., Mclaughlin, K. A., Keyes, K. M., & Hasin, D. S. (2010). The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations: A Prospective Study. American Journal of Public Health, 100(3), 452-459.
[3] Grant et al. (2011). Injustice at every turn: A report of the National Transgender Discrimination Survey. Washington, DC; National Center for Transgender Equality and National Gay and Lesbian Task Force.
http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf
[4] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

LGBTQ patients are already more likely to delay getting necessary medical care. In the latest Report of the 2015 U.S. Transgender Survey, nearly one in four respondents reported not seeing a doctor when they needed to for fear of being mistreated. For those that had sought health services in the last year, respondents reported having at least one negative experience, such as refusal of treatment or having to teach the provider about transgender people.[4] Moreover, the lack of data in national surveys and administrative claims make it a challenge to comprehensively study disparities in this population, and more research is needed to enhance clinical care.[5]

The data that we do have indicates that discrimination has detrimental impacts on the physical and mental health of the LGBTQ population.[6] To reduce the cost of health care and achieve our goal of creating a healthier nation, the specific needs of LGBTQ patients must be examined and effectively addressed.

All the undersigned associations have adopted policies or otherwise support addressing the specific health concerns of LGBTQ people, including opposition to discrimination in health care and insurance coverage based on an individual's sexual orientation or gender identity. As part of that commitment, our organizations support public and private health insurance coverage for treatment of gender dysphoria when medically necessary.

In sum, we stand firmly behind Section 1557's gender identity protections and oppose any modifications to the rule that would weaken those protections and thereby jeopardize the health and well-being of LGBTQ populations.

We urge you to reconsider plans to revise the Section 1557 regulations and ensure HHS adopts strategies to focus on better access to health services and improved health outcomes for the millions of LGBTQ people in the United States.

Sincerely,

American Academy of Nursing
American Academy of PAs
American Academy of Pediatrics
American Academy of Psychiatry and The Law
American Association for Geriatric Psychiatry
American College Health Association
American College of Physicians
American Medical Association
American Medical Student Association
American Medical Women's Association
American Nurses Association
American Pediatric Surgical Association

[5] Reisner et al. (2016). Global Health Burden and Needs of Transgender Populations: A Review. *The Lancet*, 388, 412-436.
[6] Hatzenbuehler ML, McLaughlin, KA, Keyes, KM, Hasin, DS. (2010). The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations: A Prospective Study. American Journal of Public Health, 100(3), 452-459.

American Psychiatric Association
American Psychological Association
American Public Health Association
Association of American Medical Colleges
Association of Nurses in AIDS Care
Doctors for America
Endocrine Society
GLMA: Health Professionals Advancing LGBTQ Equality
HIV Medicine Association
LBGT Physician Assistant Caucus
National Association of Social Workers
National Council for Behavioral Health
National Council of Asian Pacific Islander Physicians
Society for Adolescent Health and Medicine
Society of General Internal Medicine
Society of Physician Assistants in Pediatrics
The Association of Gay and Lesbian Psychiatrists
United States Professional Association for Transgender Health
World Professional Association for Transgender Health

EXHIBIT D-18

August 9, 2019

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Section 1557 NPRM, RIN 0945-AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically

Re: Comment on Proposed Rule Regarding Section 1557, Health Care Rights Law

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

The ACLU-WV is a non-profit, non-partisan organization whose mission is to protect and expand the rights guaranteed under the US and West Virginia Constitutions. The ACLU-WV has over 2,000 members. Throughout our history, the ACLU-WV has combatted discrimination against individuals and groups and advocated for equal treatment under the law. This has included equality in healthcare, whether it be reproductive care, care for people with disabilities, or gender-affirming care.

The rule currently in place implementing Section 1557, titled "Nondiscrimination in Health Programs and Activities" (the "Current Rule"), was developed after years of review and consideration of comments from a variety of stakeholders. The Current Rule meets a critical need and fulfills Congress's intent to provide "equal access to health services and health insurance that all individuals should have, regardless of their race, color, national origin, age, or disability." 81 Fed. Reg. 31,459. Discrimination in the health care context leads to lasting harms to people's health and wellbeing, and the Department made detailed factual findings to that effect in support of the Current Rule: People subject to discrimination postpone or fail to obtain health services and are denied necessary care; such discrimination exacerbates health disparities in underserved communities.

The Proposed Rule, however, is yet another attempt by the Trump Administration and the Department of Health and Human Services (the "Department" or "HHS") to undermine access to health care for the most vulnerable individuals and communities, while emboldening discriminatory and dangerous denials of care. The Proposed Rule's explicit reductions in the scope of antidiscrimination protections, as well as the implicit invitation for health care providers to undermine access to care, completely disregard the potential harms to individuals trying to access health care and coverage. This approach is contrary to the statutory language of Section 1557, and is a reversal of the reasoned policy decisions of the Current Rule. Further, it will fail to accomplish its stated goal to decrease confusion, instead increasing the burdens and costs of compliance.

For these reasons, as well as the ones that follow, the ACLU-WV recommends that the Department decline to finalize the Proposed Rule in its entirety.

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

There is a need for anti-discrimination protection in healthcare. The ACLU-WV has represented same-sex married couples when spouses were denied insurance by employers. In West Virginia people with substance-abuse disorders turned away from healthcare by providers. And in West Virginia, 1 in 5 trans individuals have been refused *basic* medical care.

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

In promulgating the Current Rule, the Department recognized the importance of affirmative regulatory protections—specifically for all enumerated forms of sex discrimination. The Current Rule defines discrimination based on sex to include discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity. 45 CFR 92.4. The Proposed Rule eliminates this key provision that clarifies what discrimination on the basis of sex encompasses, and removes explanatory examples of prohibited activity. The Proposed Rule also amends regulations—and incorporates an abortion exemption—that are unrelated to Section 1557. These changes are without justification and will directly harm patients seeking care.

1. The proposed amendments abandon LGBT individuals and people seeking reproductive health care, who depend on HHS to protect their statutory rights.

Section 1557 and the Current Rule are intended to protect people from the pervasive problem of sex-based discrimination in the health care context. Lesbian, gay, bisexual, and transgender ("LGBT") patients, as well as people who seek or have obtained reproductive health services, face discrimination based on sex in accessing health care. This discrimination can range from providers using harassing or abusive language to completely refusing necessary medical care. Sex-based exclusions from health care coverage can also make essential medical care unaffordable. For example, some transgender and non-binary individuals are subject to discriminatory categorical exclusions for health care related to gender transition that put necessary health care out of financial reach. By eliminating the definition of discrimination on the basis of sex, as well as stripping protections against discrimination based on gender identity and sexual orientation from other unrelated HHS regulations, the Proposed Rule will invite such discrimination against LGBT individuals and people seeking reproductive health care.

The Department fails to even consider the impact that the Proposed Rule would have on individuals who are protected under the Current Rule. Roughly 6,100 people, 0.42% of the West Virginia population identify as transgender. Department must prioritize the impact that inviting discrimination against patients will have on public health, particularly the harms to transgender and non-binary individuals, as well as people who need or have obtained pregnancy-related health services, all of

whom would no longer have explicit regulatory protections against sex discrimination if the Proposed Rule is finalized.

2. The proposed amendments do not provide clarity, but only create more confusion.

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

Because discrimination based on sex would still be prohibited, discrimination based gender identity would remain unlawful under Section 1557 as well. Courts have consistently held that Title IX's prohibition on sex discrimination protects individuals from discrimination based on gender nonconformity. See *EEOC v. R.G. &. G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 572 (6th Cir. 2018), cert. granted in part, 139 S. Ct. 1599 (2019); *Whitaker ex rel. Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ*., 858 F.3d 1034, 1046–54 (7th Cir. 2017); *Glenn v. Brumby*, 663 F.3d 1312, 1316 (11th Cir. 2011); *Schwenk v. Hartford*, 204 F.3d 1187, 1201 (9th Cir. 2000); *Rosa v. Park W. Bank & Tr. Co*., 214 F.3d 213, 215–16 (1st Cir. 2000). District courts across the country have also recognized that discrimination against transgender individuals because their gender identity diverges from their sex assigned at birth violates the plain text of Section 1557. See *Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 953 (D. Minn. 2018); *Flack v. Wis. Dep't of Health Servs*., 328 F. Supp. 3d 931, 951 (W.D. Wis. 2018); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1098–1100 (S.D. Cal. 2017). Given the extensive legal precedent, the Department cannot simply assert by regulation that covered entities will not be liable for gender identity discrimination claims where such discrimination is prohibited by the statutory text.

Further, while the preamble to the Proposed Rule spends an inordinate amount of time attempting to justify the elimination of gender identity as an identified form of sex discrimination, it does not explain why the other definitional provisions are eliminated as well. Removing the definition of sex discrimination cannot change the underlying legal precedent that the current definition was based on and that still prohibits discrimination on the enumerated bases, including discrimination based on sex stereotyping, pregnancy discrimination, and pregnancy-related conditions. For example, in West Virginia, *Frank's Shoe Store v. Human Rights Com'n, (*365 SE 2d 251, 1986) supports the argument that discrimination based on sex encompasses discrimination based on pregnancy. To the extent there is variance among West Virginia laws and federal courts as to what constitutes discrimination based on sex, the Current Rule provides crucial uniformity.

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

The Proposed Rule would unnecessarily incorporate the abortion exemption from Title IX into regulations implementing Section 1557. Incorporating the abortion exemption violates the text and purpose of Section 1557, which prohibits discrimination "on the ground[s] prohibited under" the referenced civil rights statutes, not the attendant exemptions contained in those statutes. 42 U.S.C. § 18116 (emphasis added). Congress has already spoken clearly as to the restrictions it intended to place on abortion care and coverage, through both the ACA itself, see 42 U.S.C. § 18023(b)(1)(A), (b)(4), as well as the Weldon, Church, and Coats Amendments. Abortion care is health care related to pregnancy, and targeting it for exclusion undermines and stigmatizes access to care that is a constitutionally protected right.

* * *

Taken as a whole, the Proposed Rule strips explicit regulatory protections for LGBT individuals and for people who require reproductive health care, indicating that the underlying purpose for the amendments is to target transgender and non-binary individuals, as well as other people who face sex-based discrimination in accessing health care and insurance coverage. That is neither consistent with the text of the statute, nor the appropriate mission of the Department. The Proposed Rule is also untimely, as the U.S. Supreme Court granted petitions for review in three cases addressing whether sex discrimination encompasses discrimination based on sexual orientation, gender identity, and discrimination against transgender individuals due to sex stereotyping under Title VII. *Altitude Exp., Inc. v. Zarda*, 139 S. Ct. 1599 (2019); *Bostock v. Clayton Cty*., Ga., 139 S. Ct. 1599 (2019); *R.G. & G.R. Harris Funeral Homes, Inc. v. EEOC*, 139 S. Ct. 1599 (2019). Because Title IX generally adopts the standards for discrimination under Title VII, the Department will need to address the practical implications of any decision by the Court through a renewed comment process. Accordingly, the Department should abandon the Proposed Rule and instead leave in place the existing rule that discrimination based on gender identity is a form of sex discrimination, as is discrimination based on pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, and sex stereotyping.

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

Historically, people with disabilities in the United States have been unable to access the health care they need because of discrimination by the health insurance industry. Prior to the ACA, people with disabilities were commonly denied or terminated from health coverage, faced annual and lifetime benefit limits, and could not find affordable coverage. Access to adequate health care at affordable rates is central to the ability of disabled people to participate fully in society.

The Department proposes to eliminate Section 92.207 of the Current Rule in its entirety, which would undermine the right of people with disabilities to challenge discriminatory benefit design. Under the Current Rule, for example, plans that cover bariatric surgery in adults but exclude such coverage for adults with particular developmental disabilities, place most or all drugs that treat a specific condition on the highest cost tiers, or exclude bone marrow transplants

regardless of medical necessity, constitute disability discrimination in violation of Section 1577. The Department claims that the provision is redundant or may be confusing in relation to the

Department's preexisting regulations. But the Current Rule is needed precisely because existing laws were insufficient to dismantle barriers to adequate health insurance for people with disabilities. The deletion thus contravenes Section 1557's plain language.

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

C. HHS should not weaken protections for individuals with Limited English Proficiency.

The Department should not eliminate the language access protections as described by the Proposed Rule. In West Virginia, there are nearly 14,000 people with limited English proficiency ("LEP"), and they should all have meaningful access to health care and coverage. Language assistance is necessary to ensure that LEP persons are guaranteed such access, and is a critical protection to combat discrimination on the basis of national origin, which encompasses discrimination on the basis of language.

The Proposed Rule would eliminate significant protections for LEP persons by removing the requirement that covered entities provide notices of legal rights and in-language taglines on significant publications. The taglines are cost-effective ways to maintain access for LEP individuals without translating entire documents. The Department ignores the impact on LEP individuals should this requirement be eliminated, relying solely on reports from health plans, with no public outreach to determine the impact of the taglines or to explore alternatives. Likewise, the Department should not eliminate references to language access plans, which are a useful tool for covered entities to fully plan how to meet the needs of LEP patients and consumers. Such plans also support covered entities' own compliance efforts, benefiting both LEP individuals and covered entities alike.

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

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

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

A. HHS Should Not Import a Religious Exemption into Section 1557.

The Proposed Rule wrongly would allow religiously affiliated healthcare providers to discriminate based on sex and to refuse access to necessary medical care, by importing Title IX's expansive religious exemptions into Section 1557. Religiously affiliated healthcare providers

make up a significant percentage of the healthcare facilities in the United States. One in six patients is now treated in a Catholic facility each year, and religious hospitals are also increasingly the only health care option in many regions. In West Virginia, over 12% of all hospital beds are in Catholic hospitals.

The proposed religious exemption violates the text and purpose of Section 1557, as well as the constitutional commitment to the separation of church and state. The statute prohibits discrimination "on the *ground*[s] prohibited under" the referenced civil rights statutes, 42 U.S.C. § 18116 (emphasis added), but does not incorporate the attendant exemptions contained in those statutes—many of which are wholly inapposite to the health care context. The Department should not reverse course by incorporating the exemption, having initially rejected invitations to do so. Further, the First Amendment forbids government action favoring religion to the point of forcing third parties to bear the costs of those beliefs. See *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 708–10 (1985). The Proposed Rule's exemption flies in the face of the careful balance courts have struck between civil rights and religious liberty, running afoul of the Establishment Clause.

Permitting a blanket religious exemption to Section 1557's nondiscrimination mandate threatens access to critical care for countless patients, especially transgender patients and patients seeking reproductive health services. The Proposed Rule altogether fails to consider the harmful consequences of importing a broad religious exemption into the health care context.

B. HHS Should Not Narrow the Scope of Covered Entities.

The Proposed Rule would further undercut Section 1557 by limiting the entities covered by the provision. Limiting the application of Section 1557's protections would sanction discriminatory denials of coverage by entities that are presently covered by Section 1557, causing confusion and serious harm to those unable to access care. Additionally, the Proposed Rule displays no awareness of the potential harm to individuals denied coverage of and access to health care due to the proposed limitations on Section 1557's application.

Excluding health insurance from Section 1557's nondiscrimination mandate as distinct from "health program or activity" is contrary to the text of the statute and the broader antidiscrimination purpose of the law. The false distinction is exacerbated by the Proposed Rule's new limitation on the application of Section 1557 in cases where the entity is not "principally engaged in the provision of health care." In such cases, under the proposal, Section

1557 would apply only to the specific operations of an entity that receive federal financial assistance—whereas Section 1557 covers all operations of entities principally engaged in health care that receive federal financial assistance. This distinction, too, is contrary to the text of the statute, which prohibits discrimination under "any health program or activity, *any part of which* is receiving Federal financial assistance." 42 U.S.C. § 18116 (*emphasis added*).

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

The Current Rule adopts a uniform standard, applicable to all grounds covered by Section 1557, and incorporates enforcement mechanisms that exist under any of the civil rights laws referenced by Section 1557. This includes a private right of action for disparate-impact claims and the availability of compensatory damages for all claims under Section 1557. In removing these provisions, the proposed rule creates a scheme in which people are denied certain legal remedies because of the type of discrimination they experience. Such a change also privileges purported business interests in relieving regulatory burdens over the interests of the public and of individuals seeking health care. However, by removing the certainty of the Current Rule, covered entities and protected individuals alike would be uncertain as to the law's requirements and protections, instead leaving them to look to four other separate civil rights laws and various agencies' implementing regulations for clues.

The Proposed Rule's silence regarding the availability of a private right of action is at worst contrary to the rights-expanding aims of the statute and, at best, purposeless. Parties asserting private rights of action pursuant to Section 1557 have significantly expanded access to health care and combatted discriminatory health care policies, and will continue to do so, regardless of regulatory language explicitly affirming that such a right exists.

The Department should also not eliminate the Current Rule's provision for disparate-impact claims, which promotes better compliance with Section 1557's nondiscrimination provisions. The disparate-impact mechanism encourages health care providers to identify disparities and to adopt solutions that make a crucial difference in eliminating those disparities for individuals and improving public health.

These enforcement mechanisms are particularly important for people of color. Addressing racial disparities in health care is a matter of life and death. Such disparities are found across a range of illnesses and health care services, even when accounting for socioeconomic factors. Disparities in health care also have historic roots. As in other sectors of society, segregated health care was once sanctioned by law, and government-sanctioned discrimination continues to have a systemic impact on access to quality health care. At the same time, research suggests that many racial and ethnic health disparities could be reduced or even eliminated if identified and addressed. A disparate-impact private right of action is a crucial enforcement mechanism to confront and redress discrimination.

The Department's proposal would instead make enforcement more difficult, and would increase confusion as to the scope of Section 1557's protections. The Department should accordingly continue to affirm existing enforcement mechanisms, including the private right of action for disparate-impact claims.

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

The Proposed Rule would unnecessarily eliminate the specific grievance procedures established under Section 1557, which would leave covered entities and impacted individuals without cohesive, uniform procedures for investigating grievances. Further, the Department should not eliminate the explicit requirement that such procedures "incorporate appropriate due process standards," which provides that the procedures in place are sufficient to address claims of

discrimination promptly and equitably. 45 CFR 92.7. Likewise, the Department should not eliminate the requirement that covered entities provide notice to the public that they do not discriminate, as the current procedure is crucial to ensure that individuals are aware of the safeguards in place and of the steps they can take to effectuate the protections under Section 1557. 45 CFR 92.8. The costs associated with the notice requirement are well worth the benefit of ensuring that protected individuals receive adequate notice of their rights.

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

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

* * *

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

Sincerely,

Eli Baumwell
(*he/him/his*)
Policy Director, ACLU-WV
ebaumwell@acluwv.org
304-345-9246 (ext. 104)

EXHIBIT D-19

CIVIL LIBERTIES COMMITTEE
OF THE
CHICAGO COUNCIL OF LAWYERS

August 12, 2019

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Section 1557 NPRM, RIN 0945-AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Re: Nondiscrimination in Health and Health Education Programs or Activities

Dear Sir or Madam:

The Chicago Council of Lawyers (Council) is a reform-minded bar association whose focus is on the needs of the poor and disadvantaged populations who often have unequal access to the justice system. The Civil Liberties Committee (Committee) is a standing committee of the Council that advocates for policies that strengthen the civil liberties of American citizens.

The Department of Health and Human Services (HHS) has proposed a rule (Proposed Rule) that purports to "clarify" the scope of Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability under any health program or activity that receives federal financial assistance. Under the Obama Administration, HHS adopted a rule (Existing Rule) that defined discrimination "on the basis of sex" to include, among other things, discrimination on the basis of gender identity. 45 CFR 92.4 (2018). The Proposed Rule would revise the Existing Rule substantially and would no longer prohibit discrimination on the basis of gender identity. *See* 84 Fed. Reg. 27846, 27852-57 (June 14, 2019).

The Committee submits these comments in opposition to the Proposed Rule. We believe that discrimination on the basis of gender identity should be prohibited both for legal and policy reasons.

As noted in the Federal Register notice publishing the Proposed Rule, a number of federal courts have rendered decisions on whether discrimination on the basis of gender identity is covered by various civil rights laws that prohibit discrimination "on the basis of sex." Different courts have answered that question differently. Although the early cases ruled that gender identity was not covered by the civil rights laws, a number of more recent cases have taken the opposite view. We believe that the legal reasoning of those more recent cases is persuasive.

For example, in *EEOC v. R.G. & G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560 (6th Cir. 2018), an employee at a Michigan funeral home was born biologically male, but decided to transition from male to female and to dress as a woman at work. After being notified of this decision by the employee, the funeral home fired the employee because "he was no longer going to represent himself as a man. He wanted to dress as a woman." The court held that the funeral home violated Title VII of the Civil Rights Act of 1964 by firing the employee on the basis of her transgender or transitioning status, ruling that discrimination on the basis of transgender and transitioning status is "necessarily discrimination on the basis of sex." It should be noted that the U.S. Supreme Court recently granted petitions for writs of certiorari in this case and two others that raised the question whether Title VII's prohibition on discrimination on the basis of sex also bars discrimination on the basis of gender identity or sexual orientation.

As a matter of public policy, discrimination on the basis of gender identity can have serious consequences in the area of health care. For example, the Arizona state employee health plan has a blanket exclusion for gender-confirming surgery, and transgender persons are not offered the opportunity to demonstrate that their transition-related surgery is medically necessary. We believe that this type of discrimination should be prohibited under Section 1557 of the Affordable Care Act so that the claims of transgender persons that gender-confirming surgery is medically necessary will be evaluated under the same standards and procedures the health plan applies to other medical treatments.

For the reasons set forth above, the Civil Liberties Committee of the Chicago Council of Lawyers urges HHS not to adopt the Proposed Rule and to retain the policies contained in the Existing Rule.

Respectfully submitted,

David Melton
Carl A. Royal
Gordon Waldron
Co-chairs of the Civil Liberties Committee

EXHIBIT D-20

Tuesday, August 13th, 2019

VIA ELECTRONIC SUBMISSION

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

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

Dear Secretary Azar:

The NARAL Pro-Choice Oregon Foundation strongly opposes the proposed changes to regulations implementing the Health Care Rights Law, also known as Section 1557 of the Affordable Care Act.

NARAL Pro-Choice Oregon Foundation supports and protects, as a fundamental right and value, a person's freedom to make individual decisions regarding the full range of reproductive choices—including preventing unintended pregnancy, bearing healthy children, and choosing legal abortion—through education, training, organizing, and research. We champion public policy that addresses disparities in reproductive health care and promotes health equity for all people. Therefore, we strongly oppose the proposed rule, which would undermine healthcare nondiscrimination protections and disproportionately impact health outcomes for those who already face the most severe barriers to care: transgender and gender nonconforming people, members of the LGBTQ community, people seeking abortion services or who have terminated a pregnancy and people whose primary language is non English.

While Section 1557 remains the law, this proposed rule aims to eliminate key protections against discrimination in healthcare. The rule poses significant risks to those the law is intended to protect, such as those who need reproductive healthcare like abortion; women of color; lesbian, gay, bisexual, transgender and queer (LGBTQ) people; people whose primary language is not English; and other members of marginalized groups who live with a disability or other chronic conditions. The proposed rule could create additional barriers and potentially lead to worse health outcomes that disproportionately impact those living at the intersections of the aforementioned identities.

If implemented, the rule would send the wrong message to healthcare providers that they are free to discriminate, creating additional barriers for marginalized members of the communities they serve. NARAL Pro-Choice Oregon Foundation believes all individuals should receive quality healthcare based on medical need without facing discrimination; the rule would allow healthcare providers to deny any care, even if it has nothing to do with a patient's gender identity or pregnancy termination. By limiting who must abide by

anti-discrimination regulations, the rule also weakens other protections against discrimination such as those protecting against racial or age-based discrimination. People's healthcare should always be based on their medical needs and should not be obstructed by personal beliefs or prejudices of their healthcare provider.

NARAL Pro-Choice Oregon Foundation strongly opposes the use of proposed regulations that attempt to eliminate or roll back critical protections guaranteed by Section 1557 and urge that this proposed rule be rescinded in its entirety.

I. The Proposed Rule Illegally Attempts to Narrow the Scope of Section 1557

The law is clear that its protections apply broadly to "any health program or activity, any part of which is receiving federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)." In keeping with the intent of the law, the 2016 final rule implementing Section 1557 applied to all health programs and activities that receive federal financial assistance from the Department, all health programs and activities administered by the Department and state-based insurance marketplaces. The 2016 final rule defines health programs and activities to include all operations of an entity receiving federal financial assistance that is principally engaged in the provision or administration of health-related services of health-related insurance coverage.

In contrast, the proposed rule violates the law in attempting to reduce the number of health insurance plans that are covered by claiming that if the issuer of a health plan is "not principally engaged in the business of providing health care (as opposed to health insurance), only its marketplace plans would be covered and any plans it offers outside the marketplace would not be subject to Section 1557."[1] Additionally, the proposed rule improperly attempts to narrow the application of Section 1557's protections to only a portion of a health care program or activity that received federal financial assistance. If this change were implemented, it would have significant consequences, particularly for consumers who purchase short-term limited duration insurance because those insurers would no longer be considered health care entities and these specific plans do not receive federal financial assistance.

This rollback could mean that certain insurance plans, like short-term plans, would not be subject to the language access requirements of the Section 1557 regulations. Short-term plans are already notorious for discriminating against consumers based on gender, gender identity, age and disability. If implemented, the proposed rule would further embolden short-term plans to discriminate against these populations by refusing to cover reproductive health care, excluding services for transition-related care, or making it more difficult for people to access primary care that insurers view as not corresponding to an individual's gender marker (such as a trans man needing a pap smear because he still has female reproductive organs).

II. The Proposed Rule Illegally Attempts to Narrow the Definition of Sex Discrimination

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

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

The proposed rule would have a disproportionate impact on LGBTQ people—especially transgender, non-binary and gender nonconforming people, who already face unique barriers to accessing care, such as high un-insurance rates, discrimination and harassment. The 2016 final rule implementing Section 1557 had clarified that health care providers cannot refuse to treat someone because of their gender identity—a regulation also supported by Oregon law. The proposed rule would allow a health care provider to refuse to treat someone because of their gender identity, even for unrelated treatments such as for a cold or a broken bone.

The 2016 final rule also clarified that insurance companies cannot categorically exclude or deny coverage for gender-affirming care, but the proposed rule illegally attempts to again open the door to such discrimination. Moreover, under the proposed rule, transgender, non-binary and gender nonconforming people assigned female at birth whose gender marker is male or non-binary could be denied coverage for critical preventative care such as a pap smear or mammogram. Similarly, transgender, non-binary and gender nonconforming people assigned male at birth whose gender marker is female or nonbinary could be denied necessary preventative care such as a prostate exam.

Transgender, non-binary and gender nonconforming people already experience high rates of discrimination and harassment in healthcare. According to the 2015 U.S. Transgender Survey, 33 percent of respondents had at least one negative experience in a health care setting relating to their gender identity in the past year.[2] According to a 2018 study from the Center for American Progress, 23 percent had a provider intentionally mis-gender or use the wrong name for them, 21 percent had a provider use harsh or abusive language when treating them and 29 percent experienced unwanted physical contact from a health provider, such as fondling, sexual assault or rape.[3]

According to the 2015 U.S. Transgender Survey, in Oregon, 33 percent of respondents had encountered a problem with their insurance relating to their gender identity in the past year, 22 percent did not see a medical provider when they needed to due to fear of discrimination or being mistreated and 36 percent reported at least one negative experience with a health care provider related to being transgender.[4] The proposed rule could impermissibly open the door to further discrimination.

The 2016 final rule made clear that sex discrimination under Section 1557 includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy or recovery therefrom, childbirth and related conditions. The proposed rule attempts to roll back these protections. Although HHS acknowledges in the preamble to this proposed rule that Title IX prohibits discrimination based on pregnancy, including termination of pregnancy, it refuses to state whether the Department would enforce those protections. While the scope of protection under Section 1557 is clear, without unambiguous implementing regulations and enforcement, illegal discrimination is likely to flourish.

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

[3] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[4] S.E. James, et al., Nat'l Ctr. for Transgender Equality, Report Of The 2015 U.S. Transgender Survey, Oregon State Report (2016), http://www.transequality.org/sites/default/files/docs/usts/USTSORStateReport%281017%29.pdf.

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

The 2016 final rule did not touch other HHS health care regulations, rightly so. The proposed rule attempts to erase all references to gender identity and sexual orientation in all HHS health care regulations, even those that are unrelated to Section 1557 such as regulations that govern a range of health care programs, including private insurance and education programs. This could result in less health care and poorer health outcomes for communities across the country.

Prior to the passage of the ACA, being transgender was treated as a pre-existing condition, which often precluded transgender people from getting or being able to afford health insurance coverage. Under the proposed rule, states and health insurance marketplaces could discriminate against LGBTQ people in eligibility determinations, enrollment periods and more. Furthermore, agents and brokers who assist with enrollment for marketplace plans could themselves discriminate against LGBTQ people.

Under the proposed rule, Programs of All-Inclusive Care for the Elderly (PACE) organizations, which serve people ages 55+, could discriminate against LGBTQ people.[5] Many older LGBTQ people report that they feel reluctant to discuss their gender identity or sexual orientation with health care providers for fear of discrimination or substandard care[6] and the proposed rule would only further discourage older adults who are a part of the LGBTQ community from sharing information relating to their health needs.

People in the LGBTQ community already face unique and significant barriers to accessing the health care they need. The proposed rule may exacerbate these already existing disparities and result in poorer health outcomes for LGBTQ people.

IV. The Proposed Rule Illegally Attempts to Eliminate Language Access Protections

The proposed rule would illegally withdraw language access protections for people with limited English proficiency (LEP) and those who have LEP family members by proposing to roll back requirements for the inclusion of taglines on significant documents and remote interpreting standards and by proposing to eliminate recommendations that entities develop language access plans.

Discrimination on the basis of national origin, including language discrimination, creates unequal access to health care. Over 25 million Americans and more than 400 thousand Oregonians are limited English proficient. An estimated 19 million LEP adults are insured. Language assistance is necessary for LEP persons to access federally funded programs and activities in the healthcare system, especially when many of them already face compounded disparities in health care in an already complicated health care system.

We assert that the notice requirement in the 2016 final rule is consistent with the long history of civil rights regulations requiring the posting of notice of rights. The notice is not redundant, as the HHS Office of Civil Rights created the option of using one consolidated civil rights notice to minimize entities' administrative burden. Without the notice, members of the public will not know what rights are available to them, such as language services and auxiliary aids, and will have limited means of knowing what to do if they face discrimination and their right to file a complaint.

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

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

We oppose removing references to language access plans because under the 2016 final rule, they are voluntary and are only a factor to be considered. We oppose any proposed change that would prioritize the small administrative needs of an entity at the expense of the individual LEP person by erecting a significant barrier to accessing health care, as doing so would weaken the standard.

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

Before the ACA, people with serious and chronic health conditions were routinely denied health insurance coverage or paid exorbitant prices for substandard plans, leaving many people without the coverage they need. Now, under the ACA, insurers can no longer charge higher premiums or deny coverage for people with pre-existing conditions. These protections have been lifesaving for millions of Americans, including more than 600 thousand Oregonians.[7]

Under the 2016 final rule, covered entities are prohibited from designing benefits that discourage enrollment by persons with significant health needs. For example, insurance providers are prohibited from placing all or most prescription drugs that treat a specific condition, such as HIV prescriptions, on the most expensive tier an insurance provider offers.[8] Additionally, covered entities are currently prohibited from using discriminatory marketing practices including those "designed to encourage or discourage particular individuals from enrolling in certain health plans."[9] The proposed rule attempts to eliminate these prohibitions which protect individuals with chronic conditions or living at the intersection of various marginalized identities.

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

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

As a result, the proposed rule would create a confusing mix of legal standards and remedies under a single law, which could limit claims of intersectional discrimination, which violates the text and intent of Section 1557. The proposed rule will ultimately make it harder for those who face discrimination to access meaningful health care and be sure that their rights will be enforced and upheld.

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[7] *Estimated Number of Nonelderly Adults with Declinable Pre-existing Conditions under Pre-ACA Practices*, Kaiser Family Foundation (2015), https://www.kff.org/other/state-indicator/estimated-number-of-non-elderly-adults-with-declinable-pre-existing-conditions-under-pre-aca-practices/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

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

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

VII. Conclusion

The proposed rule could cause significant harm, especially for underserved populations that already struggle to access health care. Those most affected will be transgender people and the LGBTQ community; people seeking reproductive healthcare, including abortion; individuals with LEP, including immigrants; those living with disabilities and people of color. The impact will be more acute for those living at the intersection of these identities. The proposed rule is dangerous and contravenes the plain language of Section 1557 specifically, and the ACA broadly.

For the above reasons, HHS and CMS should not finalize the proposed rule.

Thank you for the opportunity to submit comments on the proposed rule. Please do not hesitate to contact Cherie Martin, Advocacy Director at cherie@prochoiceoregon.org to provide further information.

Sincerely,

NARAL Pro-Choice Oregon Foundation

EXHIBIT D-21

August 8, 2019

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

Submitted electronically to www.regulations.gov

Re: Nondiscrimination in Health and Health Education Programs and Activities [HHS-OCR-2019-0007; RIN 0945-AA-11]

Dear Secretary Azar:

The American Nurses Association (ANA) submits the following comments in response to the Notice of Proposed Rulemaking (proposed rule) Nondiscrimination in Health and Health Education Programs and Activities. The proposed rule seeks to make comprehensive changes to regulations promulgated in 2016 to implement Section 1557 of the Affordable Care Act (ACA).[1] Section 1557 bars discrimination in health care against persons based on race, color, sex, national origin, age and disability; provides for enforcement of the protections conferred; and authorizes the Department of Health and Human Services (HHS) to further refine the meaning of Section 1557 through regulations.

ANA is the premier organization representing the interests of the nation's 4.0 million RNs, through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. ANA members also include the four advanced practice registered nurse roles (APRNs): nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs) and certified registered nurse anesthetists (CRNAs).[2] ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

[1] Nondiscrimination on the Basis of Race, Color, National Origin, Sex, Age, or Disability in Health Programs or Activities Receiving Federal Financial Assistance and Health Programs or Activities Administered by the Department of Health and Human Services or Entities Established under Title I of the Patient Protection and Affordable Care Act. 45 C.F.R. Part 92 (81 Fed. Reg. 31376. May 18, 2016).

[2] The Consensus Model for APRN Regulation defines four APRN roles: Certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model

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ANA has adopted as a core principle that the health care system must ensure access to health care for all;[3] Section 1557 of the ACA is an essential tool to safeguard such access, and one that should be broadly interpreted.[4] Congress included Section 1557 when it enacted the ACA nearly a decade ago as a comprehensive approach to expanding access to health care while improving quality and patient experience.

As an informed and active stakeholder in the implementation of health care policy, ANA sees the proposed rule as a fundamental change in direction that is antithetical to our principles of health system transformation, namely universal access to a standard package of essential health care services for all citizens and residents.[5] The proposed rule would remove key definitions and mechanisms in the 2016 rule that make Section 1557 meaningful to all, especially to people who otherwise face discriminatory barriers to care. Though progress has been made on this front since the ACA was enacted, discrimination in health care settings remains a grave and widespread problem and contributes to a wide range of health disparities.

In short, ANA believes this new rulemaking is misguided and irresponsible, and is out of step with the values of the nursing profession. We believe the proposal should be rescinded entirely so that the existing Section 1557 regulations remain available to protect access to health care for all patients. ANA comments are detailed below. Briefly, we summarize key proposals of significant concern to ANA, discuss the implications of these changes for nurses, and outline why we support retaining the provisions in the 2016 rule.

HHS SEEKS TO ELIMINATE SAFEGUARDS AGAINST DISCRIMINATION IN HEALTH CARE

The proposed rule would substantially alter HHS' current approach to discrimination in health care, removing a number of safeguards built into the 2016 regulations. Among the significant revisions proposed, HHS seeks to eliminate provisions clarifying the health care rights of LGBTQ+ individuals. If finalized, the rule's definition of sex discrimination under Section 1557 would no longer include discrimination based on gender identity or sex-stereotyping. Additionally, there would be no prohibition to insurance plans denying or limiting health care

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describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation. Web: https://www.nursingworld.org/certification/aprn-consensus-model/

[3]ANA's Principles for Health System Transformation 2016 Web: https://www.nursingworld.org/~4afd6b/globalassets/practiceandpolicy/health-policy/principles-healthsystemtransformation.pdf

[4] Congress has repeatedly expressed that it intends civil rights laws to be broadly interpreted in order to effectuate their remedial purposes. See Kang v. U. Lim Am., Inc., 296 F.3d 810, 816 (9th Cir. 2002); see also H. Rep. No. 102–40(I), at 88, U.S. Code Cong. & Admin. News at 626 (stating that "remedial statutes, such as civil rights law[s], are to be broadly construed").

[5]Ibid

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coverage based on gender identity. Without these protections, providers and payers can deny care to transgender persons and to other LGBTQ+ patients based on sex-stereotyping.

The proposed rule also takes a new approach to women's health care rights that could serve to limit women's access to care. The new definition of sex discrimination under Section 1557 would not explicitly extend to discrimination based on pregnancy, false pregnancy, abortion, or recovery from childbirth. There are also references to existing exemptions that attempt to elevate provider options to withhold care over patients' interests, which we believe will undermine access.

Additionally, the proposed rule would, reduce the reach and scope of the Section 1557 regulations, leaving more patients exposed to discriminatory practices from providers, payers, and programs. Illustrative, but not exhaustive, are proposals to scale back the definition of health care entities governed by the rule, as well as meaningful access for individuals with limited English proficiency (LEP), and notice and grievance provisions.

The proposed rule goes beyond these extensive revisions to rules implementing Section 1557. The proposed rule would also end the protections against discrimination on the basis of gender identity and sex stereotyping that are written into 10 other HHS rules, such as those governing Medicaid managed care and private insurance.

PROPOSED CHANGES ARE INCONSISTENT WITH NURSING VALUES AND ETHICAL OBLIGATIONS

As discussed more below, the impacts of this rule are at odds with the basic tenets of nursing, on which all our patients rely for meaningful access to care. ANA is dismayed by the implications of these changes, which would enable health care practices that are wholly incompatible with the ethics and values of the nursing profession. Provision 1 of the *Code of Ethics for Nurses*[6] deals explicitly with the moral and ethical obligations in caring for all patients: "The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person."[7] This includes respect for the human dignity of the patient and the demand that nurses must never behave prejudicially – which is to say, with unjust discrimination.

These values, and the standards that flow from them, protect patients from experiencing very real harms that result from discrimination in health care. Specifically:

[6]American Nurses Association. *Code of Ethics for Nurses with Interpretive Statements*. 2015: Second Edition.
[7]Ibid: Pg. 1.

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- ***Ethical obligations require nurses to address the specific concerns for the health care rights of LGBTQ+ patients.***
- ***Nursing ethics require nurses to respect the health care decisions of their patients, including women exercising their option to terminate a pregnancy.***

Ethical obligations require nurses to address the specific concerns for the health care rights of LGBTQ+ patients. ANA explicitly condemns discrimination based on sexual orientation, gender identity, and/or expression in health care and recognizes that it continues to be an issue despite the increasing recognition and acceptance of LGBTQ+ populations. Nurses are ethically called upon to "lead in the development, dissemination, and implementation of changes in public and health policies that support protection against discrimination due to sexual orientation, gender identity, and/or expression."[8]

LGBTQ+ populations experience a significant rate of discrimination in health care settings, and also experience negative health outcomes compared with the overall population.[9] Negative health outcomes that disproportionately affect LGTBQ+ individuals include: Increased instances of mood and anxiety disorders and depression, and an elevated risk for suicidal ideation and attempts; higher rates of smoking, alcohol use, and substance use; higher instances of stigma, discrimination, and violence; less frequent use of preventive health services; and increased levels of homelessness among LGBTQ+ youth.[10]

Men who have sex with men (MSM) and transgender women also experience significantly higher rates of HIV/AIDS infections, complications, and deaths; this burden falls particularly heavily on young, African-American MSM and transgender women. Transgender individuals also face particularly severe discrimination in health care settings: 33 percent of transgender patients say that a health care provider turned them away because of being transgender.[11]

[8] American Nurses Association. Nursing Advocacy for LGBTQ+ Populations. 2018. Accessible at https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/nursing-advocacy-for-lgbtq-populations/

[9] Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S. Kaiser Family Foundation. May 2018. Web: http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US

[10] U.S. Institute of Medicine Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. Washington, DC: National Academies Press; 2011.

[11] James, Sandy E. et al. The Report of the U.S. Transgender Survey. 2016: 96-97. Web: www.ustranssurvey.org/report

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As the lead agency implementing the ACA and a recent champion to end HIV disparities,[12] HHS should be concerned with promoting health care access for LGBTQ+ individuals. Section 1557 and existing nondiscrimination regulations are necessary and essential to protect access, and should be zealously enforced, rather than eliminated.

Nursing ethics require nurses to respect the health care decisions of their patients, including women exercising their options regarding pregnancy. The Code of Ethics for Nurses recognizes patients' rights to self-determination and calls upon nurses to respect the decisions of an individual under their care.

> Patients have the moral and legal right to determine what will be done with and to their own person; to be given accurate, complete, and understandable information in a manner that facilitates an informed decision; and to be assisted with weighing the benefits, burdens, and available options in their treatment, including the choice of no treatment.[13]

Provision 2 of the Code of Ethics also holds that a nurse's primary commitment is to the patient.

These core tenets extend to care for pregnant women and safeguard their access to the full range of available reproductive health care, including abortion. The proposed rule, it appears, attempts to give more weight to circumstances in which a pregnant woman may be denied access to abortion. The proposed change would also seek to redefine sex discrimination to exclude discrimination based on pregnancy and related conditions. This change appears intended to allow a provider to deny care to a woman having a miscarriage or who has had an abortion. We believe the overall impact of these changes will be to reduce access with discriminatory effect on women of reproductive age.

We therefore strongly oppose attempts to weaken protections created by Section 1557, including these proposed regulatory changes that we believe would reduce access contrary to our principles of health system transformation and the *Code of Ethics for Nurses*.

EXISTING NONDISCRIMINATION RULES ARE NECESSARY TO ENSURE ACCESS

We believe that existing regulations for Section 1557 and other HHS programs fulfill the intent of Congress to protect people from discrimination in health care that denies them access. The 2016 rules, especially, take important steps to safeguard access for people who often face

[12] Azar, Alex. Ending the HIV Epidemic: A Plan for America. February 2019. Web: https://www.hhs.gov/blog/2019/02/05/ending-the-hiv-epidemic-a-plan-for-america.html

[13] ANA Code of Ethics, Provision 1.4.

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unique barriers to care, including LGQTQ+ individuals. For these individuals, sex discrimination may take specific form in health care, such as coverage limitations and encounters with providers who deny them care based on their gender identity or sex-stereotyped characteristics.

The proposed rule extensively cites one court decision supporting HHS' new, narrower reading of the bar against discrimination in health.[14] However, other federal courts have determined that the protections of Section 1557 should be interpreted to allow broad application. For example, a federal court in Wisconsin found the state's Medicaid program could not exclude gender-affirming care. Notably, the court found that this protection against discrimination derived directly from the ACA law. [15]

Section 1557 should be implemented in a manner that promotes access for those who are subject to discrimination. In this light, we do not see a rationale for dismantling the protections that are established in the 2016 rules. This proposed rule should be rescinded in its entirety and HHS should follow and vigorously defend the 2016 rules and other nondiscrimination regulations.

If you have questions, please contact Ingrida Lusis, Vice-President, Policy and Government Affairs (Ingrid.Lusis@ana.org or (301) 628-5081).

Sincerely,

Debbie Hatmaker

Debbie Hatmaker, PhD, RN, FAAN
Chief Nursing Officer / EVP

cc: Ernest Grant, PhD, RN, FAAN, ANA President
Loressa Cole, DNP, MBA, RN, NEA-BC, FACHE, ANA Chief Executive Officer

[14]Franciscan Alliance, Inc., et al. v. Burwell, et al., 227 F. Supp. 3d 660 (N.D. Tex. 2016).
[15]Flack v. Wis. Dep't of Health Servs. 328 F. Supp. 3d 931 (W.D. Wis. 2018). See also Prescott v. Rady Children's Hospital – San Diego, 265 F. Supp. 3d 1090 (S.D. Cal. 2017).

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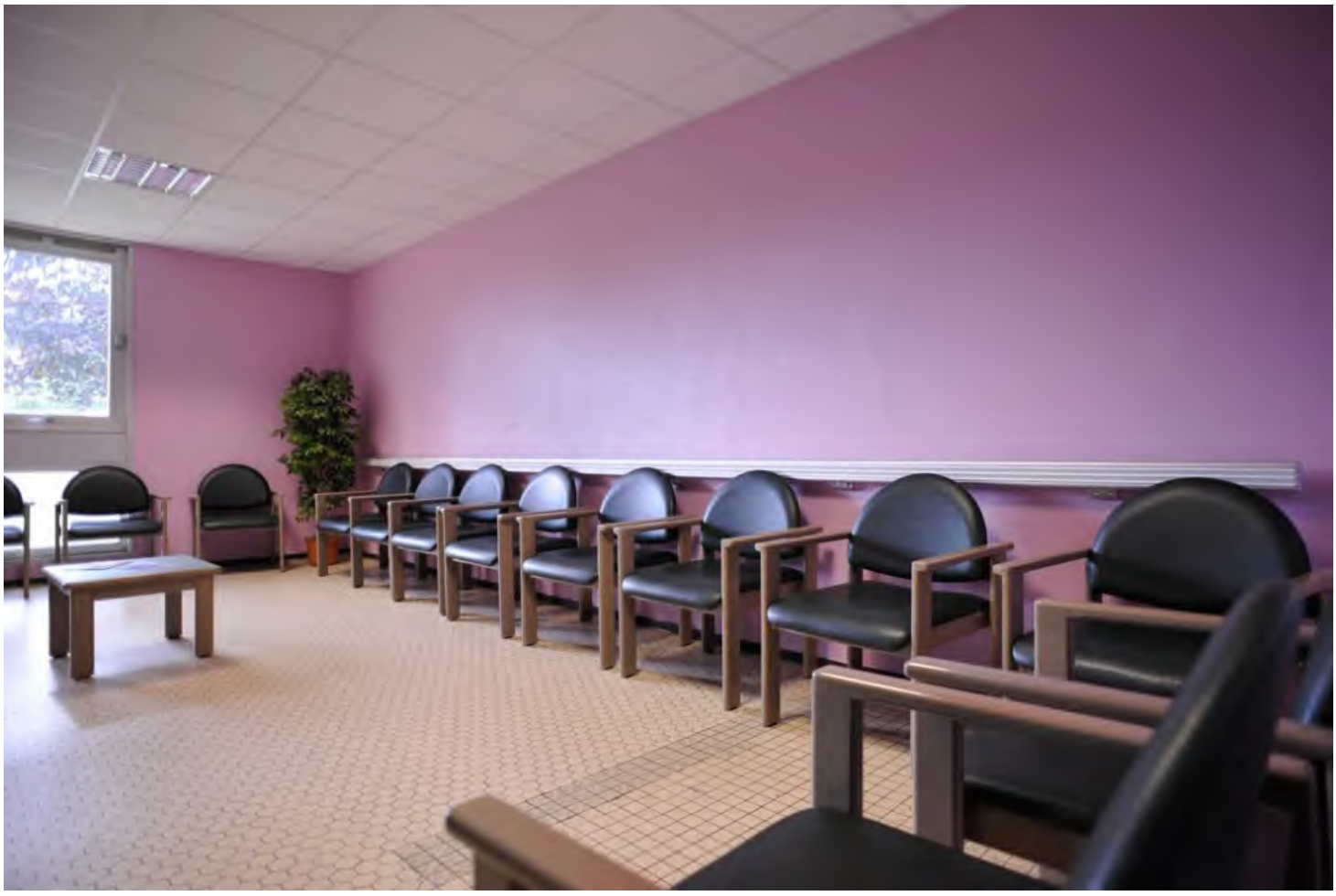
EXHIBIT D-22

Center for American Progress

LGBT

Discrimination Prevents LGBTQ People from Accessing Health Care

By Shabab Ahmed Mirza and Caitlin Rooney | Posted on January 18, 2018, 9:00 am



Getty/BSIP, UIG

A waiting room, March 2015.

All people who need medical care should be able to see their doctor without worrying about being mistreated, harassed, or denied service outright. The Affordable Care Act (ACA) helped address this

issue by prohibiting health care providers and insurance companies from engaging in discrimination. As a result of several court rulings and an Obama administration rule, LGBTQ people are explicitly protected against discrimination in health care on the basis of gender identity and sex stereotypes. However, conservative forces and the Trump-Pence administration are seeking to make it easier for health care providers to discriminate against LGBTQ people and women.

Discrimination in health care settings endangers LGBTQ people's lives through delays or denials of medically necessary care. For example, after one patient with HIV disclosed to a hospital that he had sex with other men, the hospital staff refused to provide his HIV medication. In another case, a transgender teenager who was admitted to a hospital for suicidal ideation and self-inflicted injuries was repeatedly misgendered and then discharged early by hospital staff. He later committed suicide. Discrimination affects LGBTQ parents as well: In Michigan, an infant was turned away from a pediatrician's office because she had same-sex parents. Even though many states, such as Michigan, lack explicit statewide laws against LGBTQ discrimination in health care, Section 1557 of the ACA provides federal protections.

New data from a nationally representative CAP survey conducted in 2017 show that LGBTQ people experience discrimination in health care settings; that discrimination discourages them from seeking care; and that LGBTQ people may have trouble finding alternative services if they are turned away. These data underscore the importance of protecting LGBTQ people from discrimination in health care.

LGBTQ people face discrimination and mistreatment at doctors' offices

Despite existing protections, LGBTQ people face disturbing rates of health care discrimination—from harassment and humiliation by providers to being turned away by hospitals, pharmacists, and doctors. The CAP survey data show the types of discrimination that many LGBTQ people face when seeking health care.

Among lesbian, gay, bisexual, and queer (LGBQ) respondents who had visited a doctor or health care provider in the year before the survey:

- 8 percent said that a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation.
- 6 percent said that a doctor or other health care provider refused to give them health care related to their actual or perceived sexual orientation.

- 7 percent said that a doctor or other health care provider refused to recognize their family, including a child or a same-sex spouse or partner.
- 9 percent said that a doctor or other health care provider used harsh or abusive language when treating them.
- 7 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).

Among transgender people who had visited a doctor or health care providers' office in the past year:

- 29 percent said a doctor or other health care provider refused to see them because of their actual or perceived gender identity.
- 12 percent said a doctor or other health care provider refused to give them health care related to gender transition.
- 23 percent said a doctor or other health care provider intentionally misgendered them or used the wrong name.
- 21 percent said a doctor or other health care provider used harsh or abusive language when treating them.
- 29 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).

Discrimination discourages LGBTQ people from seeking health care

Discrimination—and even the potential for discrimination—can deter LGBTQ people from seeking care in the first place. CAP survey data show that discrimination played a role in preventing a significant number of LGBTQ people from seeking health care. In the year prior to the survey, 8 percent of all LGBTQ people—and 14 percent of those who had experienced discrimination on the basis of their sexual orientation or gender identity in the past year—avoided or postponed needed medical care because of disrespect or discrimination from health care staff. Among transgender people, 22 percent reported such avoidance. With regard to preventative screenings, 7 percent of LGBTQ respondents reported avoiding or postponing care in the year prior to the survey, while 17 percent of LGBTQ respondents who had experienced discrimination that year and 19 percent of transgender people reporting avoidance during that period.

An earlier CAP analysis reported other findings from this survey that also indicated the effect of discrimination on LGBTQ people's willingness to seek out health care. In that analysis, 6.7 percent of LGBTQ people reported that they avoided doctor's offices in the past year out of fear of discrimination. This avoidance behavior is even more common among LGBTQ people who reported having experienced discrimination in the past year: 18.4 percent reported avoiding doctor's offices to avoid discrimination, nearly seven times the rate of LGBTQ people who had not experienced discrimination in the past year, at 2.7 percent. These CAP data are consistent with other research. The 2015 U.S. Transgender Survey found that nearly 1 in 4 transgender people (23 percent) had avoided seeking needed health care in the past year due to fear of discrimination or mistreatment due to their gender identity.

Finding another doctor is not an answer for all LGBTQ patients

The expansion of legislation, lawsuits, and administrative rule-making allowing for broad religious exemptions from providing services puts another impediment in the way of LGBTQ people receiving medical care. For those patients that do seek medical care and are turned away by providers, alternatives may not be easily accessible. This concern is exacerbated by a shortage of medical providers in key areas of treatment (such as mental health care) and geographic areas (such as rural communities).

CAP survey data show that many LGBTQ people would face significant difficulty finding an alternative provider if they were turned away by a health care provider, such as a hospital, clinic, or pharmacy.

- 18 percent of LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different hospital.
- 17 percent of LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different community health center or clinic.
- 8 percent of LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different pharmacy.

LGBTQ people living outside of a metropolitan area report a high rate of difficulty accessing alternative services, which may be because such services could be further away and transportation costs have the potential to be higher.

- 41 percent of nonmetro LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different hospital.
- 31 percent of nonmetro LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different community health center or clinic.
- 17 percent of nonmetro LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different pharmacy.

Transgender people also report difficulty accessing alternatives at a high rate:

- 31 percent of transgender people said it would be "very difficult" or "not possible" to find the same type of service at a different hospital.
- 30 percent of transgender people said it would be "very difficult" or "not possible" to find the same type of service at a different community health center or clinic.
- 16 percent of transgender people said it would be "very difficult" or "not possible" to find the same type of service at a different pharmacy.

Some people may go to LGBTQ community health centers to avoid such discrimination, but they are not widely available across the United States, and many do not provide comprehensive services. A total of 13 states—mainly those in the central United States—do not have any LGBTQ community health centers. On the U.S. Transgender Survey, 29 percent of respondents seeking transition-related care reported having to travel 25 miles or more to access such care.

Conclusion

Despite the importance of protecting people from discrimination in health care settings, current regulations are under attack. On August 23, 2016, a group of conservative religious organizations and eight states filed a lawsuit against the U.S. Department of Health and Human Services (HHS), challenging the 1557 rule. They made dubious claims that the nondiscrimination protections would require doctors to provide treatment that violated their religious beliefs, such as transition-related surgeries for transgender patients. Even though numerous courts have ruled that laws such as 1557 protect LGBTQ people, in December 2016, a single federal judge issued a nationwide injunction prohibiting HHS from enforcing the 1557 rule's prohibition on discrimination on the basis of gender identity. On May 2, 2017, the Trump-Pence administration filed a motion indicating that the 1557 rule was under review, and in August, it announced that HHS had already written a draft proposal to roll back the rule. Given the Trump-Pence administration's record on LGBTQ issues, new regulations will

likely deny the existence of protections to LGBTQ people and make equal health care access and treatment more difficult to obtain for this historically marginalized community. While the administration cannot change the protections for LGBTQ people that exist under the law, a regulatory rollback would cause fear and confusion for patients and promote discrimination by providers and insurers.

Shabab Ahmed Mirza is a research assistant for the LGBT Research and Communications Project at the Center for American Progress. Caitlin Rooney is a Research Assistant for the LGBT Research and Communications Project at the Center.

Methodology

To conduct this study, CAP commissioned and designed a survey, fielded by GfK SE, which surveyed 1,864 individuals about their experiences with health insurance and health care. Among the respondents, 857 identified as lesbian, gay, bisexual, and/or transgender, queer, or asexual, while 1,007 identified as heterosexual and cisgender/nontransgender. Respondents came from all income ranges and are diverse across factors such as race, ethnicity, education, geography, disability status, and age. The survey was fielded online in English in January 2017 to coincide with the fourth open enrollment period through the health insurance marketplaces and the beginning of the first full year of federal rules that specifically protect LGBTQ people from discrimination in health insurance coverage and health care. The data are nationally representative and weighted according to U.S. population characteristics. Metro is defined as a metropolitan core-based statistical area and nonmetro is defined as anything else, including micropolitan core-based statistical areas and locations outside of a core-based statistical area.

Additional information about study methods and materials are available in prior analyses and from the authors. Results reported in this column may differ slightly (two-tenths of 1 percent) but not substantively from other analyses of these data due to the statistical program employed.

The authors would like to thank Sharita Gruberg, Frank Bewkes, and Laura E. Durso from the Center for American Progress as well as Harper Jean Tobin, Katie Keith, and Kellan Baker for their contributions to this column.

Center for American Progress

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EXHIBIT D-23

13 August 2019

Centers for Medicare and Medicaid
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, D.C. 20201

RE: Nondiscrimination in Health and Health Education Programs or Activities
Submitted via electronic comments at http://www.regulations.gov

To Whom it May Concern:

On behalf of the Pennsylvania Commission on LGBTQ Affairs and the administration of Pennsylvania Governor Tom Wolf, please accept the following comments regarding Nondiscrimination in Health and Health Education Programs or Activities. The Commission requests that that the Centers for Medicare and Medicaid and the Office of Civil Rights of the U.S. Department of Health and Human Services specifically include gender identity, gender expression, and sexual orientation under its definition of discrimination based on sex in Section 1557 of the Patient Protection and Affordable Care Act.

The Pennsylvania Commission on LGBTQ Affairs advises Governor Wolf on policies, procedures, legislation, and regulations that impact LGBTQ individuals and communities. Additionally, we develop, review, and recommend policies in the areas of health and human services that impact LGBTQ Pennsylvanians to ensure that they can live long and healthy lives.

Limiting protections to only include biological sex will leave members of our LGBTQ communities vulnerable to discrimination and will potentially restrict their access to vital and necessary physical and mental healthcare.

Our transgender communities, specifically, are at heightened risks of discrimination without protections for gender identity, expression, and sexual orientation. Transgender and gender non-conforming people face rampant discrimination in health care settings, are regularly denied needed care, and experience a range of health risks. According to the United States Transgender Survey, 33% of transgender patients experienced stigma or discrimination when

seeing a healthcare professional. Additionally, 34% of respondents reported postponing medical care when sick or injured due to discrimination and disrespect.[1]

For the reasons outlined above, we urge the Centers for Medicare and Medicaid at the Office for Civil Rights of the U.S. Department of HHS to include gender identity, gender expression, and sexual orientation as part of its definition of sex in Section 1557 of the Patient Protection and Affordable Care Act. We appreciate the opportunity to provide comment from Pennsylvania and the Wolf administration on these proposed changes.

Sincerely,

Todd C. Snovel
Executive Director
PA Commission on LGBTQ Affairs

Dr. Katharine Dalke
Dr. Gerald Montano
Adrian Shankar
Co-Chairs, Health Workgroup
PA Commission on LGBTQ Affairs

[1] A Report of the 2015 U.S. Transgender Survey:
https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

EXHIBIT D-24

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

August 13, 2019

Submitted via www.regulations.gov

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

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

I. Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Sex discrimination based on gender identity

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

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

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

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

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

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

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

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

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

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

b. Sex discrimination based on sex stereotyping

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

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

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

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

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

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

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

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

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

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

d. **Religious Exemption**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Remote interpreting services

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

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

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

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

b. Taglines

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

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

c. Language access plans

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

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

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

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

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

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

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

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

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

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

a. Nondiscrimination notice and grievance procedure requirements

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

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

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

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

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

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

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

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

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

b. Private right of action and compensatory damages

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

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

c. Enforcement Mechanisms

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

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

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

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

IX. Conclusion

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

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

Sincerely,

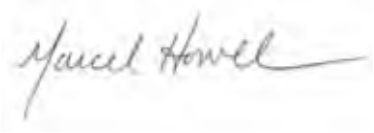

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EXHIBIT D-25

URGE
UNITE FOR REPRODUCTIVE & GENDER EQUITY

August 13, 2019

VIA ELECTRONIC SUBMISSION

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

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

Dear Secretary Azar:

URGE: Unite for Reproductive & Gender Equity submits these comments in response to the Department of Health and Human Services' ("HHS", "the Department") and the Center for Medicare and Medicaid Services ("CMS") Notice of Proposed Rulemaking ("proposed rule," "NPRM") to express our concerns with the proposed rule entitled "Nondiscrimination in Health and Health Education Programs or Activities," published in the Federal Register on July 14, 2019.

URGE's values include the ability for all people to access the health care they need free from interference and discrimination. This is why we strongly oppose this proposed rule which would give health care providers and entities the ability to discriminate against patients.

This Proposed Rule would implement regulations which would embolden health care entities and providers to reinstate discriminatory practices against their health care patients.

URGE: Unite for Reproductive & Gender Equity is the only national reproductive justice organization organizing and mobilizing young people throughout the South and Midwest. URGE works in five states across the South and Midwest: Alabama, Georgia, Texas, Ohio, and Kansas. URGE envisions a world where each of us can live, love, create families, express our gender, and enjoy sexuality with liberation, power, and joy, without stigma, scarcity, or interference. By mobilizing young people across the South and Midwest for reproductive justice, we are one step closer to achieving that vision and full liberation for all.

I. This Proposed Rule Would Undermine the Intent of 1557 of the Patient Protection and Affordable Care Act.

Section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination on the basis of sex, national origin, race, color, age or disability in any health plan that recieves federal financial assistance or any program that is administered by an executive agency under Title I of the Patient Protection and Affordable Care Act or any organization or entitiy established under Title.[1] Section 1557 has been in effect and enforced by the Health and Human Services Office for Civil Rights.[2]

Section 1557 builds on longstanding civil rights laws such as Title VI of the Civil Rights Act of 1964 (Title VI), Title IX of the Education Amendments of 1972 (Tilte IX), Section 504 of the Rehabilitation Act of 1973 (Section 504), and the Age Discrimination Act of 1975 (Age Act).[3] Thus, the purpose of Section 1557 of the Patitent Protection and Affordable Care Act is to build on already present federal protections against discrimination. Specifically, 1557 focuses on discrimination in the healthcare setting by preventing entities and providers recieving federal assistance from discriminating against patients by outlining protected classes such as race and sex.

Because of the above summary of section 1557 of the Affordable Care Act, it is clear that its purpose it to safeguard patients in the stated protected classes from discrimination and if discrimination does occur, provide them with legal recourse for such discrimination. The Department and CMS's proposed rule however, would undermine the clear purpose and intent of section 1557 of the Affordable Care Act by narrowing the discrimination protections. According to the Department, the purpose of the proposed rule is to among other things "..clarify the scope of section 1557" as well as " eliminate provisions that are inconsistent or redundant with pre-existing civil rights statutes and regulations prohibiting discrimination on the basis of race, color, national origin, sex, age, and disability."[4]

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[1] Centers for Medicare & Medicaid Services, Nondiscrimination in Health and Health Education Programs or Activities.
https://www.federalregister.gov/documents/2019/06/14/2019-11512/nondiscrimination-in-health-and-health-education-programs-or-activities
[2] HHS, Section 1557 of the Patient Protection and Affordable Care Act.
https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html
[3] HHS, Summary Final Rule Implementing Section 1557 of the Affordable Care Act.
https://www.hhs.gov/civil-rights/for-individuals/section-1557/summary-of-final-rule/index.html
[4] Centers for Medicare & Medicaid Services, Nondiscrimination in Health and Health Education Programs or Activities.
https://www.federalregister.gov/documents/2019/06/14/2019-11512/nondiscrimination-in-health-and-health-education-programs-or-activities

Further, under Section II. Reasons for Proposed Rulemaking in the federal register, the Department states that it believes, "The final rule exceeded its authority under Section 1557, adopted erroneous and inconsistent interpretation of civil rights law, caused confusion, and imposed unjustified and unnecessary costs."[5] The Department also goes on to say, ".. the Rule's prohibitions of discrimination on the basis of gender identitiy, and without accompanying stautory protetcions, termination of pregnancy are substantively unlawful under the APA."[6] This belief and interpretation of Section 1557 seems to undermine and be contrary to its original purpose and intent. As stated in the summary above, the purpose of Section 1557 of the Affordable Care Act as initially enacted was to build upon long standing civil rights laws. Further, the summary of Section 1557 also states that because of the purpose and intent to build upon current civil rights and discrimination laws, Section 1557 would also "build upon prior civil rights laws to prohibit sex discrimination in health care."[7] Additionally, in the spirit of building upon current civil rights laws, Section 1557 also provides protections for those with a disability, language barriers, as well as explicitly does not include a religious exemption.[8] Common synonyms for the term "build" or the phrase "build on" includes terms such as "increase", "enlarge", and "to use as a foundation."[9] Thus, given the stated summary and intent by HHS to "build on" existing civil rights law in health care, as it stands it is not necessarily inconsistent with civil rights law and to alter Section 1557 as this proposed rule attempts to undermine its purpose, and intent.

II. This Proposed Rule Would Roll Back Language Access Protections under 1557 of the Patient Protection and Affordable Care Act.

One of the many protections that Section 1557 has that builds upon existing civil rights laws is the ability of those to access information needed regardless of language barriers. Under Section 1557, "covered entities must make reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be

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[5] Centers for Medicare & Medicaid Services, Nondiscrimination in Health and Health Education Programs or Activities. https://www.federalregister.gov/documents/2019/06/14/2019-11512/nondiscrimination-in-health-and-health-education-programs-or-activities

[6] Centers for Medicare & Medicaid Services, Nondiscrimination in Health and Health Education Programs or Activities. https://www.federalregister.gov/documents/2019/06/14/2019-11512/nondiscrimination-in-health-and-health-education-programs-or-activities

[7] HHS, Summary Final Rule Implementing Section 1557 of the Affordable Care Act. https://www.hhs.gov/civil-rights/for-individuals/section-1557/summary-of-final-rule/index.html

[8] HHS, Summary Final Rule Implementing Section 1557 of the Affordable Care Act. https://www.hhs.gov/civil-rights/for-individuals/section-1557/summary-of-final-rule/index.html

[9] Merriam Webster., https://www.merriam-webster.com/dictionary/build

encountered in their health programs and activities."[10] Additionally, "covered entities are encouraged to develop and implement a language access plan."[11]

The Department's proposed rule would roll back protections for people with limited English proficiency (LEP). Specifically, the Department seeks to change the requirements for the use of taglines on documents by proposing to eliminate recommendations that entities develop a language access plan.[12] If this proposed rule is implemented individuals with LEP would not be protected and as such would not be able to access the health care information they need.

URGE works with young people across the South and Midwest. Many of these young people has family, friends, or simply know someone with limited English proficiency. People, especially young people of color, LGBTQIA+ young people, and young immigrants already face extreme barriers when trying to access affordable, competent, quality, and non-discriminatory health care services. This proposed rule if implemented would only further increase barriers of access to what should be a basic fundamental right for all people. This rule would especially harm those with limited English proficiency who are low income. All people regardless of language barriers should be able to access the information needed to make decisions about their health care services.

III. This Proposed Rule Would Narrow the Definition of Sex Discrimination Under Section 1557 of the Affordable Care Act Disproportionately Harming Women & LGBTQ+.

As stated above Section 1557 of the Affordable Care Act was designed to build on current civil rights legislation and provide discrimination protections for patients in the health care system. In addition to other protections Section 1557 prohibits sex discrimination in health care.[13] The proposed rule however would significantly narrow the definition of sex discrimination under 1557. Specifically it would affect those who experience sex discrimination based on gender identity, sex stereotyping, and pregnancy.

Currently in Section 1557 of the Affordable Care Act, marginalized communities are protected from gender based discrimination. Sex discrimination in health care

[10] HHS, Summary Final Rule Implementing Section 1557 of the Affordable Care Act. https://www.hhs.gov/civil-rights/for-individuals/section-1557/summary-of-final-rule/index.html
[11] HHS, Summary Final Rule Implementing Section 1557 of the Affordable Care Act. https://www.hhs.gov/civil-rights/for-individuals/section-1557/summary-of-final-rule/index.html
[12] Centers for Medicare & Medicaid Services, Nondiscrimination in Health and Health Education Programs or Activities. https://www.federalregister.gov/documents/2019/06/14/2019-11512/nondiscrimination-in-health-and-healt
[13] HHS, Summary Final Rule Implementing Section 1557 of the Affordable Care Act. https://www.hhs.gov/civil-rights/for-individuals/section-1557/summary-of-final-rule/index.html

disproportionately affect women, LGBTQ+ folks, and those living at the intersection of multiple identities. The 2016 rule also includes a prohibition of sex discrimination on the basis of gender identity, including for transgender and non binary people.

Not only does URGE work with young people, but many of our young people identify as LGBTQ+. Unfortunately however, "LGBT young people experience various challenges because of how others respond to their sexual orientation or gender identity/expression."[14] When it comes to discrimination, 71% of young people in a study done by The Trevor Project reported experiencing discrimination either to sexual orientation or gender identity. [15] There are additional barriers and challenges specifically for LGBTQ+ people of color. According to the 2015 U.S. Transgender Survey, 33 percent had at least one negative experience in a health care setting relating to their gender identity in the past year and the rates were higher for Native respondents, Middle Eastern Respondents, Multi-racial respondents, and respondents with a disability.[16]

According to the Center for American Progress, LGBTQ+ people face disturbing rates of health care discrimination- from harassment and humiliation by providers ti being turned away by hospitals, pharmacists, and doctors.[17] Young LGBTQ+ people not only face discrimination in health care, but because of discrimination are discouraged from seeking care, and also have a harder time finding alternative options for health care.[18] As an organization that works to mobilize and amplify the voices of young people, especially young LGBTQ+ folks of color, it is vital that our young people are able to live their lives free from shame, stigma, violence, and discrimination. If implemented, this proposed rule further marginalize young LGBTQ+ folks and give license for providers and entities to discriminate.

Section 1557 as finalized in 2016 adopted the definition of sex stereotyping under *Price Waterhouse v. Hopkins*.[19] This Supreme Court case ruled that sex discrimination included sex

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[14] Youth.Gov, LGBT. https://youth.gov/youth-topics/lgbtq-youth

[15] The Trevor Project, (2019). National Survey on LGBTQ Youth Mental Health. https://www.thetrevorproject.org/wp-content/uploads/2019/06/The-Trevor-Project-National-Survey-Results-2019.pdf

[16] S.E. James, et al., Nat'l Ctr. for Transgender Equality, Report Of The 2015 U.S. Transgender Survey 96-97 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[17] Center for American Progress (2018). Discrimination Prevents LGBTQ People from Accessing Health Care. https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/

[18] Center for American Progress (2018). Discrimination Prevents LGBTQ People from Accessing Health Care. https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/

[19] 490 U.S. 228 (1989).

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stereotyping in addition to what was traditionally considered sex discrimination. This proposed rule however, aims to erase Supreme Court precedent that recognizes that discrimination based on sex also includes discrimination based on sex stereotyping. If implemented, the proposed rule would be contrary to established Supreme Court precedent. Discrimination based on sex stereotyping could affect and potentially become a cause of action for anyone who does not conform to the traditional, societal notions and expectations when it comes to sex. How someone expresses their gender may or may not align with societal expectations of how they should express their gender. For example, a young bisexual woman may be cisgender, but also androgynous.[2021] If implemented this rule could allow discrimination against a person who does not conform to societal expectations of gender expression.

Section 1557 as finalized and and implemented in 2016 provided that sex discrimination included pregnancy, and pregnancy related conditions, and procedures. The Department states that the prohibition against sex discrimination includes termination of pregnancy, but does not state state whether it would enforce those protections and even proposes to delete the 2016 final rule's clarification that the ban on sex discrimination includes all pregnancy related care.[22] If implemented this rule could end the protections for patients who choose to have an abortion or who experience a miscarriage or ectopic preganancy.

This year we have seen various states attempt to restrict or outright ban abortion. Out of the five states across the South and Midwest that URGE works in, three of them (Alabama, Georgia, and Ohio) passed abortion bans during their legislative session.[23] At URGE our young people are abortion positive and know that deciding if, when, and/or how to parent is a decision that should be up to each person, not elected officials or federal agencies. In a climate where there is a push to regulate the bodies of people, the last thing young people need is a rule that would roll back their protection against discrimination in health care.

IV. This Proposed Rule Would Add Religious Exemptions to Section 1557 Resulting in Discrimination of Already Marginalized Communitites

[20] Androgyny is defined as the quality or state of being neither specifically feminine or masculine. https://www.merriam-webster.com/dictionary/androgyny

[21] Cisgender mean a person who's gender identifies corresponds with the sex they were assigned at birth. https://www.merriam-webster.com/dictionary/cisgender

[22] Centers for Medicare & Medicaid Services, Nondiscrimination in Health and Health Education Programs or Activities. https://www.federalregister.gov/documents/2019/06/14/2019-11512/nondiscrimination-in-health-and-health-education-programs-or-activities

[23] Guttmacher Institute (2019), State Policy Trends at Mid-Year 2019: States Race to Ban or Protect Abortion. https://www.guttmacher.org/article/2019/07/state-policy-trends-mid-year-2019-states-race-ban-or-protect-abortion

In this proposed rule the Department has added religious exemptions to Section 1557 of the Affordable Care Act. Originally in the final rule that finalized Section 1557 in 2016, religious exemptions were not included. By including religious exemptions in this proposed rule, the Department is clearly in violation of the original language, and intent of Section 1557. If implemented, this proposed rule would not only be contrary to intent, but also result in sex discrimination which would disproportionately affect already marginalized communitites.

Religious exemptions are another attempt to allow health care entities and/or providers to discriminate. This would disproportionately harm women and LGBTQ+ people seeking health care services. If implemented, people could be further discriminated against while seeking care simply because of who they are. LGBTQ people are pften refused health care services because of their gender identity and/or sexual orientation.[24] After not being able to access care due to discrimination and refusal of care, it becomes difficult and sometimes impossible for LGBTQ people to find another provider.[25] This can be especially for people who live in rural areas.

In addition to discrimination against people for who they are, if a religious exemption is included in this proposed rule it could result in further discrimination and denial of care for other areas as well such as people seeking birth control or abortion services. There are already too many unnecessary restrictions on abortion that either prevent or delay a pregnant person from getting the care they need.[26] These unnecessary restrictions such as mandatory waiting periods, parental involvement laws, and further delay the care that people need. For people living in rural areas and others who face barriers accessing the care they need due to geography, their challenges are further exacerbated. If people are refused the care they need due to their provider's religious and moral beliefs, people seeking sexual, and reproductive health care services including abortion would find it even more diffcult and at times impossible for them to get the care they need. No provider should be allowed to discriminate against their patients.

V. Conclusion.

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[24] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[25] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[26] Rachel K Jones & Jenna Jerman, Time to Appointment & Delays in Accessing Care Among U.S. Abortion Patients. https://www.guttmacher.org/sites/default/files/report_pdf/delays-in-accessing-care.pdf

If implemented this proposed rule would completely undermine the intent and purpose of Section 1557 of the Affordable Care Act. The clear purpose of implementing Section 1557 of the Affordable Care Act is to ensure that everyone access to quality health care services free from interference, violence, and discrimination. Section 1557 was designed and implemented to protect patients from discrimination based on sex, race, color, national origin, age and disability status. Further, it builds upon the existing protected classes under civil rights law to clearly protect those with limited English language proficiency, and to protect patients from discrimination based on gender identity and sexual orientation.

The clear purpose of Section 1557 of the Affordable Care Act is to continue and increase protections for those who are already marginalized and targeted by those in power. Given the current climate we are in as a country it is important now more than ever to safeguard the rights and protections of those of us who face continued attacks. This proposed rule would do the opposite and roll back our rights and existing protections in the health care setting. **That is why I urge the Department and CMS to reject this proposed rule in its entirety.**

Thank you for the opportunity to submit comments on the Proposed Rule. Please do not hesitate to contact us via Monica Edwards, URGE If/When/How Policy Fellow, at medwards@urge.org to provide further information.

Sincerely,

Kimberly Inez McGuire
URGE Executive Director

EXHIBIT D-26

August 13, 2019

Submitted via the Federal eRulemaking Portal

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

Re: RIN 0945-AA11 Nondiscrimination in Health and Health Education Programs or Activities

Dear Secretary Azar:

We are writing on behalf of the HIV Health Care Access Working Group ("HHCAWG") – a coalition of over 100 national and community-based HIV service organizations representing HIV medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV-related health care and support services. We appreciate the opportunity to provide comments to the Department of Health and Human Services ("HHS" or "the Department") on "Nondiscrimination in Health and Health Education Programs or Activities" ("Proposed Rule"), the proposed changes to the current regulations ("Final Rule") implementing Section 1557 of the Patient Protection and Affordable Care Act ("ACA").

We are deeply concerned that the proposed regulatory changes fail to reflect the broad protections provided by law, and that the changes would obfuscate and weaken one of the nation's strongest nondiscrimination protections for vulnerable communities. Section 1557 protects individuals from discrimination on the basis of race, color, national origin, sex, age, and disability in certain health programs or activities by incorporating four civil rights laws.[1] Section 1557 protects against intersectional discrimination, or discrimination based on multiple protected characteristics, by allowing people to file complaints of such discrimination with an enforcement agency. While the Department does not have authority to change law, the Proposed Rule attempts

[1] Patient Protection and Affordable Care §1557, 42 U.S.C. §18116.

to change implementation in a way that is contrary to the plain language of the law and, if finalized, would create a vague, unworkable rule with significant impacts on people living with HIV and other chronic illnesses and disabilities, lesbian, gay, bisexual, transgender, and queer ("LGBTQ") people, people who need reproductive health care (including abortion), women of color, and people whose primary language is not English – all people who already experience significant barriers when accessing health care.

Given the numerous uncertainties and flaws that arise from the Proposed Rule, HHCAWG strongly urges the Department to rescind its proposal in its entirety and avoid a devastating misinterpretation of a key nondiscrimination provision that has and continues to protect people in a wide range of health programs and activities.

I. The Department impermissibly narrows the scope of nondiscrimination regulations by limiting the types of covered entities that will be subject to Section 1557 enforcement.

The Proposed Rule dramatically narrows the scope of the Department's Section 1557 enforcement by applying inappropriate restrictions to the types of health programs and activities that must comply with the nondiscrimination provision of the ACA. By carving out entities who are not principally engaged in the business of providing health care services, HHS proposes a limited understanding of a "health program or activity," unnecessarily distinguishing "health insurance" from "health care."[2] For people living with significant medical conditions, consistent access to affordable and nondiscriminatory health insurance is often the *only* way to access the health care needed to manage chronic conditions. The coverage and design of health insurance can have a significant impact on health care access and health outcomes for people living with major illness.[3]

The Proposed Rule's attempt to narrow the scope of Section 1557 runs counter to the underlying broad remedial purpose of the statute. Federal civil rights laws governing sex-based

[2] The Department chose to forgo such a distinction when proposing changes to regulations protecting religious refusals in health care settings, defining a health program or activity to include "the provision or administration of any . . . health related insurance coverage . . . or any other service related to health or wellness . . . through insurance, or otherwise." Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3,880, 3,893 (Jan. 26, 2018).

[3] Approximately 60% adults in the United States have at least one chronic disease, with 42% of all U.S. adults having two or more chronic conditions. CHRISTINE BUTTORFF, ET AL., RAND CORPORATION, MULTIPLE CHRONIC CONDITIONS IN THE UNITED STATES 6 (2017), https://www.rand.org/content/dam/rand/pubs/tools/TL200/TL221/RAND_TL221.pdf. Adults living with multiple chronic conditions are more likely to use the health care system, including visiting the emergency room, receiving outpatient care, filling prescriptions, and staying in a hospital for inpatient care. *Id*. at 14. Adults with chronic conditions are also more likely to incur out-of-pocket spending under both public and private insurance, making health plan design and cost-sharing important for financial planning. *Id.* at 17. *See also* JILL BERNSTEIN, ET AL., MATHEMATICA POLICY RESEARCH, HOW DOES INSURANCE COVERAGE IMPROVE HEALTH OUTCOMES (April 2010), available at https://www.mathematica-mpr.com/our-publications-and-findings/publications/how-does-insurance-coverage-improve-health-outcomes; Benjamin D. Sommers, et al., *Health Insurance Coverage and Health – What the Recent Evidence Tells Us*, 377 NEW ENG. J. MED. 586 (2017).

discrimination are appropriately given "a sweep as broad as its language."[4] The Civil Rights Restoration Act of 1987 was even enacted to "[r]estore the broad scope of coverage and to clarify the application of" disability-based discrimination law.[5] Moreover, a close reading of the ACA undermines the proposed distinction that health insurance lies outside of the reach of Section 1557 generally. Within the same statutory section as Section 1557 is a provision adopting the definitions of the Public Health Service Act, 42 U.S.C. § 300gg-91. Those definitions, in turn, describe a wide array of health insurance plans, even using the word "program" as synonymous with "group health plan."[6]

In the Proposed Rule, HHS introduces a convoluted framework to determine whether an entity is considered a covered entity and thus subject to the Department's enforcement of these civil rights protections.[7] These carve outs and distinctions are not only confusing to health programs and activities (who now must expend resources to clarify the required extent of their own compliance), but people living with HIV and other chronic illnesses and consumers who may not fully understand the intricacies of a health care organization will have difficulty determining when to expect compliance with nondiscrimination protections.

HHS also proposes to redefine the types of federal financial assistance that could make an entity subject to Section 1557 enforcement and the extent to which a covered entity must then comply with regulation. The Proposed Rule would limit the definition of federal financial assistance to money that HHS directly administers.[8] In doing so, some health-related federal assistance would no longer subject entities to antidiscrimination protections because HHS only plays a role in (and is not directly responsible for) administering the funding. Such an interpretation is contrary to a plain reading of the statute as Section 1557 not only uses the broad term "Federal financial assistance" (without a modifier to limit financial assistance to that which the Department administers directly) but also includes "credits" as an example of relevant Federal financial assistance.[9]

Furthermore, the Department proposes to split the operations of entities who are not principally engaged in providing health care services, and only require the operations receiving federal financial assistance to comply with Section 1557 regulations.[10] This interpretation is also contrary

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[4] Grove City College v. Bell, 465 U.S. 555, 564 (1983) (quoting North Haven Board of Education v. Bell, 456 U.S. 512, 521 (1982)).

[5] Civil Rights Restoration Act of 1987, Pub. L. No. 100-259, 102 Stat. 28 (1988).

[6] 42 U.S.C. § 300gg-91(a)(3).

[7] For example, the Proposed Rule suggests that while the Department would expect state Medicaid programs to comply with the Proposed Rule due to receipt of federal financial assistance, it would not require the Centers for Medicare & Medicaid Services to fully comply with Section 1557. Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27,846, 27,862 (proposed June 14, 2019).

[8] The Department notably chose to define federal financial assistance broadly in other regulations. Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170 (May 21, 2019).

[9] The Affordable Care Act helped make health insurance more affordable by providing advanced premium tax credits to most consumers purchasing private insurance on the Marketplace. According to the Proposed Rule however, such credits would not qualify as federal financial assistance as HHS only plays a role in the administration of the credits.

[10] Generally, the Final Rule prohibits insurers that receive federal financial assistance in one of its health products from discriminating in *any* of its lines of business. The Department is proposing to exempt all lines of business apart

to a plain reading of Section 1557, which states that a person shall not "be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, *any part of which* is receiving Federal financial assistance[.]"[11] By keeping "any health program or activity" as the object of the sentence and not "any part of a health program or activity which receives Federal financial assistance," the statute clearly indicates that the receipt of federal financial assistance in one part of a covered entity will subject the larger entity to Section 1557.

If these inaccurate interpretations of Section 1557 are finalized, people living with chronic illness will have difficulty knowing when and to what extent an entity must comply with federal regulations. People living with significant health needs require access to health programs and affordable health care plans that do not openly discriminate against members due to their race, color, national origin, sex (including gender identity, sexual orientation, and sex stereotypes; and pregnancy, childbirth, and related medical conditions), age, and disability. When they do not have access to affordable, non-discriminatory health care coverage, people living with chronic illnesses and disabilities face medical debt, are unable to access specialist care, and have difficulty managing their chronic conditions. Additionally, the proposed changes would be unduly burdensome on consumers who would have to follow a vague, illogical scheme to determine when and where they can file complaints with OCR about discrimination in health settings.

II. The Department's proposed deletion of provisions that explicitly describe prohibited discriminatory practices would make the regulations vague and burdensome for people living with HIV and other chronic illnesses and disabilities, and fails to include adequate discussion regarding whether proposed deletions are indicative of shifts in policy.

The Proposed Rule eliminates key provisions in the Final Rule and unnecessarily and inappropriately burdens people living with HIV and other chronic illnesses and disabilities. People living with HIV and other chronic illnesses regularly face discrimination in health care settings, including the refusal of health care, the provision of lower-quality health care, and the approval of insurance plans that place covered nationally-recommended guideline regimens on the highest cost-sharing tier.[12] The Final Rule clearly describes how certain insurer and provider practices are

from the program or product receiving financial assistance. This not only is contrary to law, but could have significant consequences for consumers when insurers are emboldened to refuse to cover care associated with chronic conditions.

[11] Patient Protection and Affordable Care §1557, 42 U.S.C. §18116 (emphasis added).

[12] Health advocates have filed multiple complaints with the Office of Civil Rights highlighting discriminatory practices experienced in health programs and settings. *See, e.g.*, Discrimination Complaint (UPMC Health Plan), Center for Health Law and Policy Innovation of Harvard Law School & AIDS Law Project of Pennsylvania (U.S. Dep't of Health and Human Services), http://www.chlpi.org/wp-content/uploads/2013/12/PA-UPMC.pdf; Discrimination Complaint (Independence Blue Cross), Center for Health Law and Policy Innovation of Harvard Law School & AIDS Law Project of Pennsylvania (U.S. Dep't of Health and Human Services), http://www.chlpi.org/wp-content/uploads/2013/12/PA-IBX.pdf; Discrimination Complaint (Highmark), Center for Health Law and Policy Innovation of Harvard Law School & AIDS Law Project of Pennsylvania (U.S. Dep't of Health and Human Services), http://www.chlpi.org/wp-content/uploads/2013/12/PA-Highmark.pdf; Discrimination Complaint, Center for Health Law and Policy Innovation of Harvard Law School & Nashville CARES (U.S. Dep't

discriminatory, in violation of Section 1557, including: Section 92.206 "Equal program access on the basis of sex"; Section 92.207 "Nondiscrimination in health-related insurance and other health-related coverage"; Section 92.208 "Employer liability for discrimination in employee health benefit programs"; and Section 92.209 "Nondiscrimination on the basis of association." These sections describe common forms of discrimination on the basis of race, color, national origin, age, disability, and sex.

While proposing to delete entire sections of regulation, the Department neglects to detail whether the deletion of these particular sections reflects a new position that the actions listed, including providing unequal access to programs or activities on the basis of sex, restricting access to gender-appropriate facilities, excluding categories of care in insurance coverage, or mistreating a person due to their partner's identity, will no longer be considered discrimination under Section 1557. People living with HIV and other chronic illnesses, people of color, and LGBTQ people have historically been subject to such discrimination in health settings.[13] Any change in policy regarding enforcement against these discriminatory practices would significantly impact all protected classes.[14]

Without more explanation as to how the deletions reflect HHS' enforcement policies, consumer groups, health providers, and other covered entities – particularly those who regularly serve people living with HIV and other chronic illnesses – are unable to provide complete and robust comment about the Proposed Rule's "balance" or address whether these policy changes are in line with congressional mandate and judicial interpretation, or whether the changes are properly addressed in the Department's regulatory impact analysis. Despite the Department's lack of enforcement towards some forms of discrimination,[15] Section 1557 and the Final Rule have been instrumental in addressing many discriminatory practices,[16] including inappropriate provider

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of Health and Human Services), http://www.chlpi.org/wp-content/uploads/2013/12/TN-Cigna.pdf; National Health Law Program & The AIDS Institute, *Re: Discriminatory Pharmacy Benefits Design in Select Qualified Health Plans Offered in Florida, Administrative Complaint filed with the HHS Office for Civil Rights* (May 28, 2014), https://healthlaw.org/resource/nhelp-and-the-aids-institute-complaint-to-hhs-re-hiv-aids-discrimination-by-fl/. These complaints have included instances where insurers have used discriminatory insurance design to sell products on the Marketplace that places most or all of the nationally-recommended front-line medications for HIV on the most expensive cost-sharing tiers (or do not cover them at all).

[13] *See, e.g.* INTERSECTING INJUSTICE: A NATIONAL CALL TO ACTION 62-76 (Lourdes Ashely Hunter, Ashe McGovern & Carla Sutherland eds., 2018), available at http://socialjusticesexuality.com/intersecting_injustice/; S.E. JAMES, ET AL., NAT'L CTR. FOR TRANSGENDER EQUALITY, THE REPORT OF THE 2015 U.S. TRANSGENDER SURVEY 247 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[14] *See generally* Susan Reif, et al., *The Relationship of HIV-related Stigma and Health Care Outcomes in the U.S. Deep South*, AIDS & BEHAVIOR (2019), available at https://link.springer.com/content/pdf/10.1007%2Fs10461-019-02595-5.pdf; Gina M. Wingood, et al., *HIV Discrimination and the Health of Women Living with HIV*, 46 WOMEN & HEALTH 99 (2007).

[15] *See* Douglas B. Jacobs & Benjamin D. Sommers, *Using Drugs to Discriminate – Adverse Selection in the Insurance Marketplace*, 372 NEW ENG. J. MED. 399 (2015); NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS, DISCRIMINATORY DESIGN: HIV TREATMENT IN THE MARKETPLACE (2016), https://www.nastad.org/sites/default/files/Discriminatory-Design-HIV-Treatment-in-the-Marketplace.pdf. Discriminatory benefit design (targeting nationally-recommended regimens for people newly diagnosed with HIV) continues to be sanctioned on the 2019 Marketplace.

[16] Tovar v. Essentia Health, 342 F. Supp. 3d 947 (D. Minn. 2018); Boyden v. Conlin, 341 F. Supp. 3d 979 (W.D. Wis. 2018); Flack v. Wis. Dep't of Health Serv., 328 F. Supp. 3d 931 (W.D. Wis. 2018); Prescott v. Rady Children's Hosp.-San Diego, 265 F. Supp. 3d 1090 (S.D. Cal. 2017); Rumble v. Fairview Health Serv., 2015 U.S. Dist. LEXIS

behavior and condition-based categorical exclusions in health insurance, and are vital parts of ending the HIV epidemic.[17] Changes to these HHS policies would be monumental and deserve adequate clarity and an opportunity for the public to provide meaningful feedback.

III. The Department's proposed deletion of provisions specific to sex discrimination are unnecessary, inappropriate, and contrary to law.

The Proposed Rule removes sections of the Final Rule that provide explicit protections against sex-based discrimination. Sex discrimination in health care has a disproportionate impact on LGBTQ people, women of color, and individuals living at the intersections of multiple identities– resulting in them paying more for health care, receiving improper diagnoses at higher rates, being provided less effective treatments, and sometimes being denied care altogether. As the first broad prohibition against sex-based discrimination in health care, Section 1557 is crucial to ending gender-based discrimination in the health care industry. In addition to personal stories and lived experience, advocacy groups have submitted surveys, studies, and reports documenting discrimination in health care against these communities and their families.[18]

The Proposed Rule deletes provisions from the Final Rule which accurately define the term "sex" and appropriately acknowledge that sex-based discrimination includes discrimination on the

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31591 (D. Minn. Mar. 16, 2015); Out2Enroll, *Summary of Findings: 2019 Marketplace Plan Compliance with Section 1557*, https://out2enroll.org/out2enroll/wp-content/uploads/2015/10/Report-on-Trans-Exclusions-in-2019-Marketplace-Plans.pdf; Out2Enroll, *Summary of Findings: 2018 Marketplace Plan Compliance with Section 1557*, https://out2enroll.org/out2enroll/wp-content/uploads/2015/10/Report-on-Trans-Exclusions-in-2018-Marketplace-Plans.pdf; Out2Enroll, *Summary of Findings: 2017 Marketplace Plan Compliance with Section 1557*, https://out2enroll.org/out2enroll/wp-content/uploads/2015/10/Report-on-Trans-Exclusions-in-2017-Marketplace-Plans.pdf; *The Brooklyn Hospital Center Implements Non-Discriminatory Practices to Ensure Equal Care for Transgender Patients*, HHS OCR (July 15, 2015), https://www.hhs.gov/sites/default/files/ocr/civilrights/activities/agreements/TBHC/statement.pdf.

[17] Increased access to these medications and nondiscriminatory medical coverage are crucial to efforts to end the HIV epidemic. AIDS UNITED & ACT NOW: END AIDS, ENDING THE HIV EPIDEMIC IN THE UNITED STATES: A ROADMAP FOR FEDERAL ACTION 40-62 (2018), available at https://www.aidsunited.org/resources/ending-the-hiv-epidemic-in-the-us.

[18] The Department's 2013 Request for Information (RIN 0945-ZA01) resulted in over 400 comments, half of which were from transgender individuals sharing their own experiences. Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,172 (Sept. 8, 2015). The Department's 2015 Proposed Rule (RIN 0945-AA02) resulted in several thousand comments, many of which were from civil rights/advocacy groups, individuals who had experienced discrimination, medical providers, legal service organizations, and medical-legal partnerships. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,376 (May 18, 2016).

Additional examples of discrimination have been described in the media and in the courtroom. *See* Katelyn Burns, *It sucks to go to the doctor if you're trans*, Vox (June 21, 2019), https://www.vox.com/first-person/2019/6/21/18692924/trump-transphobia-health-care-discrimination-protections; Oliver Knight, *Catholic Bishops Stopped My Surgery Because I'm Transgender*, ACLU (March 21, 2019), https://www.aclu.org/blog/lgbt-rights/transgender-rights/catholic-bishops-stopped-my-surgery-because-im-transgender; *Faces of Breast Cancer: Jay Kallio*, New York Times (2014), https://www.nytimes.com/interactive/projects/well/breast-cancer-stories/stories/717; Yusef Najafi, *A Life Remembered*, METRO WEEKLY (Dec. 20, 2006), https://www.metroweekly.com/2006/12/a-life-remembered/ ("[Tyra] Hunter's story gained national attention in 1995 when it was discovered that rescue workers had interrupted her medical treatment upon discovering she had male genitalia. Instead of providing treatment for Hunter's severe injuries, rescue workers spent time making derogatory comments.").

basis of gender identity, sex stereotyping, and termination of pregnancy. The Proposed Rule removes the entire definitions section,[19] incorporating a few definitions into other sections and concluding that terms not otherwise defined in the Proposed Rule are "clear enough to obviate the need for further definition."[20]

According to discussion in the preamble however, HHS has an inaccurate understanding of sex-based discrimination that is unnecessary, inappropriate, and contrary to law. HHS' justification for deleting the definitions section fails to adequately consider the totality of case law interpreting the term "sex" in civil rights protections and ignores the weight of Supreme Court and appellate court decisions. In 1989, the Supreme Court ruled that discrimination on the basis of sex (as prohibited in Title VII) included behavior based on expectations about how one should act or behave based on their sex.[21] In doing so, the Supreme Court recognized that existing federal law prohibited discrimination on the basis of sex stereotypes.[22]

The Court's opinion has had strong influence on both Title VII and Title IX jurisprudence because it acknowledged and endorsed the idea that discrimination on the basis of sex encompasses discrimination on the basis of sex-linked characteristics, including dress, personality, and appearance.[23] In the Proposed Rule however, HHS looks to implement a more narrow understanding than that taken up by the Supreme Court.[24] The Department also shifts away from broad judicial, legislative, and administrative interpretations of sex that include gender identity, and summarily dismisses the legal authority of four appellate courts in favor of advancing its own view of what constitutes sex-based discrimination under Title IX.[25]

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[19] Definitions, 45 C.F.R. § 92.4.

[20] Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. at 27,860.

[21] Price Waterhouse v. Hopkins, 490 U.S. 228 (1989).

[22] "As for the legal relevance of sex stereotyping, we are beyond the day when an employer could evaluate employees by assuming or insisting that they matched the stereotype associated with their group, for, '[i]n forbidding employers to discriminate against individuals because of their sex, Congress intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes.'" Price Waterhouse v. Hopkins, 490 U.S. 228, 251 (1989) (citation omitted).

[23] Some courts have applied this interpretation to extend Title VII's nondiscrimination protections to sexual orientation. *See* Zarda v. Altitude Express, 883 F.3d 100, (2d Cir. 2018), *cert. granted*, 139 S. Ct. 1599 (U.S. April 22, 2019) (No. 17-1623); Hively v. Ivy Tech Cmty. Coll., 853 F.3d 339 (7th Cir. 2017). While some circuit courts do not consider sexual orientation to be actionable under Title VII, they have broadened their interpretation of Title VII to include gender non-conformity. *See* Evans v. Georgia Reg'l Hosp., 850 F.3d 1248, 1254 (11th Cir. 2017), *cert. denied*, 138 S. Ct. 557 (2017); Smith v. Salem, 378 F.3d 566, 574 (6th Cir. 2004) ("After *Price Waterhouse*, an employer who discriminates against women because, for instance, they do not wear dresses or makeup, is engaging in sex discrimination because the discrimination would not occur but for the victim's sex. It follows that employers who discriminate against men because they *do* wear dresses and makeup, or otherwise act femininely, are also engaging in sex discrimination, because the discrimination would not occur but for the victim's sex.").

[24] Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. at 27,884.

[25] *See* Doe by & through Doe v. Boyertown Area Sch. Dist., 897 F.3d 518 (3d Cir. 2018), *cert. denied*, 2019 U.S. App. Lexis 3666 (U.S. May 28, 2019) (No. 18-658); Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ., 858 F.3d 1034, 1051 (7th Cir. 2017), *cert. dismissed*, 138 S. Ct. 1260 (U.S. 2018); G.G. v. Gloucester Cty. Sch. Bd., 822 F.3d 709, 718 (4th Cir. 2016), *vacated*, 137 S. Ct. 1239 (U.S. 2017) (vacating judgment and remanding the case back to the Fourth Circuit in light of new Department of Education guidance); Dodds v. U.S. Dept. of Education, 845 F.3d 217 (6th Cir. 2016).

Attempts to erase established Supreme Court and appellate court precedent misleads health providers, other covered entities, and consumers to believe that discrimination on the basis of sex stereotyping and gender identity is sanctioned by the agency and permitted under law. This misunderstanding can significantly impact people living with chronic illness, as studies have shown that LGBT people often have higher rates of chronic health conditions and encounter barriers to care exacerbated by stigma and discrimination.[26] Additionally, the wide variance in state protections for transgender people and the subsequent burdens on consumers, insurers, and state agencies has underscored the need for a federal "floor" of nondiscrimination protections.[27]

While the Department acknowledges that it has not fully captured how the Proposed Rule would negatively impact the civil rights of transgender and gender non-conforming people, HHS proposes deletions that would allow organizations to reintroduce discriminatory policies and practices. Analyses have shown that Section 1557 has resulted in a number of affordable health care plans removing coverage exclusions for transition-related care.[28] Rescinding these explicit

[26] *See, e.g.*, Kellan Baker & Jeff Krehely, *How Health Care Reform Will Help LGBT Elders*, 21 PUBLIC POLICY & AGING REPORT 19 (2011); Walter O. Bockting, et al., *Stigma, Mental Health, and Resilience in an Online Sample of the US Transgender Population*, 103 AM. J. PUB. HEALTH 943, 943 (2013); CECILIA CHUNG, ET AL., TRANSGENDER LAW CENTER, POSITIVELY TRANS: INITIAL REPORT OF A NATIONAL NEEDS ASSESSMENT OF TRANSGENDER AND GENDER NON-CONFORMING PEOPLE LIVING WITH HIV (2016), http://transgenderlawcenter.org/wp-content/uploads/2016/02/PositivelyTrans-2015-7-border-FINAL.pdf; ANDREW CRAY, ET AL., CENTER FOR AMERICAN PROGRESS, SEEKING SHELTER: THE EXPERIENCES AND UNMET NEEDS OF LGBT HOMELESS YOUTH 18-19 (2013), https://cdn.americanprogress.org/wp-content/uploads/2013/09/LGBTHomelessYouth.pdf; ANN P. HAAS, ET AL., SUICIDE ATTEMPTS AMONG TRANSGENDER AND GENDER NON-CONFORMING ADULTS: FINDINGS OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 2 (2014), https://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf (finding that survey respondents living with HIV (51%), survey respondents living with disabilities (55-65%), and survey respondents who have had a health care provider refuse to treat them due to their gender identity (60%) had higher prevalence of suicide attempts); LAMBDA LEGAL, WHEN HEALTH CARE ISN'T CARING: LAMBDA LEGAL'S SURVEY OF DISCRIMINATION AGAINST LGBT PEOPLE AND PEOPLE WITH HIV 9-16 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf; Ilan H. Meyer, *Why Lesbian, Gay, Bisexual, and Transgender Public Health?*, 91 AM. J. PUB. HEALTH 856, 856-57 (2001); Office of Disease Prevention and Health Promotion, *Lesbian, Gay, Bisexual, and Transgender Health*, https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health (last visited Aug. 13, 2019); Cigna, *LGBT Health Disparities* (Feb. 2017), https://www.cigna.com/individuals-families/health-wellness/lgbt-disparities.

[27] Removal of discrimination protections for the transgender community will create uncertainty for consumers and insurance companies, and increase the burden on state regulatory agencies. Letter from 18 Insurance Commissioners to Secretary Alex M. Azar II (Aug. 5, 2019), https://www.insurance.ca.gov/0400-news/0100-press-releases/2019/upload/nr057LtrToAzarSec1557-080519.pdf. The Proposed Rule would also create an "uneven playing field among insurers." *Id* on 2.

[28] *See, e.g.*, Out2Enroll, *Summary of Findings: 2017 Marketplace Plan Compliance with Section 1557*, https://out2enroll.org/out2enroll/wp-content/uploads/2015/10/Report-on-Trans-Exclusions-in-2017-Marketplace-Plans.pdf. The Department suggests that because Judge O'Connor issued a preliminary injunction against enforcement of parts of the Final Rule prior to the 2017 plan year, consumers "could not have developed a reliance interest on the enjoined parts of the rule." Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. at 27,886. However, insurers selling Qualified Health Plans in 2017 would have had to complete a multi-month long certification process with the Department and were marketing and enrolling consumers into their plans prior to Judge O'Connor's preliminary injunction on New Year's Eve. Additionally, the Department had finalized Marketplace rules that prohibited insurers from using market practices or benefit designs that discourage the enrollment of people with significant health conditions or discriminate against people due to their gender identity in 2013 and prohibited exchanges and Qualified Health Plan issuers from discriminating on the basis of gender identity in 2012. Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 Fed. Reg. 13,406, 13,438 (Feb. 27, 2013) (codified as 45 C.F.R. §§ 147.104(e)); Patient Protection and Affordable Care

protections would encourage covered entities to return to pre-ACA practices of discriminating against consumers who are transgender or who otherwise seek coverage of transition-related services.

IV. The Department proposes changes to Section 1557 regulations that impermissibly introduce new religious exemptions into nondiscrimination provisions and would allow increased discrimination against vulnerable communities.

Sex discrimination takes many forms and can occur at every step in the health care system—from obtaining affordable insurance coverage to the treatment received in examination rooms. Sex-based discrimination can have serious adverse impacts, including higher costs for health care coverage, improper diagnoses, and less effective treatments.[29] Additionally, the effects of sex discrimination for women of color can compound other forms of discrimination they face, including racial discrimination, and disparities they already experience in access to health care and positive health outcomes.[30]

The Proposed Rule attempts to roll back protections for certain types of sex discrimination under Section 1557, including discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related conditions. Although HHS acknowledges in the Proposed Rule's preamble that the prohibition against sex discrimination includes termination of pregnancy, the Department refuses to state whether it would enforce those protections. Instead, the Department proposes to delete the Final Rule's clarification that the ban on sex discrimination includes all pregnancy-related care, and in doing so, illegally attempts to eliminate express protections that apply to someone who has had an abortion or has experienced a miscarriage or ectopic pregnancy and needs care for those conditions as well. While the scope of protection under Section 1557 is clear, illegal discrimination is likely to flourish if implementing regulations and HHS enforcement is purposefully ambiguous.

The Proposed Rule seeks to unlawfully incorporate Title IX's "Danforth Amendment", which carves out abortion care and coverage from the ban on discrimination of sex in the education context. Congress did not include the Title IX exceptions, including the Danforth Amendment, either explicitly or by reference, in Section 1557. The Proposed Rule's unlawful incorporation of the Danforth Amendment is yet another attack on abortion care and serves as an additional barrier for people to access affordable and comprehensive health care. These attacks could embolden illegal discrimination that will fall heaviest on those least able to seek health care elsewhere, including women living in rural areas and women of color, who already face harassment and

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Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,447 (codified as 45 CFR 155.120(c)(2), 156.200(e)). These rules were well noted by consumer advocacy organizations and highlighted in outreach to the LGBT community.

[29] *See generally* ROBERT WOOD JOHNSON FOUNDATION, ET AL., DISCRIMINATION IN AMERICA: FINAL SUMMARY 13 (2018), https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2018/rwjf443620.

[30] *See generally* MARTHA HOSTETTER & SARAH KLEIN, THE COMMONWEALTH FUND, *IN FOCUS: REDUCING RACIAL DISPARITIES IN HEALTH CARE BY CONFRONTING RACISM* (2018), https://www.commonwealthfund.org/publications/newsletter-article/2018/sep/focus-reducing-racial-disparities-health-care-confronting.

discrimination by providers during pregnancy, contributing to Black and Native American women's unacceptably high rates of health-related pregnancy complications and death.[31]

The Proposed Rule also attempts to impermissibly apply Title IX's religious exemption, along with other unrelated rules, to Section 1557's prohibition on sex discrimination in health programs and activities. The Department's attempt to incorporate these restrictions violates the plain language of the statute and is contrary to the express purpose of Section 1557. If finalized, these new restrictions could allow for religiously-affiliated hospitals and other health care entities to discriminate against patients based on sex, disproportionately harming LGBTQ people, people seeking reproductive health services, including abortion care, and those living at the intersection of these identities.[32]

Allowing a religious exemption to Section 1557's protection against sex discrimination could have far-reaching negative consequences. Incorporating Title IX's religious exemption could create new instances in which health care providers, including insurance companies, hospitals, doctors, or nurses, allow their beliefs to determine patient care, opening the door to illegal discrimination and substandard care. The proposed changes would impact a broad range of health care services, including contraception, certain fertility treatments, abortion, gender-affirming care, and end-of-life care.[33] Studies have already tracked the proliferation of entities that use religious beliefs to discriminate against patients and the growing number of religiously-affiliated entities that provide health care and related services, but refuse to provide certain care based on religious beliefs.[34] The Proposed Rule would encourage these entities to engage in illegal discrimination, and would have the impact of blocking vulnerable communities from the health care they need.

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[31] *See, e.g.*, NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, BLACK WOMEN'S MATERNAL HEALTH (2018), http://www.nationalpartnership.org/our-work/resources/health-care/maternity/black-womens-maternal-health-issue-brief.pdf; Lucy Truschel & Cristina Novoa, *American Indian and Alaska Native Maternal and Infant Mortality: Challenges and Opportunities*, CENTER FOR AMERICAN PROGRESS (July 9, 2018), https://www.americanprogress.org/issues/early-childhood/news/2018/07/09/451344/american-indian-alaska-native-maternal-infant-mortality-challenges-opportunities/.

[32] For more information about how religious exemptions can embolden discrimination against vulnerable communities, see comments made in response to "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" (RIN 0945-ZA03) submitted by the NMAC (formerly the National AIDS Minority Council) and the Williams Institute.

[33] Many professional associations have issued statements against the denial of care based on religious objections to the services in question or the patient in need. *See, e.g.,* American College of Obstetricians and Gynecologists, *America's Frontline Physicians Urge Trump Administration to Protect Transgender Patients and Women's Reproductive Health*, https://m.acog.org/About-ACOG/News-Room/Statements/2019/Physicians-Urge-Trump-Administration-to-Protect-Transgender-Patients-and-Womens-Health?p=1 (May 28, 2019) (joined by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, the American Osteopathic Association, and the American Psychiatric Association); World Professional Association for Transgender Health, *WPATH Board Responds to Health Care Policies and Practices Imposed by Certain Religious Institutions*, https://www.wpath.org/media/cms/Documents/Public%20Policies/2019/5-16_Religious%20Institution%20Health%20Policies.pdf (May 17, 2019) (joined by the American Medical Association, the American Psychological Association, the American Psychiatric Association, and the American Academy of Pediatrics).

[34] *See, e.g.*, LOIS UTTLEY, ET AL., AM. CIVIL LIBERTIES UNION & MERGERWATCH, *MISCARRIAGE OF MEDICINE: THE GROWTH OF CATHOLIC HOSPITALS AND THE THREAT TO REPRODUCTIVE HEALTH CARE* (2013), http://www.mergerwatch.org/storage/pdf-files/Growth-of-Catholic-Hospitals-2013.pdf; LOIS UTTLEY & CHRISTINE KHAIKIN, GROWTH OF CATHOLIC HOSPITALS AND HEALTH SYSTEMS: 2016 UPDATE OF THE MISCARRIAGE OF MEDICINE REPORT (2016), http://www.mergerwatch.org/storage/pdf-files/MW_Update-2016-MiscarrOfMedicine-report.pdf.

V. The Department proposes changes to Section 1557 regulations that impermissibly eliminate and weaken protections for individuals who are limited English proficient.

The Department's proposed changes to language access provisions would eliminate and weaken protections for individuals who are limited English proficient ("LEP individuals"). Limited English proficiency often exacerbates the effects of low health literacy, especially when LEP individuals do not have access to materials that help them better understand basic health information, access preventive services, or avoid adverse events.[35] These barriers can complicate the management of chronic illnesses and disabilities, and lead to poorer health outcomes for already disadvantaged communities.[36] The Department failed to follow its own balancing principles (identified in the 2003 HHS LEP Guidance[37]) when it created a proposed rule that focused most significantly on the costs of compliance to covered entities, devoting minimal discussion and analysis to the costs to LEP individuals and prioritizing organizations over the communities Section 1557 is meant to protect.

HHCAWG strongly opposes the repeal of the requirement that covered entities provide a notice of nondiscrimination that informs the public of their legal rights. While this change impacts all individuals,[38] including native English speakers, the change will have a disproportionate impact on LEP individuals and those who are unfamiliar with applicable civil rights protections. The Department has provided no explanation for how individuals will be aware of their rights and how elimination of notices will not deny LEP individuals, individuals living with chronic illnesses and disabilities, and others with meaningful access to nondiscriminatory health care.

We also strongly oppose the Department's proposed repeal of the requirement for covered entities to provide in-language taglines informing recipients of the availability of language assistance on significant documents. Taglines are not only well-supported by long-standing federal regulations, guidance, and practice,[39] but they are necessary to ensure that LEP individuals are

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[35] *See, e.g.*, Tentine Sentell & Kathryn L. Braun, *Low Health Literacy, Limited English Proficiency, and Health Status in Asians, Latinos, and Other Racial/Ethnic Groups in California*, 17 J. HEALTH COMM. 82 (2012).

[36] *See generally* Chandrika Divi, et al., *Language Proficiency and Adverse Events in U.S. Hospitals: A Pilot Study*, 19 INT'L J. QUALITY IN HEALTH CARE 60 (2007).

[37] "First we must ensure that federally assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English." Guidance to Federal Financial Assistance Recipients: Providing Meaningful Access to Individuals Who Have Limited English Proficiency in Compliance With Title VI of the Civil Rights Act of 1964, 68 Fed. Reg. 34,698, 34,699 (June 10, 2003).

[38] Many people in protected classes are unaware or do not feel confident in their knowledge of their civil rights. *See, e.g.*, CECILIA CHUNG, ET AL., TRANSGENDER LAW CENTER, POSITIVELY TRANS: INITIAL REPORT OF A NATIONAL NEEDS ASSESSMENT OF TRANSGENDER AND GENDER NON-CONFORMING PEOPLE LIVING WITH HIV (2016), http://transgenderlawcenter.org/wp-content/uploads/2016/02/PositivelyTrans-2015-7-border-FINAL.pdf.

[39] *See* DOJ Public dissemination of title VI information, 29 C.F.R. § 42.405(d)(1); HHS Consumer assistance tools and programs of an Exchange, 45 C.F.R. § 155.205(c)(2)(iii); CMS (Medicaid Managed Care) Information requirements, 42 C.F.R. § 438.10(d)(3); DOL Discrimination prohibited based on national origin, including limited English proficiency, 29 C.F.R. § 38.9(g)(3); USDA (SNAP) Program administration and personnel requirements, 7 C.F.R. § 272.4(b); Guidance to Federal Financial Assistance Recipients: Providing Meaningful Access to

made aware of and are reminded that auxiliary aids and services or language assistance services are available. The requirement to include taglines in all significant communications also prompts covered entities to ensure these resources are available for LEP members at all stages of receiving and paying for covered benefits.

HHCAWG's membership, including several provider organizations and community health centers, strongly oppose the Proposed Rule's repeal of requirements that help LEP consumers understand the protections and resources available to them in health settings. The fact that an "overwhelming majority of beneficiaries speak English" does not provide compelling support to rescind protections designed for beneficiaries who have limited English proficiency.[40] The Proposed Rule repeals provisions that were practical, effective, fiscally responsible, reasonable, and responsive to the circumstances relevant to health care programs and activities, and instead prioritizes covered entities' resources and consumers' "annoyance" over the civil rights of LEP individuals.

VI. In general, the Department inappropriately proposes changes to Section 1557 and other unrelated regulations, and should rescind the Proposed Rule in its entirety to avoid sanctioning the violation of civil rights and weakening robust enforcement mechanisms.

The Department's Proposed Rule is inappropriately broad and introduces premature changes to Section 1557 regulations and other unrelated rules. The Department notably proposes changes to sections of the CFR that were promulgated separately from and prior to the 2016 Final Rule.[41] In some cases, these rules arise out of statutes different from Section 1557, statutes that the Department fails to consider in its totality in the Proposed Rule. If the Proposed Rule is implemented, express prohibitions on discrimination based on sexual orientation and gender identity would be eliminated from regulations addressing private insurance, certain Medicaid and Medicare organizations, and education programs. These programs are especially important for LGBT people living with HIV as Medicaid serves as the largest source of insurance coverage for people living with HIV and an increasing number of people living with HIV are aging into the Medicare program.[42]

Individuals Who Have Limited English Proficiency in Compliance With Title VI of the Civil Rights Act of 1964, 68 Fed. Reg. 34,698 (June 10, 2003).

[40] Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. at 27,858-59.

[41] Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. at 27,889-94 (proposing to amend 45 C.F.R. §§ 147.104(e), 155.120(c)(ii), 155.220(j)(2), 156.200(e), 156.1230(b)(3); 42 C.F.R. §§ 438.3(d)(4) 438.206(c)(2), 438.262; 42 C.F.R. §§ 460.98(b)(3), 460.112(a)).

[42] Kaiser Family Foundation, *Medicaid and HIV* (Oct. 2016), http://files.kff.org/attachment/Fact-Sheet-Medicaid-and-HIV; Kaiser Family Foundation, *Medicare and HIV* (Oct. 2016), http://files.kff.org/attachment/Fact-Sheet-Medicare-and-HIV. Medicaid also helps millions of people living with disabilities. State-by-state statistics can be found at Matt Broaddus, *On Its Anniversary, a Look at How Medicaid Helps People in Every State,* CENTER ON BUDGET AND POLICY PRIORITIES (July 30, 2019), https://www.cbpp.org/blog/on-its-anniversary-a-look-at-how-medicaid-helps-people-in-every-state.

Additionally, the Department prematurely proposes changes to Section 1557 regulations. The Supreme Court is scheduled to hear oral arguments and address whether sex-based discrimination protections in employment law extend to discrimination based on sexual orientation and gender identity.[43] While these cases rely on Title VII and not Title IX, the Supreme Court's resulting decisions will undoubtedly introduce new considerations for the Department and the public should have the opportunity to address the impact of the Court's decisions on HHS' interpretation of Section 1557.

The Department also includes changes that would undermine the enforcement of and remedies available to protected classes for Section 1557 violations. The Proposed Rule removes provisions that recognize a private right of action in federal court and allow for money damages in administrative and judicial actions bought under Section 1557. The Proposed Rule also attempts to limit available enforcement mechanisms for each protected characteristic to those available under their respective reference statutes (Title Vi, Title IX, Section 504 of the Rehabilitation Act, and the Age Discrimination Act). However, Section 1557 built and expanded prior civil rights laws such that individuals seeking to enforce their rights would have access to the full range of civil rights remedies and not be limited to only the remedies provided to a particular protected group under a specific law.[44] These proposed changes undermine the plain language of Section 1557 and would produce a weak, confusing mix of legal standards and remedies that would be difficult for federal and state agencies to enforce. The Proposed Rule would also make it more difficult for consumers with complaints of intersectional discrimination to file complaints with HHS.

VII. Conclusion

Given the numerous uncertainties and flaws that arise from the Proposed Rule, HHCAWG strongly urges the Department to rescind the Proposed Rule in its entirety. The proposed changes would impact the ability for people living with HIV and other chronic illnesses and disabilities to access health care coverage that fully addresses their health care needs. Implementing the Proposed Rule would bring about additional costs (for both consumers and covered entities) and would encourage the expansion of discriminatory practices among providers, health insurers, and other covered entities. Instead, we urge HHS to more vigorously address complaints of discrimination already on file, and hold covered entities accountable to complying with the Final Rule.

Thank you for the opportunity to comment on the Proposed Rule. Our comments include numerous citations to supporting research, in many cases including direct links for HHS' benefit in reviewing our comments. We direct HHS to each of the sources cited and we request that the full text of each source, along with the full text of our comments be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act. Please contact Phil Waters at pwaters@law.harvard.edu with the Treatment Access Expansion Project or

[43] Zarda v. Altitude Express, 883 F.3d 100, (2d Cir. 2018), *cert. granted*, 139 S. Ct. 1599 (U.S. April 22, 2019) (No. 17-1623); R.G. & G.R. Harris Funeral Homes, Inc. v. EEOC, 884 F.3d 560 (6th Cir. 2018), *cert. granted*, 139 S. Ct. 2049 (U.S. May 13, 2019) (No. 18-107).

[44] Section 1557 expressly provides individuals all "rights, remedies, procedures, or legal standards" available under the cited civil rights statutes and gives people access to "enforcement mechanisms provided for and available under such title VI, title IX, section 794, or the Age Discrimination Act shall apply for purposes of violations of this subsection." Patient Protection and Affordable Care §1557, 42 U.S.C. §18116.

Amy Killelea at akillelea@nastad.org with the National Alliance of State and Territorial AIDS Directors if we can be of assistance.

Respectfully submitted by:

ADAP Educational Initiative | AIDS Alabama | AIDS Action | Baltimore AIDS Alliance for Women, Infants, Children, Youth & Families | AIDS Foundation of Chicago | AIDS Research Consortium of Atlanta | AIDS United | American Academy of HIV Medicine | APLA Health | AIDS Resource Center of Wisconsin | Bailey House, Inc. | Black AIDS Institute | Communities Advocating Emergency AIDS Relief (CAEAR) | Community Access National Network (CANN) | Georgia AIDS Coalition | Harm Reduction Coalition | HealthHIV | HIV Medicine Association | Housing Works | Human Rights Campaign | iHealth | John Snow, Inc (JSI) | Legal Council for Health Justice | Michigan Positive Action Coalition | Minnesota AIDS Project | National Alliance of State and Territorial AIDS Directors | National Coalition for LGBT Health | National Latino AIDS Action Network | NMAC | Positive Women's Network - USA | Project Inform | Rocky Mountain CARES | San Francisco AIDS Foundation | SisterLove | Southern AIDS Coalition | St. Louis Effort for AIDS | The AIDS Institute | The Food is Medicine Coalition | Treatment Access Expansion Project | Treatment Action Group | Thrive Alabama

EXHIBIT D-27a

FUNDERS FOR LGBTQ ISSUES

July 25, 2019

Submitted via www.regulations.gov

Secretary Alex Azar
Department of Health and Human Services, Office for Civil Rights
Attention: Section 1557 NPRM, RIN 0945-AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

RE: Comments in Opposition to Section 1557 NPRM, RIN 0945-AA11, "Nondiscrimination in Health and Health Education Programs or Activities"

To Whom It May Concern:

I am writing on behalf of Funders for LGBTQ Issues to express our strong opposition to the proposed regulatory reform regarding Section 1557 of the Patient Protection and Affordable Care Act published in the Federal Register on June 14, 2019.

Funders for LGBTQ Issues works to increase the scale and impact of philanthropic resources aimed at enhancing the well-being of lesbian, gay, bisexual, transgender and queer communities, promoting equity, and advancing racial, economic and gender justice. We are a network of more than 80 foundations, corporations, and other grantmaking institutions that collectively award more than $1 billion in funding annually, including more than $100 million specifically devoted to LGBTQ issues.

With an awareness that LGBT Americans are 25 percent more likely to lack healthcare coverage compared to non-LGBT Americans, our network is actively working to address health disparities affecting LGBT Americans.[1] We know that LGBT Americans suffer from higher rates of cancer, cardiovascular disease, HIV/AIDS infection, and mental health issues.[2] Our most recent tracking report on LGBTQ grantmaking by U.S. foundations identified $27.6 million in funding aimed at improving the health and wellbeing of the more than 11.3 million Americans who openly identify as lesbian, gay, bisexual, or transgender.[3,4] Legislation or rules that reduce

[1] The Williams Institute, UCLA School of Law, "LGBT Data & Demographics," accessed July 16, 2019. https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#demographic

[2] Brown, J., Maulbeck, B.F, (2015) *Vital Funding: Investing in LGBTQ Health and Wellbeing*. Retrieved from Funders for LGBTQ Issues Website: https://lgbtfunders.org/wp-content/uploads/2018/04/Vital_Funding.pdf

[3] Kan, L.M., Maulbeck, B.F., Wallace, A. (2018) *2017 Tracking Report: Lesbian, Gay, Bisexual, Transgender, and Queer Grantmaking by U.S. Foundations*. Retrieved from Funders for LGBTQ Issues Website: https://lgbtfunders.org/wp-content/uploads/2018/02/2017TrackingReport_Final.pdf

protections or limit health care access for LGBT Americans run counter the goals of our network and jeopardize the health of millions of people already facing alarming health crises.

As such, we oppose the proposed rules change, which will inflict unnecessary harm on LGBT Americans -- in particular, more than one million transgender Americans.[5] The proposal to remove the protections of Section 1557 is counter to long-standing federal court decisions from across the country that classified discrimination on the basis of sexual orientation and gender identity as sex discrimination. Nearly seven million LGBT Americans live in states without any protections against sexual orientation and gender identity discrimination in public accommodation.[6] Section 1557 was wisely added to clarify existing law that discrimination against LGBT persons in healthcare settings and in insurance benefits coverage is unlawful; the proposed rule change would sow confusion among healthcare workers and insurance companies and give the impression that such discrimination is permissible. Given that one in three transgender Americans report having had at least one negative experience with a healthcare provider, such as verbal harassment or refusal of treatment entirely, the proposed regulations would only further discourage more than one million transgender Americans from seeking medical care.[7]

Furthermore, the broad religious exemptions proposed in the change threaten to turn personal and religious beliefs into a smokescreen for discrimination. They could be used not only to deny care to LGBT individuals but also to prevent people from accessing needed reproductive healthcare, letting doctors decide who is "worthy" of treatment. Allowing medical providers to use their personal beliefs rather than their professional obligations to decide whom they will serve could result in a wide range of people being turned away from potentially life-saving care: LGBT people, unmarried people, or people who have had an abortion or need one. The result would be a "patchwork" of unequal access to reproductive healthcare across the country, where the nature and quality of care available would be based on the happenstance of geography rather than need.

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[4] The Williams Institute, UCLA School of Law. (2019) *Adult LGBT Population in the United States*. Retrieved from Williams Institute Website https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Population-Estimates-March-2019.pdf

[5] The Williams Institute, UCLA School of Law. (2019) *Adult LGBT Population in the United States*. Retrieved from Williams Institute Website: https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Population-Estimates-March-2019.pdf

[6] The Williams Institute, UCLA School of Law (2019) *LGBT People in the U.S. Not Protected by State Nondiscrimination Statutes*. Retrieved from Williams Institute Website: https://williamsinstitute.law.ucla.edu/wp-content/uploads/Equality-Act-April-2019.pdf

[7] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016) *The Report of the 2015 U.S. Transgender Survey*. Retrieved from National Center for Transgender Equality Website: https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

We also oppose the proposed rules change because of negative impact it will have on the health outcomes of immigrants -- nearly one million of whom identify as lesbian, gay, bisexual, or transgender.[8] By eliminating not only vital anti-discrimination protections but also the requirement that health programs post notices about the availability of language access programs, the proposed change to Section 1557 makes it harder for people with limited English proficiency or other disabilities to access medical care. Without meaningful access to information about their rights to care, patients and their family members with limited English proficiency would be less able to file complaints with HHS or in courts if their rights are violated. Moreover, as the current administration has shown outright hostility to immigrants, eliminating Section 1557's specific mandate that discrimination based on immigration status is prohibited may discourage immigrants from seeking healthcare altogether, for fear that doing so would also subject them to increased scrutiny about their immigration status. Any segment of the population that is forced to forgo treatment poses a threat to the health of the entire population.

For all the aforementioned reasons, we believe the proposed change to Section 1557 of the Patient Protection and Affordable Care is not only a step backwards but also highly inconsistent with the original intent of the law to expand access to healthcare and insurance. We hope you will reconsider the proposed change to Section of 1557 in the service of securing a healthier future for all Americans.

We thank you for your consideration.

Sincerely,

Ben Francisco Maulbeck
President
Funders for LGBTQ Issues

[8] Machado, D. Maulbeck, B.F. (2014) *Pathways Forward: Foundation Funding for LGBTQ Immigration Issues*. Retrieved from Funders for LGBTQ Issues Website: https://lgbtfunders.org/wp-content/uploads/2018/04/Pathways_Forward_2014.pdf

the Williams INSTITUTE

LGBT Data & Demographics
Switch Topic

ALL
Select a State

ALL
Select a Characteristic

Male 42%

Female 58%

LGBT Gender Ratio

25%

Percentage with Income <$24K

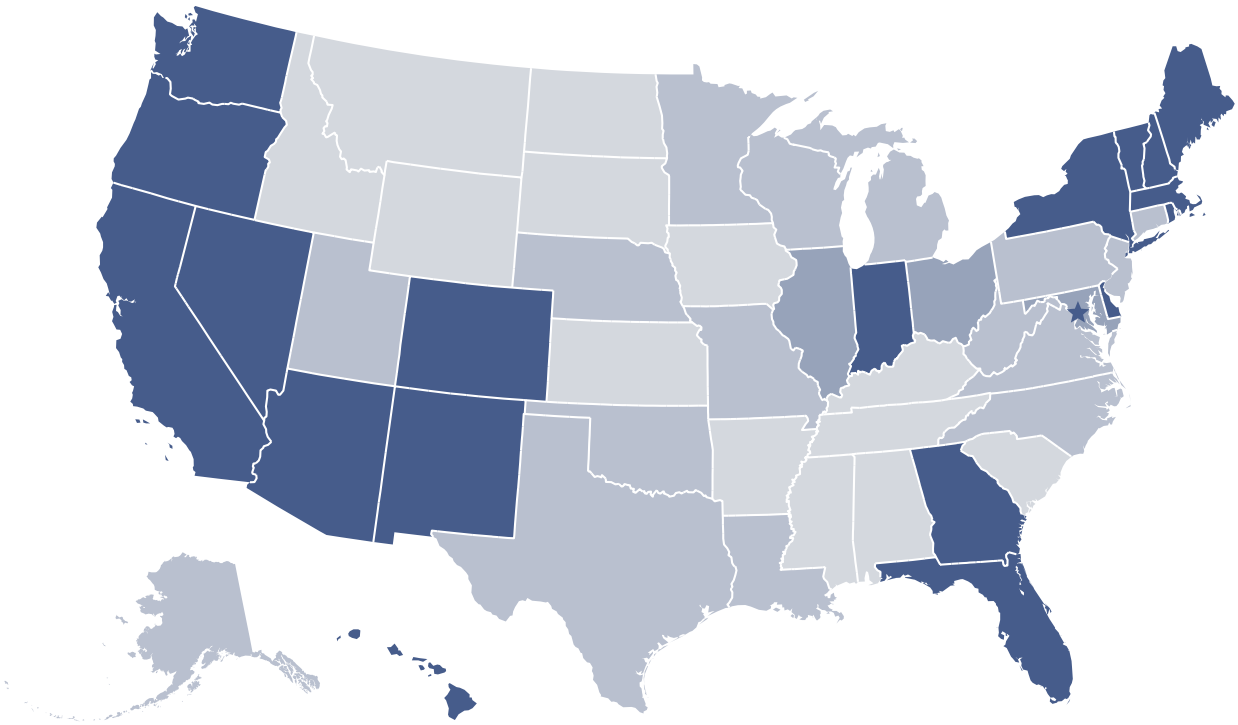
4.5%

29%

Percentage with Children

AREA SELECTION

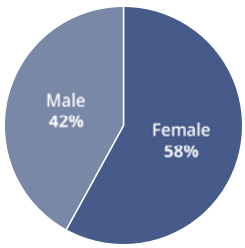
4.5% and above



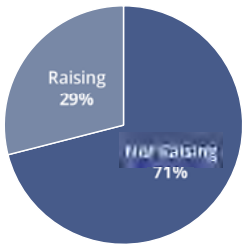
WHO IS INCLUDED IN THE LGBT ESTIMATES?

The Gallup Daily tracking survey asks respondents, "Do you, personally, identify as lesbian, gay, bisexual, or transgender?". We include all individuals in the data that self-identified as LGBT (both single and coupled). That is who is presented on these maps and charts. Thus, these data give a peek at the characteristics of the LGBT community living in the United States as a whole.

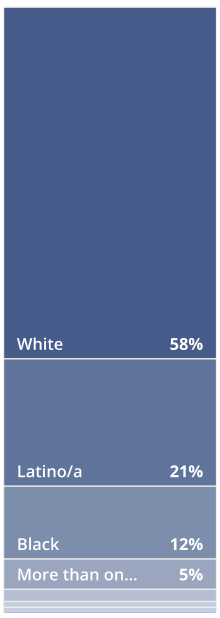
Characteristics of LGBT People: United States



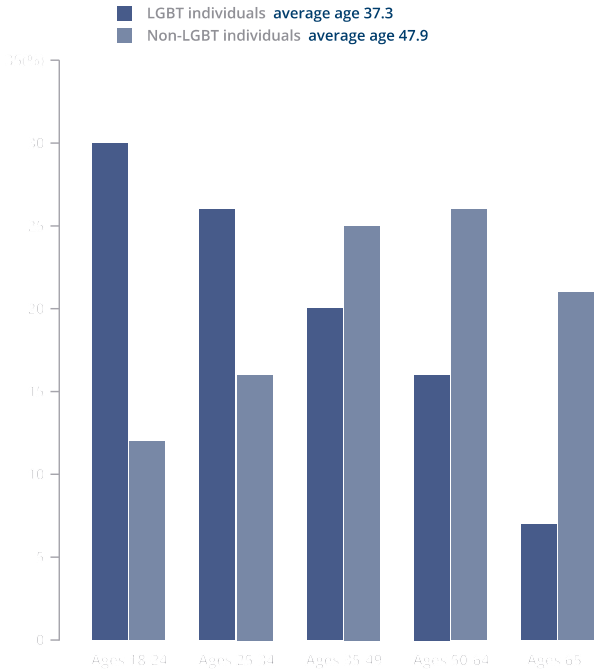
GENDER



% RAISING CHILDREN

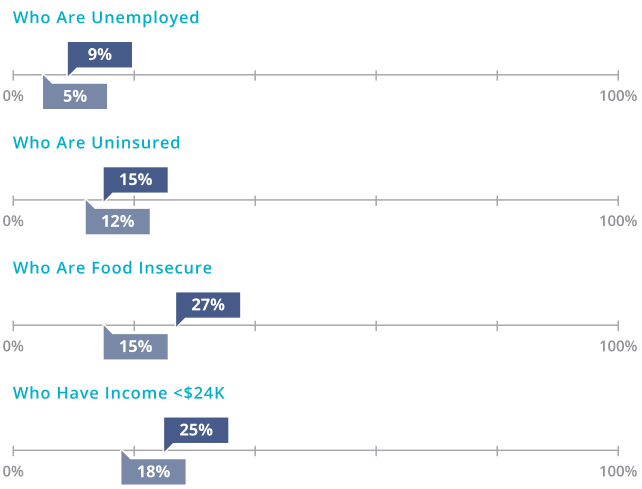


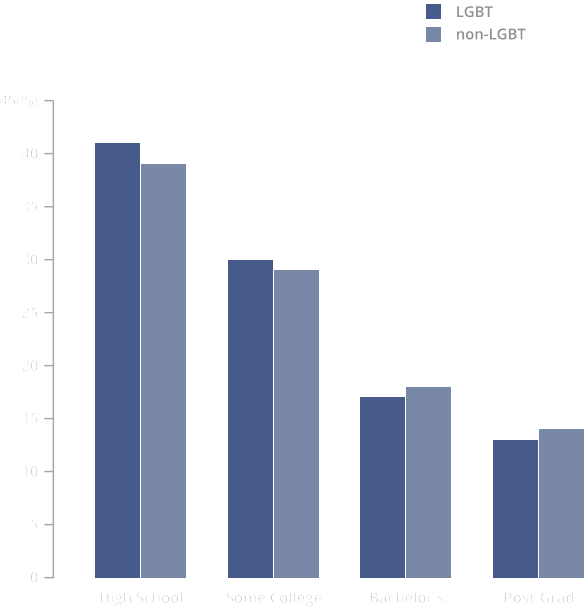
RACE/ETHNICITY



AGE DISTRIBUTION

Socioeconomic Indicators: United States





EDUCATIONAL ATTAINMENT

LGBT People Rankings: United States

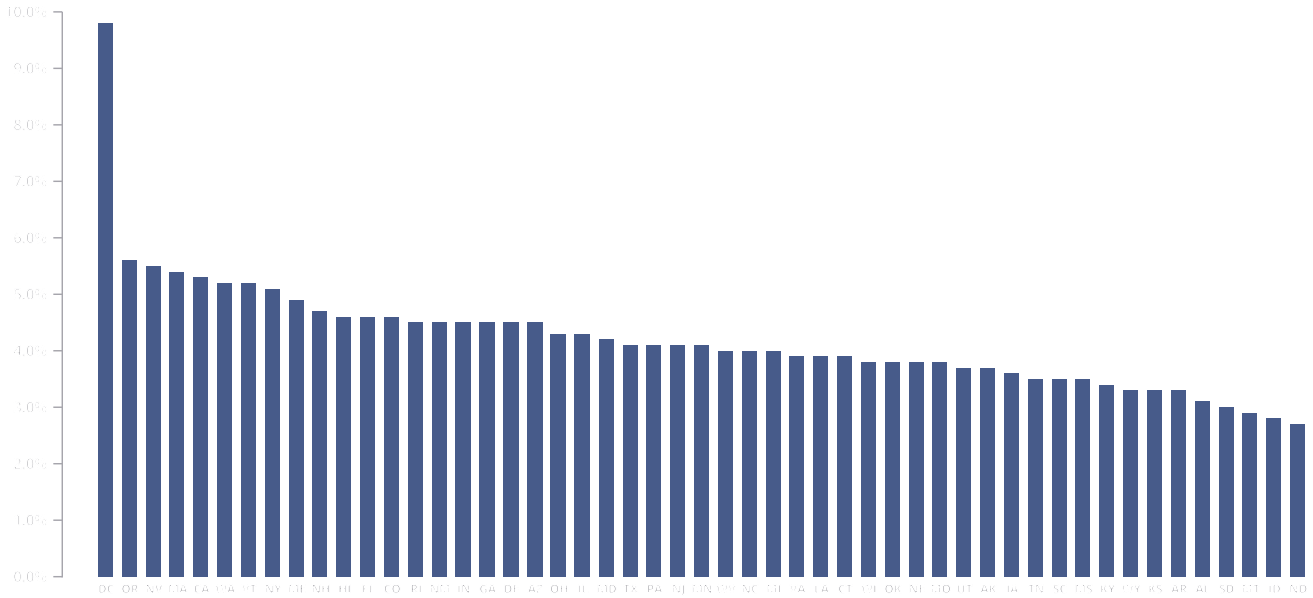
RANK	STATE	% OF LGBT INDIVIDUALS WITH CHILDREN	LGBT PERCENTAGE
1	District Of Columbia	9%	[illegible]
2	Oregon	23%	[illegible]
3	Nevada	22%	[illegible]
4	Massachusetts	21%	[illegible]
5	California	24%	[illegible]
6	Washington	28%	[illegible]
7	Vermont	23%	[illegible]
8	New York	22%	[illegible]

RANK	STATE	% OF LGBT INDIVIDUALS WITH CHILDREN	LGBT PERCENTAGE
9	Maine	21%	[illegible]
10	New Hampshire	31%	[illegible]
11	Hawaii	30%	[illegible]
12	Florida	24%	[illegible]
13	Colorado	25%	[illegible]
14	Rhode Island	19%	[illegible]
15	New Mexico	29%	[illegible]
16	Indiana	34%	[illegible]
17	Georgia	27%	[illegible]
18	Delaware	35%	[illegible]
19	Arizona	25%	[illegible]
20	Ohio	30%	[illegible]

State Comparison: All LGBT Individuals

LGBT PERCENTAGE OF POPULATION

Select a Statistic to Compare



About the Data

ABOUT THE DATA

Analysis in this interactive utilize data collected for the Gallup Daily Tracking survey. Respondents were obtained through list-assisted random digit dial (70% cell phone, 30% landline) and randomly assigned to one of two surveys within the Daily Tracking survey—the Gallup-Sharecare Well-Being Index or the Gallup Politics and Economy survey. Both surveys are interviewer-administered by telephone, may be completed in English or Spanish, and contain some of the same questions. Each year between 2012 and 2016, a sample of approximately 350,000 U.S. adults ages 18 and up who reside in the 50 states and the District of Columbia participated in the surveys. In 2017, Politics and Economy survey respondents were recruited daily, and those assigned to the Well-Being Index were recruited daily for the first half of 2017, then weekly starting in July 2017, resulting in a slightly smaller sample for 2017 (approximately 341,000). Data have been aggregated across surveys.

LGBT IDENTIFICATION

LGBT identity is based on response to the question, "Do you, personally, identify as lesbian, gay, bisexual, or transgender?" Respondents who answered "yes" were classified as LGBT, those answering "no" were classified as non-LGBT. Those who did not answer the LGBT identity item (2017: 6.4% weighted, n=21,082; 2015-2017: 5.5% weighted, n=57,562; 2012-2017: 6.3% weighted, n=69,555), because they refused to answer the question or said "I don't know," were excluded from analyses; however, they are included in the denominator used to estimate % LGBT. All n's are unweighted.

NATIONAL (ALL AND FILTERED BY SEX)

Data from 2017 are presented. All proportions are weighted using Gallup post-stratification national sampling weights and allow estimates to be representative of the U.S. national population.

NATIONAL (FILTERED BY RACE)

Aggregated data from 2015-2017 are presented. All proportions are weighted using Gallup post-stratification national sampling weights and allow estimates to be representative of the U.S. national population.

STATE (ALL AND FILTERED BY SEX)

Aggregated data from 2015-2017 are presented for most states. Additional data collected from June 1, 2012 through December 31, 2017 were aggregated for 13 states with smaller samples (200 LGBT respondents in the 2015-2017 aggregated dataset): Alaska, Delaware, Hawaii, Idaho, Mississippi, Montana, New Hampshire, North Dakota, Rhode Island, South Dakota, Vermont, West Virginia, and Wyoming. All proportions are weighted using Gallup post-stratification state sampling weights that account for differences in 2017 survey sampling fractions.

UNSTABLE ESTIMATE

"*" Indicates an unstable estimate due to an insufficient sample size (n<30) and/or 95% confidence interval width as per suppression guidance provided in Parker JD, Talih M, Malec DJ, et al. National Center for Health Statistics Data Presentation Standards for Proportions. National Center for Health Statistics. Vital Health Stat 2(175). 2017.

GENDER

Respondents were classified as male or female, based on their response to the question, "I am required to ask, are you male or female?"

RAISING CHILDREN

Children in household, among adults age 25 and over, defined as > 1 child under the age of 18 living in the respondent's household. Only reported for respondents aged 25 and over. Question and sampling weight from the Gallup-Sharecare Well-Being Index survey only.

RACE AND ETHNICITY

Race/ethnicity was defined on the basis of responses to two questions -- Hispanic, Latino, or Spanish origin (yes/no) and race (chose all that apply.) Respondents who indicated that they are Hispanic, Latino, or of Spanish origin were classified as Latino/a or Hispanic and all non-Hispanic respondents were classified by race (single race or more than one race.) When estimates were unstable for specific racial/ethnic groups, these groups were aggregated and labeled all other races.

WHITE/ALL OTHER RACES

All other races includes respondents who were Latino/a or Hispanic, Black or African American, Asian, American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, or more than one race. Dichotomized race/ethnicity is reported when estimates for six or more race/ethnicity categories are unstable.

AGE DISTRIBUTION

Dichotomized age is reported when estimates for more than one age category (18-24; 25-34; 35-49; 50-64; 65+) are unstable.

EDUCATIONAL ATTAINMENT

≤ High school includes respondents who obtained a high school diploma or GED certificate as well as those who did not complete high school. Some college includes respondents who obtained any post-secondary school technical, vocational or college training that did not yield a four-year Bachelor's degree. Bachelor's degree refers to a four-year degree from a college or university. > Bachelor's degree includes respondents who completed any schooling beyond the four-year degree.

COLLEGE EDUCATION

College education was defined as reporting having earned at least a four-year Bachelor's degree (including those earning a Bachelor's degree and any additional schooling) at the time they were surveyed. Only reported only for respondents aged 25 and over. Dichotomized college education is reported when two or more educational attainment categories (≤ High school; Some College; Bachelor's degree; Post-graduate) are unstable.

UNEMPLOYED

Employment status among respondents in the labor force was dichotomized as either employed (including full-time or part-time employment), or unemployed (those currently unemployed, but actively looking for work and able to work).

HEALTH INSURANCE

Question and sampling weight from the Gallup-Sharecare Well-Being Index only for 2012 through 2016, and from both Gallup surveys in 2017.

FOOD INSECURITY

Food insecurity was defined as ever "not having enough money to buy food that you or your family needed" in the past twelve months. Question and sampling weight from the Gallup-Sharecare Well-Being Index survey only.

HOUSEHOLD INCOME

In 2017, the poverty threshold for a family of four was slightly over $25,086. Source: U.S. Census Bureau. Preliminary Estimate of Weighted Average Poverty Thresholds for 2017.

About This Project

The **LGBT Data & Demographics** site was originally built and published in 2016 by The Williams Institute with support from the Ford Foundation and the assistance of designers and technology developers at TWO-N. The core team who created this work included **Angeliki Kastanis**, **Gary J. Gates**, and **Matt Strieker**. In 2018, **Shoshana Goldberg** and **Kerith Conron** added to this foundation and provided updated and expanded Gallup estimates about LGBT people to the site.

Contact: williamsinstitute@law.ucla.edu

Designed & developed by

Preferred Citation:

LGBT Demographic Data Interactive. (January 2019).
Los Angeles, CA: The Williams Institute, UCLA School of Law.

EXHIBIT D-27b

Funders for LGBTQ Issues Special Report | January 2015

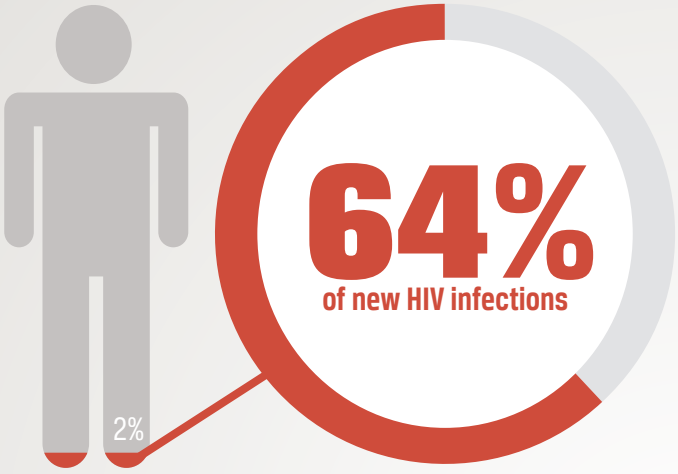
VITAL FUNDING

Investing in LGBTQ Health and Wellbeing

FUNDERS FOR LGBTQ ISSUES

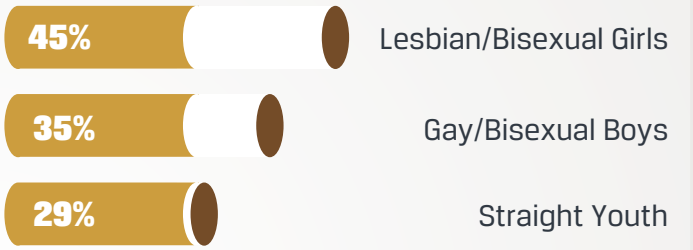
The Need

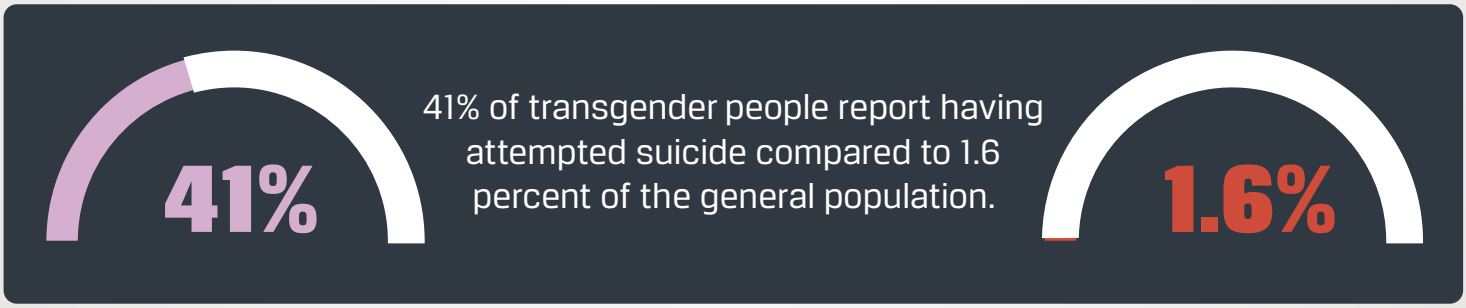
Like other minorities, lesbian, gay, bisexual, and transgender communities face significant health disparities.



Gay and bisexual men and other men who have sex with men account for **64 percent of new HIV infections** even though they make up only about 2 percent of the population.

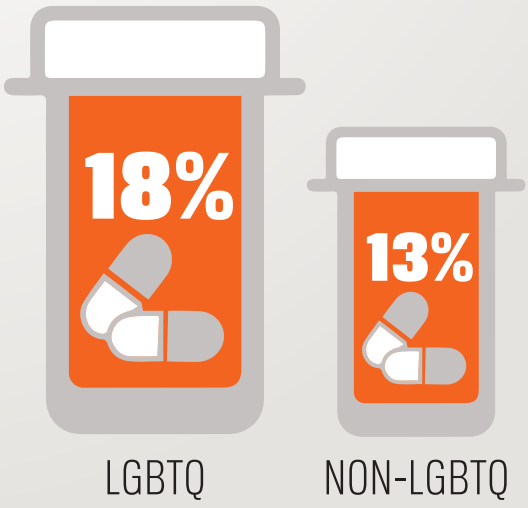
LGBTQ youth are more likely to smoke



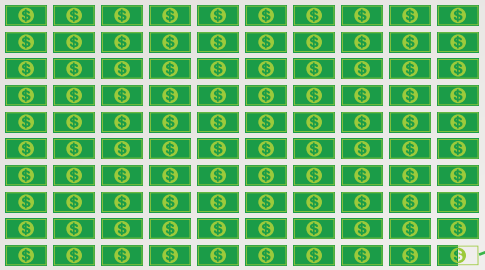


LGBTQ people are more likely to lack health insurance.

18% of LGBTQ adults have no health insurance compared to about 13% of non-LGBTQ adults

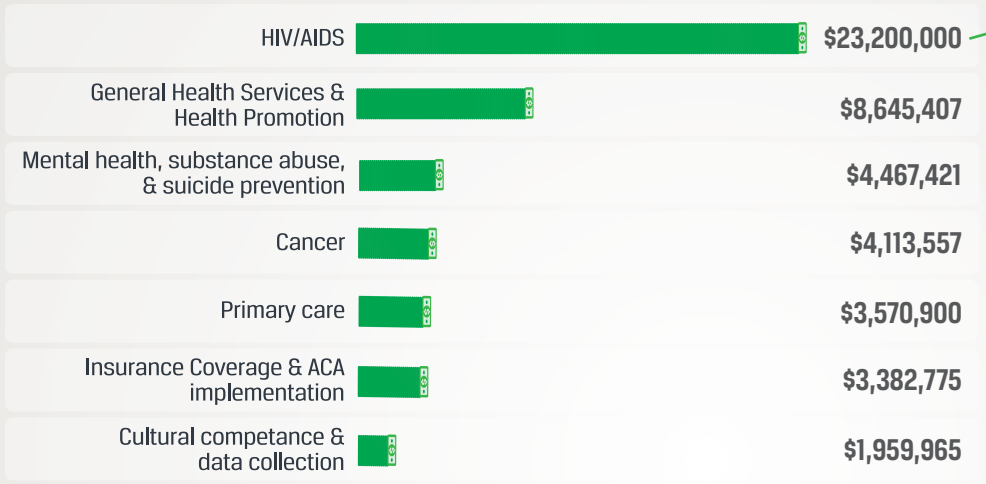


The Funding



Between 2011-2013, foundations and corporations awarded more than **$50 million for LGBTQ health**.

On average, less than one half of one percent of foundation funding for health is for LGBTQ communities.



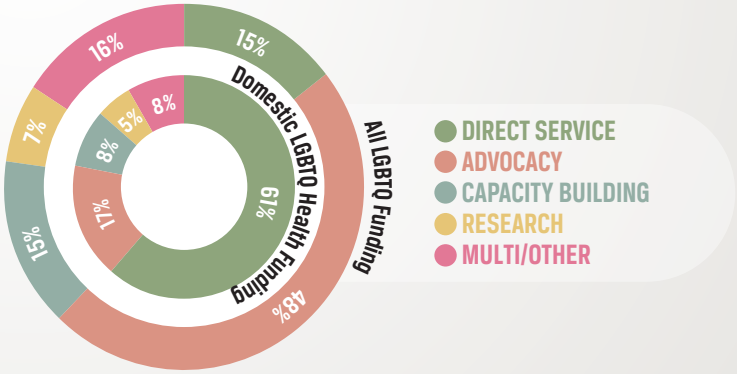
Of U.S. funding for HIV/AIDS, only 21% targets LGBTQ communities - although LGBTQ people account for the majority of new infections.

HEALTH ISSUES FUNDED

Nearly half of LGBTQ health funding was for HIV/AIDS prevention and treatment, with significant portions also devoted to primary care, mental health and substance abuse, cancer, and insurance coverage.

STRATEGIES FUNDED

While advocacy is the most commonly funded strategy for LGBTQ funding overall, **direct service is the most commonly funded strategy for LGBTQ health.**



The Opportunity

In a rapidly changing policy landscape for both healthcare and LGBTQ rights, funders concerned about health disparities, HIV/AIDS, and LGBTQ communities have **several unique opportunities for increased impact on LGBTQ health.**

- Explore Collaborative Efforts to Address Mental & Behavioral Health & Other Social Determinants Related to Stigma.
- Increase Access to Insurance Coverage for LGBTQ People.
- Build Capacity of the HIV/AIDS and LGBTQ Health Services Sector.
- Increase LGBTQ Cultural Competence of Health Service Providers and Systems.
- Strengthen HIV/AIDS and LGBTQ Health Policy and Advocacy Infrastructure.

INTRODUCTION

The movement for lesbian, gay, bisexual, transgender and queer (LGBTQ) rights has seen amazing progress in recent years, on issues ranging from the freedom to marry to inclusion in the military. Yet even with these advances in legal equality, many LGBTQ people still face basic challenges when it comes to quality of life. LGBTQ people are at greater risk for mental and behavioral health challenges, and for diseases such as HIV/AIDS and cancer. Many of us lack health insurance and face other barriers to accessing health care—especially among those who are transgender, people of color, undocumented or economically disadvantaged. In short, we are more likely to get sick, and we are less likely to get the care we need.

This report, *Vital Funding: Investing in LGBTQ Health and Wellbeing*, assesses the scale and character of foundation funding for the health and well-being of LGBTQ communities. Drawing on the data collected for our annual tracking reports on LGBTQ funding, we find that domestic foundation funding for LGBTQ health totaled $50.4 million for 2011 - 2013. Considering the magnitude of the health disparities facing LGBTQ communities, this is a fairly modest amount – and it is highly dependent on a small set of dedicated funders.

When it comes to LGBTQ health, we face daunting challenges, but we also have impressive assets to build on. As a community and as a movement, we have time and again demonstrated our ability to come together to support one another, to advocate for ourselves, and to build lasting institutions. Across the country, there are hundreds of LGBTQ community centers, health centers, and HIV/AIDS service agencies, and other community groups advancing LGBTQ health. There are also a growing number of non-LGBTQ-focused institutions—from hospitals to research centers—seeking to improve their competence, expertise, and effectiveness in working with LGBTQ communities.

In the philanthropic sector, LGBTQ health offers a unique opportunity for LGBTQ funders, HIV funders, and health funders to come together, to learn from each other, and to leverage grant dollars in creative ways. We are honored to have the support of the Robert Wood Johnson Foundation for this effort, and to have wonderful allies in organizations such as Funders Concerned About AIDS and Grantmakers In Health. We hope this report will provide a starting point for a broad and diverse group of funders to develop strategies for lasting and powerful impact on the health and wellbeing of LGBTQ communities.

Take care,

Ben Francisco Maulbeck
President

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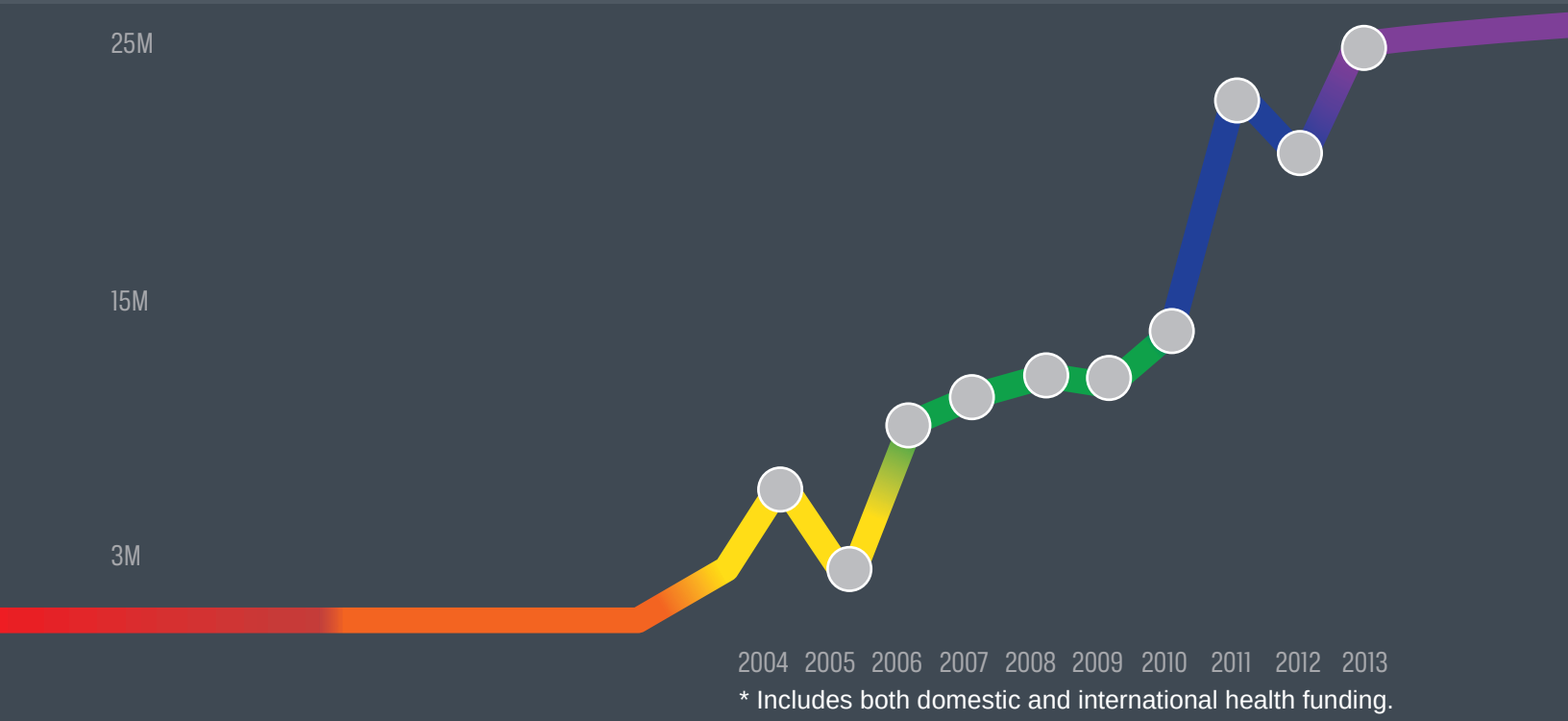
LGBTQ Health Funding

2004-2013



* Includes both domestic and international health funding.

The Need

HEALTH DISPARITIES

Like other minority groups, the LGBTQ community faces significant health disparities, particularly around issues of HIV, cancer, cardiovascular health, and mental health. These disparities tend to be especially severe among various LGBTQ subpopulations such as people of color, youth, older adults, and transgender people.

HIV

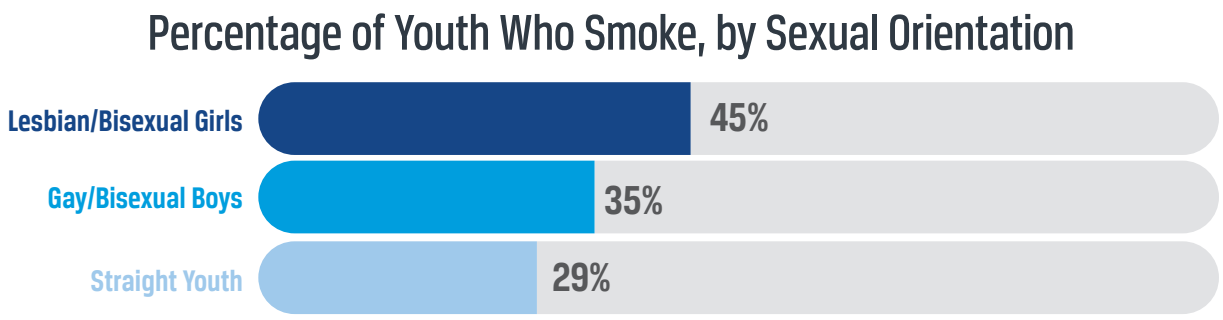
Despite decreasing HIV incidence rates in the general U.S. population, rates among men who have sex with men (MSM) and transgender women have continued to rise. In 2010, there was an estimated 12-percent increase in new infections among men who have sex with men, who accounted for more than three-quarters of new infections among men and nearly two-thirds of all new infections. There is an especially high prevalence among youth between 13-24 years of age, Black men, and Latino men.[1] Young Black gay and bisexual men showed the greatest increase of new cases from 2008-2011.[2] Among transgender women, the incidence is more difficult to estimate because gender identity is not tracked by most data collection sources. Still, we know that transgender people, and African American trans women in particular, face severe risks of HIV. Based upon a 2008 meta-analysis of 29 studies focusing on trans health, 28 percent of trans women tested positive for HIV. When adjusted for population size, trans women are nearly twice as likely as gay and bisexual men to contract HIV.[3] Gay men and trans people not only face these higher rates of infection, but are also more likely to face obstacles to diagnosis and treatment.

Cancer

Due to higher rates of obesity, smoking, alcohol consumption, and delayed engagement in preventative healthcare, LGBTQ people are at increased risk for developing various types of cancer. LGBTQ people are at higher risk for both colon cancer and lung cancer. Lesbians and bisexual women are at increased risk for breast cancer and gynecological cancers. Gay and bisexual men face increased risk for both prostate cancer and anal cancer. One major contributor to increased risk for gynecological cancers, anal cancer, and, in some cases, oral cancers is HPV. Many members of the LGBTQ community perceive low risk regarding HPV and are less inclined to have Pap smears or anal Pap tests, which is critical to detecting potential symptoms of HPV, gynecological cancers, and anal cancer.[4] It is hard to assess the specific numbers of cancer-related cases in the LGBTQ community, given that no large national data has been collected on sexual orientation or gender identity among the major cancer-related entities; improved data collection on sexual orientation and gender identity around cancer would enable development of more targeted strategies for prevention and early treatment of cancers in LGBTQ communities.

Substance Abuse

Disparities around HIV, cancer and other health conditions can be attributed in part to behavioral risk factors such as substance use and addiction, particularly tobacco and alcohol use. LGBTQ people are 2-3 times more likely to be addicted to tobacco compared to general population. It is estimated that over 30,000 LGBTQ people die annually because of tobacco-related causes. A recent adolescent health survey found that same-sex attracted individuals were more likely to smoke (45 percent of girls and 35 percent of boys) compared to other youth (29 percent).[5] Additionally, it is estimated that approximately 30 percent of gays and lesbians have substance abuse problems related to alcohol. LGBTQ youth are almost 200 percent more likely to use substances compared to heterosexual youth.[6] This contributes to various types of cancer, cardiovascular health concerns, and sexual health risks resulting from behavioral choices made while under the influence.



Mental Health

In part, higher rates of substance abuse among LGBTQ people are tied to coping strategies in the face of discrimination and stigma, as well as historical socialization processes and community-building opportunities that most often occurred in bars and clubs. LGBTQ individuals are more likely to report feelings of depression and anxiety. In fact, it is estimated that close to 720,000 LGBTQ community members suffer from serious mental illness.[7] LGBTQ people have higher rates of suicide and attempts, especially among transgender people—41 percent of whom report attempting suicide at some point in their lives, compared to 1.6 percent of the general population.[8] These mental health challenges are even more prevalent among youth and elders.

SOCIAL DETERMINANTS OF HEALTH

Social determinants are environmental factors—whether place-based or sociocultural—that contribute to health outcomes. Many of the health disparities faced by LGBTQ communities are due to inequities related to social determinants. The LGBTQ community has been subjected to a long history of legal inequality, social marginalization, and other forms of discrimination based on sexual orientation or gender identity. These systems of discrimination have resulted in inequities around housing access, employment and socioeconomic status, and other stresses, which in turn contribute to poor health.

Homelessness

It is estimated that LGBTQ youth make up to 40 percent of the homeless youth population.[9] Within this population of LGBTQ homeless youth, nearly two-thirds are people of color.[10] Many more LGBTQ youth are also in the fostercare and the juvenile justice system. The high rate of homelessness among LGBTQ youth is in part attributable to lack of family acceptance and fears of repercussions for coming out.

Family Rejection

Not only can family rejection directly lead to problems such as homelessness, it also has long-term health consequences. Researchers have found that LGBTQ people who are rejected by their families in adolescence are more likely to experience depression, low self-esteem, substance abuse, and other health problems in adulthood. LGBTQ people who feel rejected by their families in their youth are more than twice as likely to have suicidal ideations in their adulthood.[11]

Poverty and Unemployment

LGBTQ people are more likely to live in poverty compared to the general population. Thirty-two percent of LGBTQ individuals have household incomes of less than $24,000, compared to 24 percent of non-LGBTQ people with incomes of less than $24,000.[12] Transgender people, youth, women, and African Americans face particularly severe income disparities.[12] A large segment of the LGBTQ community is also underemployed or unemployed. Transgender individuals are the most impacted, as they are often discriminated against by employers or potential

employers and lack explicit legal protections in most jurisdictions. In fact, 44 percent of transgender individuals are underemployed, and they are twice as likely to be unemployed.[13] LGBTQ individuals also have higher living costs because they are often ineligible for various incentives and tax breaks afforded to heterosexual married couples. Additionally, gay families on average have the lowest annual incomes and often do not qualify for some federal assistance programs like WIC.[14]

Violence and Bullying

Based on reports from LGBTQ-focused anti-violence programs, more than 2,000 LGBTQ people were the victims of hate-motivated violence in 2013. Only 45 percent of these survivors of violence reported the incident to the police; of those who did report, nearly one-third reported hostility, being unjustly arrested, being subjected to excessive force, or other forms of police misconduct.[13] LGBTQ people also experience high levels of intimate-partner violence. Forty-four percent of lesbians and 61 percent of bisexual women have experienced intimate-partner violence, compared to 35 percent of heterosexual women.[14] LGBTQ youth are also more likely to face violence and other forms of bullying. Eighteen and a half percent of gay and lesbian high school students and 15.5 percent of bisexual students reporting threatened or injured with a weapon on school property, compared to 6.1 percent of heterosexual students.[15] These experiences of bullying, hate violence, and intimate partner violence are likely to contribute to depression and other mental health challenges, difficulties accessing care, and to other social determinants such as economic security.

Delayed Care

LGBTQ individuals are less likely to engage in preventive health and treatment services. Delayed engagement in health care is a leading cause for many of the poor health outcomes plaguing the LGBTQ community. LGBTQ individuals report feeling their healthcare providers are less culturally responsive and understanding of their needs. This causes some to avoid healthcare engagement or for those engaging in care to not disclose their sexual and/or gender identity for fear of discrimination.

HEALTH INSURANCE COVERAGE

Lack of health insurance is another major factor contributing to poor health outcomes for LGBTQ people. Nearly 18 percent of LGBTQ adults have no health insurance compared to about 13 percent of non-LGBTQ adults.[16] Legal inequality contributes to this gap; in states that do not recognize marriage equality or same-sex partnerships, LGB people are unable to attain health insurance through a same-sex spouse's employer. Advancements in marriage equality and the Affordable Care Act (ACA) have helped increase the number of LGBTQ people with health insurance. Among LGBTQ people living below 400 percent of federal poverty guidelines, the ACA has decreased the uninsured population from 34 percent to 26 percent.[17] Despite this progress, LGBTQ people face discrimination and unique barriers to accessing health insurance coverage in many jurisdictions. Transgender people face particularly severe barriers when it comes to insurance; more than one-third have no health insurance, even after the first year of the ACA's full implementation. Even among those who do have health insurance, they are often denied coverage by health plans that exclude necessary medical care for transgender people.[18]

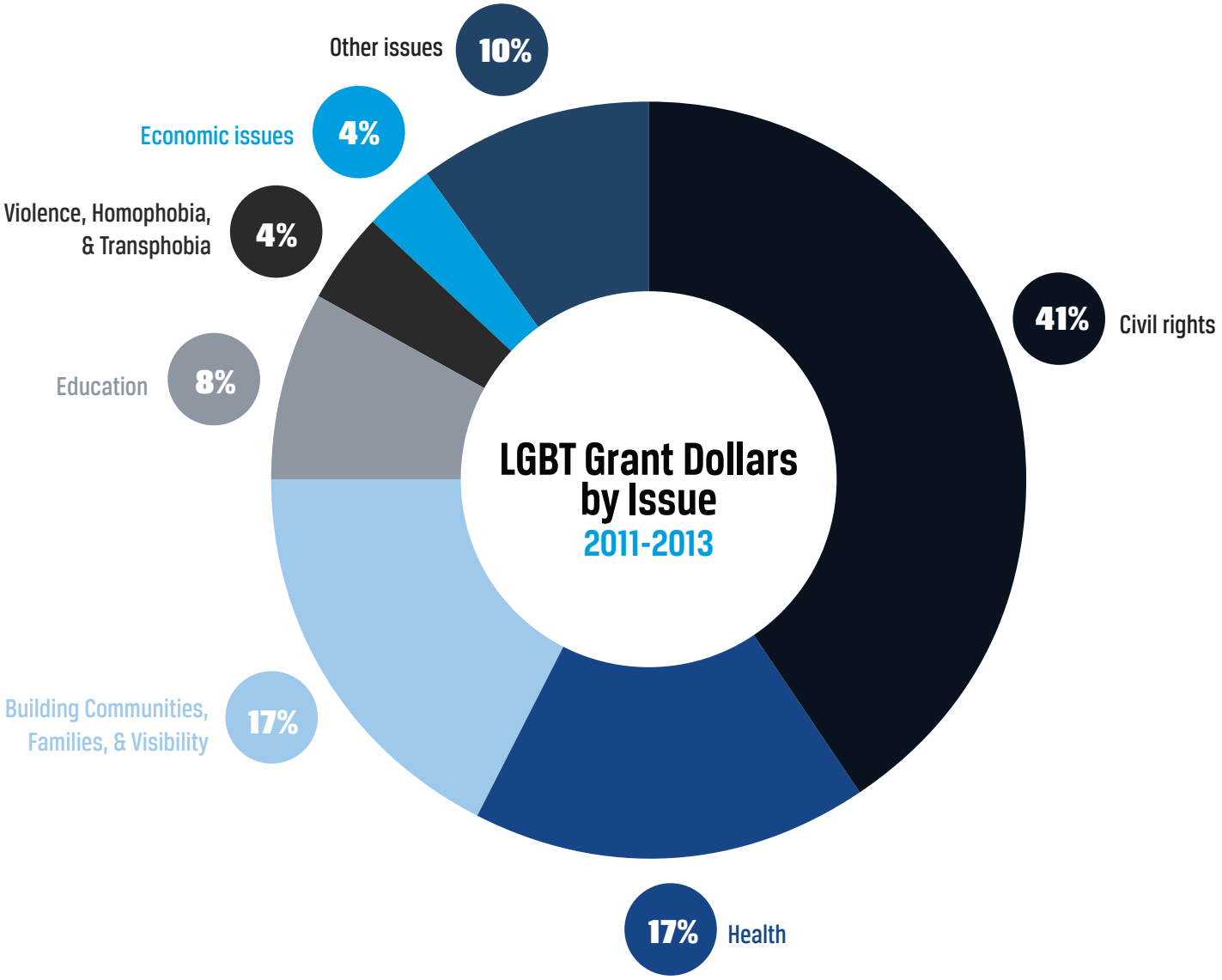
Percentage of Uninsured Adults, by Sexual Orientation and Gender Identity

Overview of LGBTQ Health Funding

U.S. FOUNDATION FUNDING FOR LGBTQ HEALTH ISSUES

In 2011-2013, foundations awarded 1,757 grants totaling $50.4 million for LGBTQ health in the U.S. Nearly half (46 percent) of these grant dollars were for HIV/AIDS, and the remaining 54 percent addressed health issues ranging from breast cancer to mental health and suicide prevention.

Health captured about 17 percent of the total $301 million in domestic LGBTQ funding for 2011-2013. This makes health the second most-funded LGBTQ issue—though it is a distant second, capturing a much smaller portion than the 41 percent for civil rights.



In the context of overall foundation funding for health, only a tiny fraction specifically targets LGBTQ communities. In 2011, foundations awarded $3 billion in grants for health in the U.S.[19] Domestic LGBTQ health funding that year was approximately $16 million, or about one half of one percent of the total. Even in the context of HIV/AIDS, only about 21 percent of HIV/AIDS funding targets gay, bisexual, and transgender communities, even though LGBTQ people account for the majority of new infections in the U.S.[20]

Who is funding LGBTQ health?

SOURCES OF LGBTQ HEALTH FUNDING

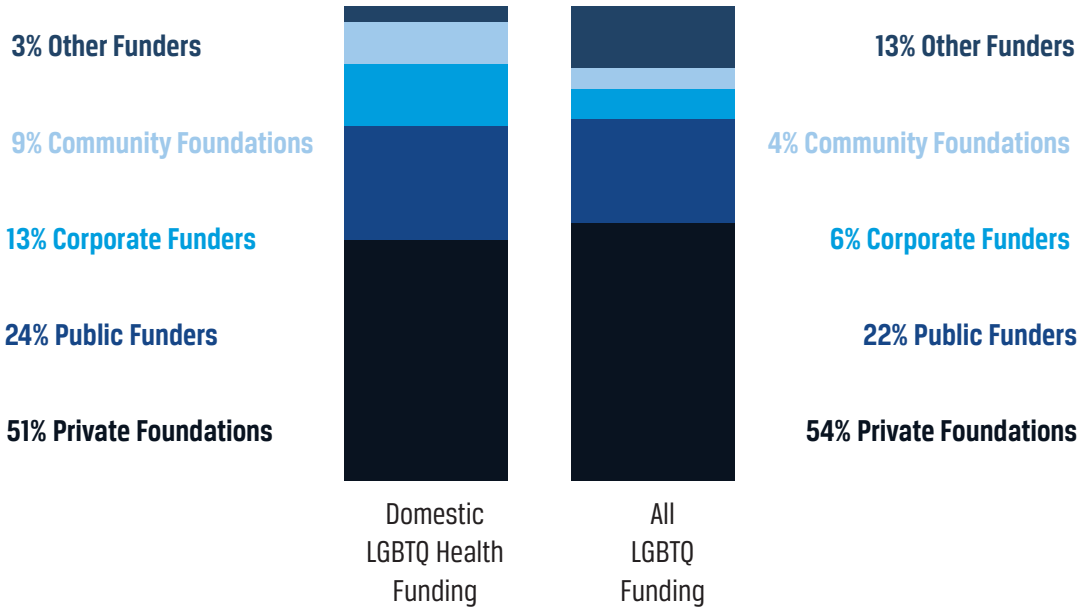
As with LGBTQ funding overall, the majority of domestic LGBTQ health funding (51 percent) is provided by private foundations. The second largest share of LGBTQ health funding (24 percent) comes from various public funders—including public LGBTQ foundations as well as public HIV/AIDS foundations, such as the Elton John AIDS Foundation.

Notably, a larger share of LGBTQ health funding comes from corporate funders, which provide 13 percent of domestic LGBTQ health funding but only 6 percent of LGBTQ funding overall. This trend is largely driven by several corporate funders that are among the top HIV/AIDS funders, such as Levi-Strauss & Co., the M.A.C. AIDS Fund, and Wells Fargo.

Community foundations also provide a larger share of LGBTQ health funding (9 percent) than they do for LGBTQ funding overall (4 percent). This is largely because a number of community foundations have invested in health services for LGBTQ communities in their local area, both for HIV/AIDS and for health needs more broadly.

Sources of LGBTQ Health Funding by Type of Funder

2011-2013



	Domestic LGBTQ Health Funding	All LGBTQ Funding
Private Foundations	$25,730,262	$220,873,346
Public Funders	$12,276,686	$90,066,522
Corporate Funders	$6,545,284	$25,757,222
Community Foundations	$4,504,809	$17,308,575
Other Funders	$1,740,000	$53,422,810
Grand Total	**$50,797,041**	**$407,428,475**

*This chart includes funds intended for regranting.

The top 25 funders awarded a total of $35.6 million in grants for LGBTQ health, accounting for about 70 percent of all LGBTQ health funding in 2011-2013. This group of 25 funders is more diverse than the list of top LGBTQ funders overall, including not only LGBTQ-specific funders but also a number of HIV funders, broadly-focused health funders, community foundations, and corporate funders.

Top 25 LGBTQ Health Funders, 2011 - 2013		
1.	Elton John AIDS Foundation, New York, NY	$4,317,556
2.	Ford Foundation, New York, NY	$4,312,000
3.	Susan G. Komen Foundation, Dallas, TX	$4,000,007
4.	M.A.C. AIDS Fund, New York, NY	$2,942,789
5.	The California Endowment, Los Angeles, CA	$2,750,773
6.	AIDS United, Washington, DC	$1,757,100
7.	Anonymous, Various Locations	$1,741,000
8.	Harry and Jeanette Weinberg Foundation, Owing Mills, MD	$1,500,000
9.	Arcus Foundation, New York, NY	$1,272,780
10.	Keith Haring Foundation, New York, NY	$1,235,000
11.	Wells Fargo Foundation, Palm Springs, CA	$1,197,355
12.	New York Community Trust, New York, NY	$1,063,150
13.	Jewish Communal Fund, New York, NY	$1,035,690
14.	The Paul Rapoport Foundation, New York, NY	$899,500
15.	Houston Endowment, Houston, TX	$690,000
16.	GE Foundation, Fairfield, CT	$600,000
17.	Levi Strauss & Co. Foundation, San Francisco, CA	$596,000
18.	Henry van Ameringen Foundation, New York, NY	$595,000
19.	San Francisco Foundation, San Francisco, CA	$548,500
20.	Healthcare Foundation of New Jersey, Millburn, NJ	$457,000
21.	Horace W. Goldsmith Foundation, New York, NY	$450,000
22.	Greater Milwaukee Foundation, Milwaukee, WI	$438,243
23.	Black Tie Dinner, Dallas, TX	$435,810
24.	District of Columbia Bar Foundation, Washington, DC	$424,000
25.	Chicago Community Trust, Chicago, IL	$390,550

What is being funded in LGBTQ health?

SPECIFIC HEALTH ISSUES FUNDED

The $27.4 million in LGBTQ health funding (other than HIV/AIDS) for 2011-2013 addressed a range of health issues, with no other issue capturing more than 20 percent of total dollars.

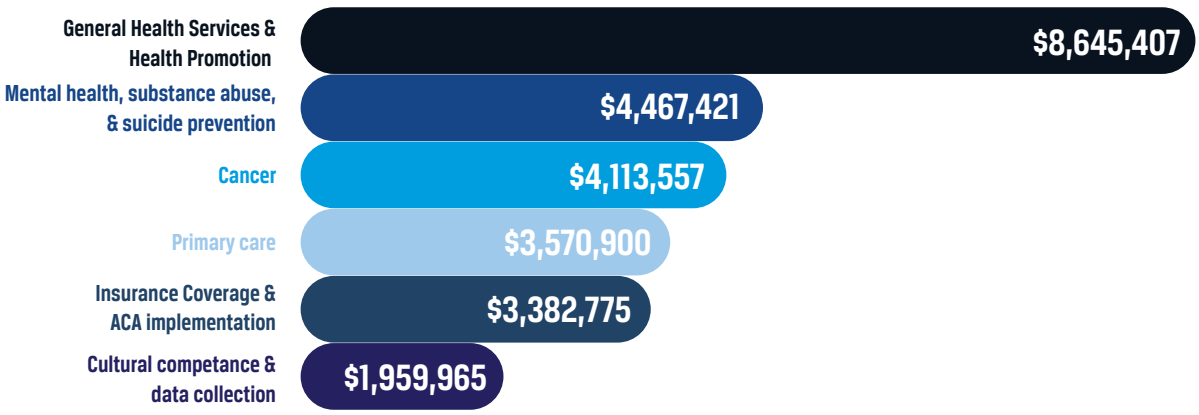
- The largest share of dollars ($8.6 million, or 17 percent of the total) went to **general health services and health promotion**, such as those offered by LGBTQ community centers, and for activities ranging from health fairs to community wellness campaigns to advance the health of LGBTQ communities.
- **Mental health, substance abuse, and suicide prevention** collectively received $4.5 million for activities ranging from suicide hotlines to addiction recovery programs.
- Services and research related to **breast cancer** and other cancers received about $4.1 million, the bulk of it from the Susan G. Komen Foundation.
- More than $3.3 million were devoted to activities related to **insurance coverage** and **implementation of the Affordable Care Act**, largely for outreach to enroll LGBTQ people in new insurance coverage options and for advocacy for LGBTQ-inclusive policies in the establishment of state health care exchanges.
- More than $3.5 million were devoted to **primary care**, largely for general support of LGBTQ health clinics and other primary care providers specifically targeting LGBTQ communities.
- **Cultural competence and data collection** received almost $2 million for data collection on LGBTQ health care needs and training of health care providers on effectively serving LGBTQ communities.
- Smaller amounts were devoted to sexual and reproductive health ($682,981), child welfare/foster care ($465,073), smoking cessation ($191,271), and food and nutrition ($108,520).

The above breakdown, however, may underestimate the level of support for certain health issues. In particular, a significant portion of HIV/AIDS grant dollars by their nature also address other health issues affecting LGBTQ communities. For example, HIV/AIDS prevention activities often address issues of mental health, addiction, and sexual and reproductive health. Similarly, many primary care providers and health service providers also offer HIV/AIDS treatment.

The wide range of issues addressed are reflected in the list of top 25 LGBTQ health grantees for 2011-2013, which include organizations addressing issues such as HIV/AIDS, reproductive health, health care reform, primary care, aging, suicide prevention, and breast cancer.

LGBTQ Health Funding by Specific Health Issue Funded

excluding HIV/AIDS, 2011-2013



Top 25 LGBTQ Health Grantees, 2011 - 2013		
1.	GMHC, New York, NY	$2,895,364
2.	SAGE, New York, NY	$2,225,000
3.	Kaiser Family Foundation, Menlo Park, CA	$1,250,000
4.	Callen-Lorde Community Health Center, New York, NY	$1,218,899
5.	AIDS Project Los Angeles, Los Angeles, CA	$1,078,287
6.	Planned Parenthood of New York City, New York, NY	$1,030,000
7.	Trevor Project, Palm Springs, CA	$1,011,976
8.	How to Survive a Plague, New York, NY	$950,000
9.	Hetrick-Martin Institute, New York, NY	$902,500
10.	Howard Brown Health Center, Chicago, IL	$896,321
11.	San Francisco AIDS Foundation, San Francisco, CA	$893,020
12.	Community Catalyst, Boston, MA	$875,000
13.	Legacy Community Health Services, Houston, TX	$810,000
14.	Fenway Community Health Center, Boston, MA	$796,976
15.	AIDS Foundation of Chicago, Chicago, IL	$694,760
16.	Mautner Project, Washington, DC	$555,163
17.	Transgender Law Center, San Francisco, CA	$543,000
18.	National Foundation for the Centers for Disease Control and Prevention, Atlanta, GA	$520,280
19.	Regents of the University of Michigan, Ann Arbor, MI	$513,000
20.	Asian & Pacific Islander Coalition on HIV-AIDS, New York, NY	$512,000
21.	Equality California Institute, West Hollywood, CA	$500,000
22.	Mazzoni Center, Philadelphia, PA	$483,538
23.	Lyon-Martin Health Services, San Francisco, CA	$466,784
24.	Lesbian, Gay, Bisexual & Transgender Community Center, New York, NY	$440,658
25.	Illinois Caucus for Adolescent Health, Chicago, IL	$402,000

TARGET POPULATIONS

LGBTQ health funding is exceptionally likely to target specific populations: 77 percent of LGBTQ health grant dollars are directed toward a specific racial group, sexual or gender identity, age group, or other demographic. This reflects philanthropic responses to specific health disparities faced by particular identity groups.

For sexual orientation and gender identity, gay men and men who have sex with men were the target population of the largest share of dollars—$10.8 million. Ninety-six percent of these dollars were for HIV/AIDS treatment and prevention. The second largest share of LGBTQ health funding targeted lesbians and other queer-identified women: $4 million, 83 percent of which was for breast cancer. About $2.9 million targeted transgender people, 34 percent of which was to advance inclusive health insurance coverage and health care reform implementation. Only $82,500 targeted intersex communities. No known LGBTQ health grants explicitly targeted bisexuals, although some of the funding targeting gay men and men who have sex with men undoubtedly supported services for significant numbers of bisexual-identified men.

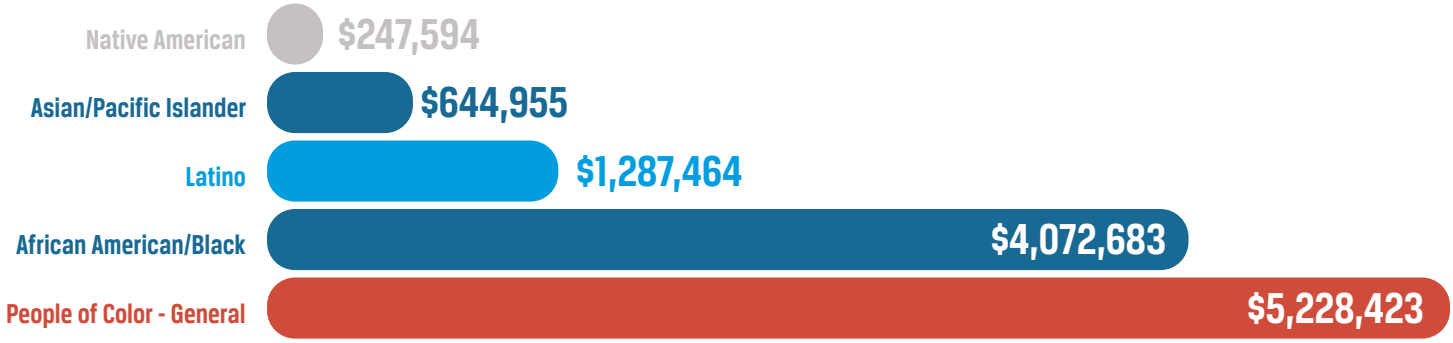
LGBTQ Health Grant Dollars Targeting Specific Sexual & Gender Identities

2011-2013

Nearly $11.4 million—or 22 percent of LGBTQ health funding—targeted LGBTQ communities of color. Approximately $4 million targeted African Americans, and another $5.2 million targeted communities of color broadly, with smaller amounts focused on Latinos, Asian American/Pacific Islanders, and Native Americans. HIV/AIDS funding accounts for the majority of LGBTQ health grant dollars targeting communities of color.

LGBTQ Health Grant Dollars Targeting People of Color

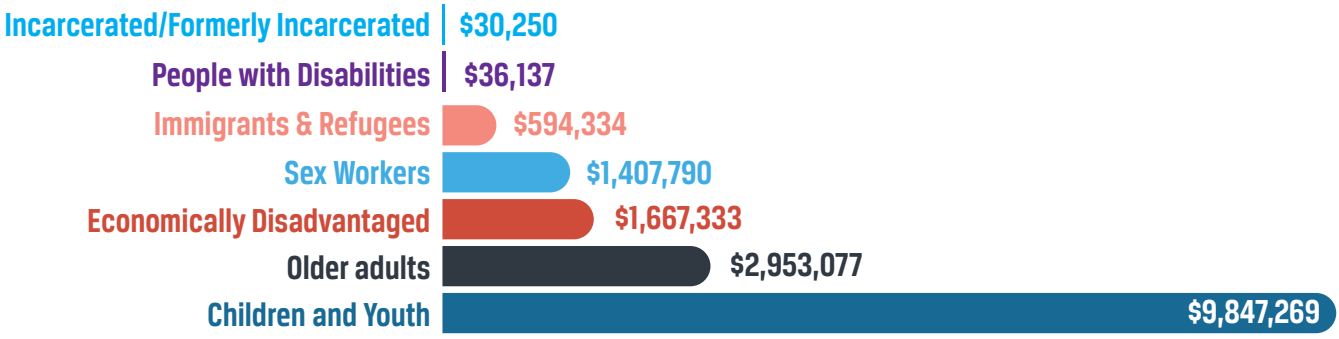
2011-2013



Significant LGBTQ health grant dollars targeted several other key population groups. In particular, $9.8 million targeted LGBTQ children and youth, and nearly $3 million targeted LGBTQ older adults. Nearly $1.7 million of LGBTQ health funding focused on the economically disadvantaged, and about $1.4 million specifically focused on sex workers.

LGBTQ Health Grant Dollars Targeting Other Populations

2011-2013

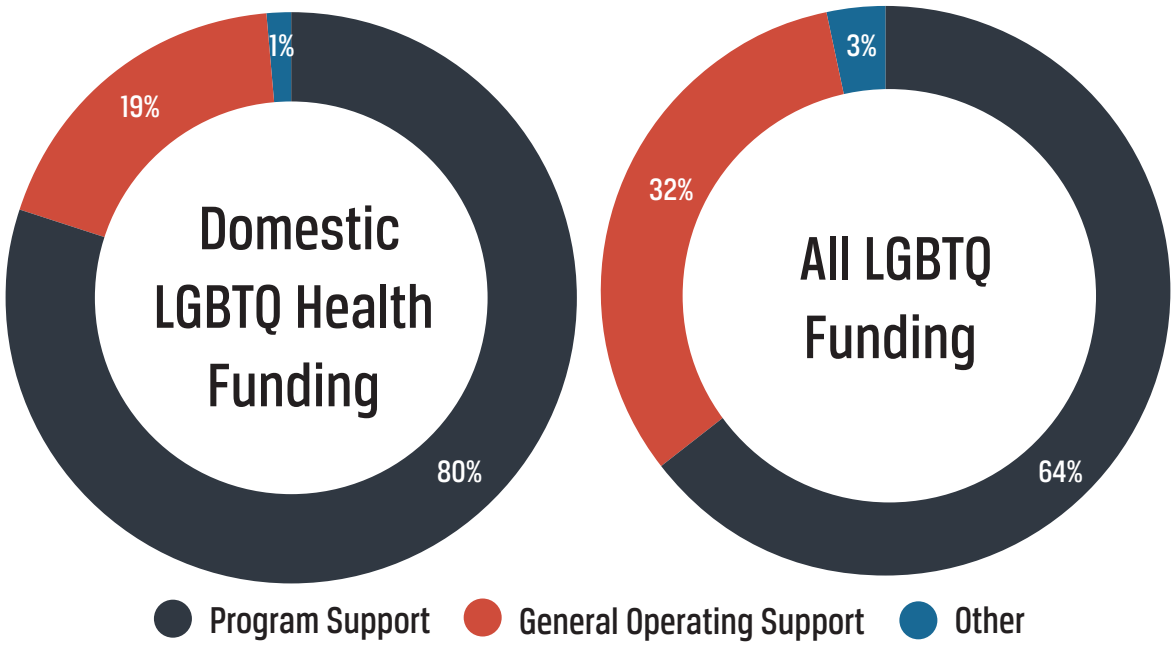


TYPE OF SUPPORT

About four-fifths of domestic LGBTQ health funding is for the support of a specific program, with the remaining fifth devoted to general operating support. LGBTQ health funding is more likely to be for programmatic support compared to overall LGBTQ funding, which sees 64 percent of grant dollars devoted to program support.

Distribution of Grant Dollars by Type of Support

2011-2013



	Domestic LGBTQ Health Funding		All LGBTQ Funding	
Program support	$40,440,003	80%	$240,907,485	64%
General operating support	$9,378,205	19%	$120,387,618	32%
Other	$670,796	1%	$12,241,889	3%
	$50,489,005	**100%**	**$373,536,992**	**100%**

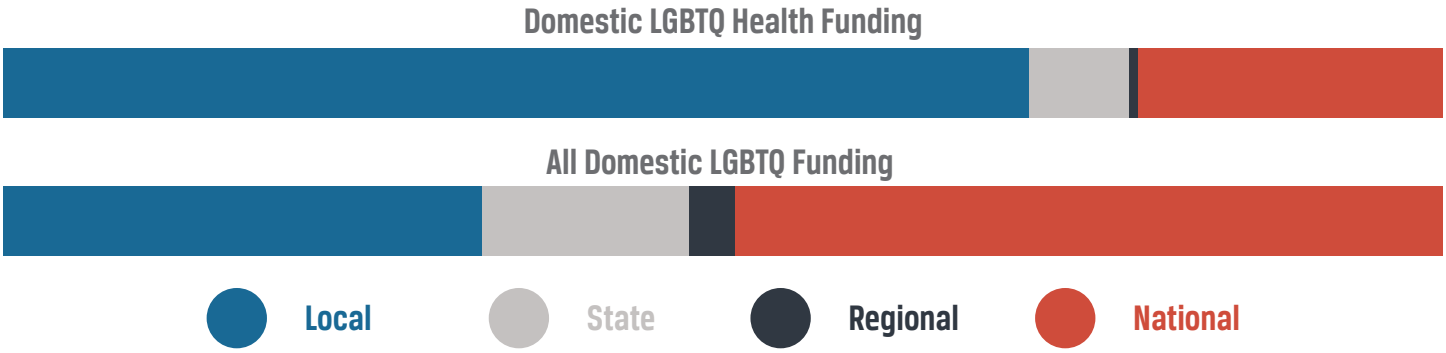
GEOGRAPHIC FOCUS

The vast majority of LGBTQ health funding—79 percent—is locally focused, and 21 percent is national in focus. The geographic focus of LGBTQ health funding is closely tied to the strategy funded; 80 percent of local dollars are devoted to direct services, and 41 percent of national dollars are devoted to advocacy.

In contrast, for all LGBTQ funding overall, a full half of dollars are devoted to national work, much of it for policy and advocacy.

Distrubution of Grant Dollars by Geographic Focus

2011-2013



	Domestic LGBTQ Health Funding 2011-2013		All Domestic LGBTQ Funding 2011-2013	
Local	$35,970,099	71%	$99,813,753	33%
State	$3,474,128	7%	$43,166,929	14%
Regional	$332,325	1%	$9,467,561	3%
National	$10,712,452	21%	$147,743,087	50%
	$50,489,005	**100%**	**$300,191,330**	**100%**

Of the approximately $40 million awarded to LGBTQ health at the local, state, and regional levels, the largest share ($17.5 million) was devoted to the Northeast region. The Midwest, the Mountain states, and the South received much lower dollar amounts, especially in proportion to their populations.

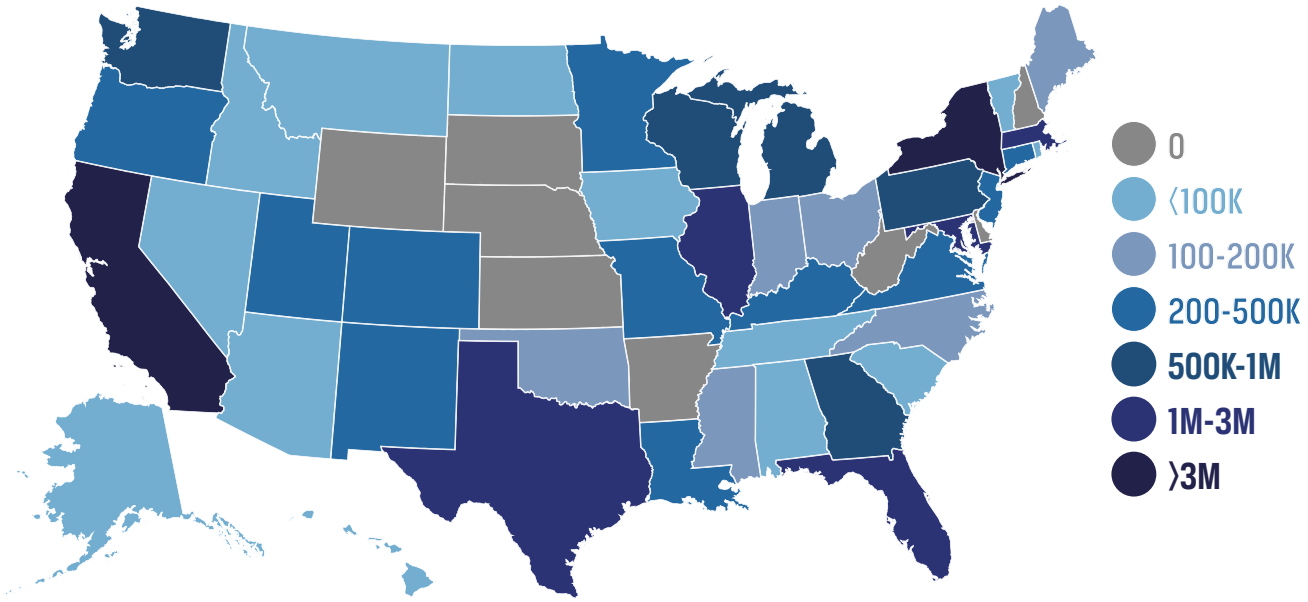
State and Local Funding for LGBTQ Health by Target Region 2011 - 2013	
Northeast	$17,530,257
Pacific	$8,940,507
South	$6,819,008
Midwest	$5,503,932
Mountain	$928,833
U.S. Territories	$40,000

Note: Does not include $14,015 awarded to anonymous individuals in undisclosed regions.

In most of these regions, much of the funding was concentrated in just one or two states. In the Northeast, the majority of funding ($11.1 million) was focused on New York. More than 88 percent of funding for the Pacific was for California—three-quarters of which was provided by funders based in California, such as The California Endowment and The California Wellness Foundation. Nearly half of Midwest funding went to Illinois, and nearly 60 percent of Southern funding focused on Florida or Texas. Each of these relatively well-funded states is home to major urban centers with large LGBTQ communities and a number of HIV/AIDS and LGBTQ-focused service providers. The disparities between states points to the challenges of addressing LGBTQ health issues outside of urban centers, and to the need for deeper engagement of more local funders in states beyond the coasts.

State and Local Funding for LGBTQ Health by Target State

2011-2013



Alabama	$34,000	Illinois	$2,600,698	Missouri	$262,352	Pennsylvania	$885,307
Alaska	$500	Indiana	$145,500	Montana	$28,100	Puerto Rico	$40,000
Arizona	$66,650	Iowa	$1,000	Nevada	$50,855	Rhode Island	$23,650
California	$7,904,237	Kentucky	$408,015	New Jersey	$399,122	South Carolina	$25,000
Colorado	$213,226	Louisiana	$306,000	New Mexico	$336,338	Tennessee	$46,000
Connecticut	$403,906	Maine	$138,780	New York	$11,121,399	Texas	$2,630,548
District of Columbia	$1,546,271	Maryland	$1,805,532	North Carolina	$146,850	Utah	$201,164
Florida	$1,401,500	Massachusetts	$1,131,790	North Dakota	$60,000	Vermont	$74,500
Georgia	$821,429	Michigan	$977,552	Ohio	$102,951	Virginia	$381,341
Hawaii	$6,073	Minnesota	$408,369	Oklahoma	$158,500	Washington	$624,392
Idaho	$32,500	Mississippi	$170,000	Oregon	$362,806	Wisconsin	$945,510

Note: Does not include $14,015 awarded to anonymous individuals in undisclosed regions.

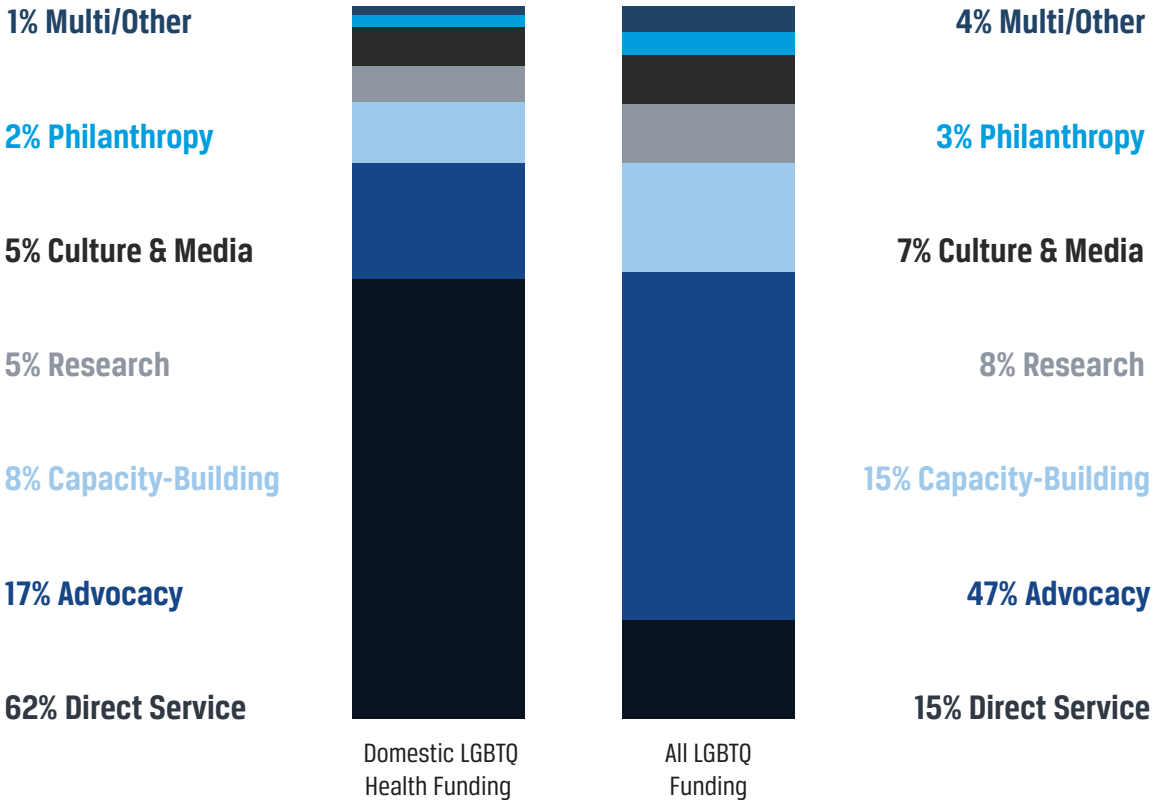
EXHIBIT D-27c

STRATEGY

Looking at LGBTQ health funding by the types of strategies funded, **direct services** garnered the majority (62 percent) of grant dollars. This was followed by **advocacy** (17 percent), **capacity building and training** (8 percent), **research** (5 percent) and **culture and media** (5 percent). In contrast, advocacy is the predominant strategy for LGBTQ funding overall, followed by capacity building, and then by direct services.

Distribution of Grant Dollars by Strategy

2011-2013



	Domestic LGBTQ Health Funding		All LGBTQ Funding	
Direct Service	$31,052,701	62%	$54,413,570	15%
Advocacy	$8,465,454	17%	$177,332,672	47%
Capacity Building	$4,108,713	8%	$55,790,537	15%
Culture & Media	$2,730,268	5%	$25,635,432	7%
Research	$2,453,134	5%	$31,474,497	8%
Philanthropy & Fundraising	$930,475	2%	$12,774,393	3%
Multiple/Other Strategies	$748,260	1%	$13,670,682	4%
	$50,489,005	**100%**	**$371,091,783**	**100%**

Funding Opportunities

RECOMMENDATIONS

This report is largely intended as a starting point for a longer assessment and series of conversations about potential high-impact funding strategies to improve the health and well-being of LGBTQ communities. However, the data herein do highlight several key gaps and opportunities for funders seeking to advance health and wellbeing in LGBTQ communities.

Explore Collaborative Efforts to Address Mental and Behavioral Health and Other Social Determinants Related to Stigma

LGBTQ communities face an especially severe disease burden in mental and behavioral health. These challenges are driven by the stigma and marginalization related to homophobia and transphobia, which are also key social determinants of HIV/AIDS and other health disparities. This is an area that relates to the priorities of a range of funders, including LGBTQ-focused funders, HIV/AIDS funders, and funders broadly concerned about health disparities and inequity.

Increase Access to Insurance Coverage for LGBTQ People

The Affordable Care Act is rapidly shifting the health policy landscape and increasing access to health insurance. Funders have an opportunity to assure that coverage outreach efforts reach LGBTQ populations, and that insurance providers do not discriminate against LGBTQ people—especially when it comes to medical care for transgender people.

Build Capacity of the HIV/AIDS and LGBTQ Health Services Sector

There is a rich array of community-based organizations providing health services specifically for the LGBTQ community, including HIV/AIDS service organizations, LGBTQ health centers, community centers, and counseling and referrals hotlines. These service providers have unparalleled cultural competence when it comes to serving LGBTQ communities. However, many lack the resources to meet the full range of needs of their communities or are heavily reliant on one or a handful of government contracts. Particularly given the current shifting health policy climate, funders have an opportunity to build the capacity of these agencies, to expand the scope of their work and to develop sustainable revenue strategies.

Increase LGBTQ Cultural Competence of Health Service Providers and Systems

Many LGBTQ people may never be able to take advantage of LGBTQ-focused service providers, particularly in rural and less densely populated areas. Funders have an opportunity to support training, curriculum development, and other efforts to increase the cultural competence of hospitals, health centers, and other mainstream health care providers, so as to maximize their ability to effectively serve LGBTQ communities. Key areas include increasing competence in providing transition-related care for transgender people and providing sexual health and HIV prevention services that are sensitive, relevant, and empowering for LGBTQ communities.

Strengthen HIV/AIDS and LGBTQ Health Policy and Advocacy Infrastructure

The LGBTQ movement has built a fairly robust set of organizations for policy advocacy at the national and state levels, but much of this infrastructure has focused on civil rights issues such as marriage equality and protections from discrimination. Much of the HIV/AIDS infrastructure in the U.S. has shifted to a services focus, with only a small number of organizations focused on advocacy for people living with HIV. Funders have an opportunity to support LGBTQ and HIV/AIDS organizations in building advocacy programs around the health policy issues that affect LGBTQ communities, including inclusive implementation of ACA exchanges, repeal of HIV criminalization laws, improving data collection on sexual orientation and gender identity, and providing government funding for health services for LGBTQ communities.

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METHODOLOGY

This report combines LGBTQ funding data captured for the *2013 Tracking Report: Lesbian, Gay, Bisexual, Transgender and Queer Grantmaking* by U.S. Foundations; the *2012 Tracking Report: Lesbian, Gay, Bisexual, Transgender and Queer Grantmaking* by U.S. Foundations; and *Lesbian, Gay, Bisexual, Transgender and Queer Grantmaking* by U.S. Foundations – Calendar Year '11. For these reports, requests for grant information were sent to nearly 700 grantmakers. All types of foundations were surveyed - private, public, community, and corporate - as well as nonprofit organizations with grantmaking programs. Information was obtained predominantly through self-reporting by grantmakers, as well as a review of 990s and annual reports.

This report specifically focuses on funding for LGBTQ health issues in the United States and captures grants made to support organizations as well as programs and projects.

The data does not include health grants to organizations or projects that are generally inclusive of LGBTQ populations unless they explicitly target LGBTQ communities or address an LGBTQ health issue. For example, a grant awarded to a local community center to support a breast cancer awareness campaign, open and welcoming to lesbians, would not have been included in the data. If that same center was funded to launch a breast cancer awareness campaign specifically targeting lesbians, then the grant would have been included.

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

ACKNOWLEDGEMENTS

Thank you to the Robert Wood Johnson Foundation, whose support made this report possible.

Many thanks to our LGBT Health Funding Summit Planning Committee, who guided the development of this report and provided helpful feedback on early drafts. We would also like to acknowledge member and long-time board member Andrew Lane, who also provided helpful feedback and guidance. Finally, many thanks to John Barnes and Sarah Hamilton of Funders Concerned About AIDS, who have been invaluable partners in the development of this report and in so much of our work on LGBTQ health issues.

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Funders for LGBTQ Issues works to mobilize the philanthropic resources that enhance the well-being of lesbian, gay, bisexual, transgender and queer communities, promote equity and advance racial, economic and gender justice.

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ISSUES

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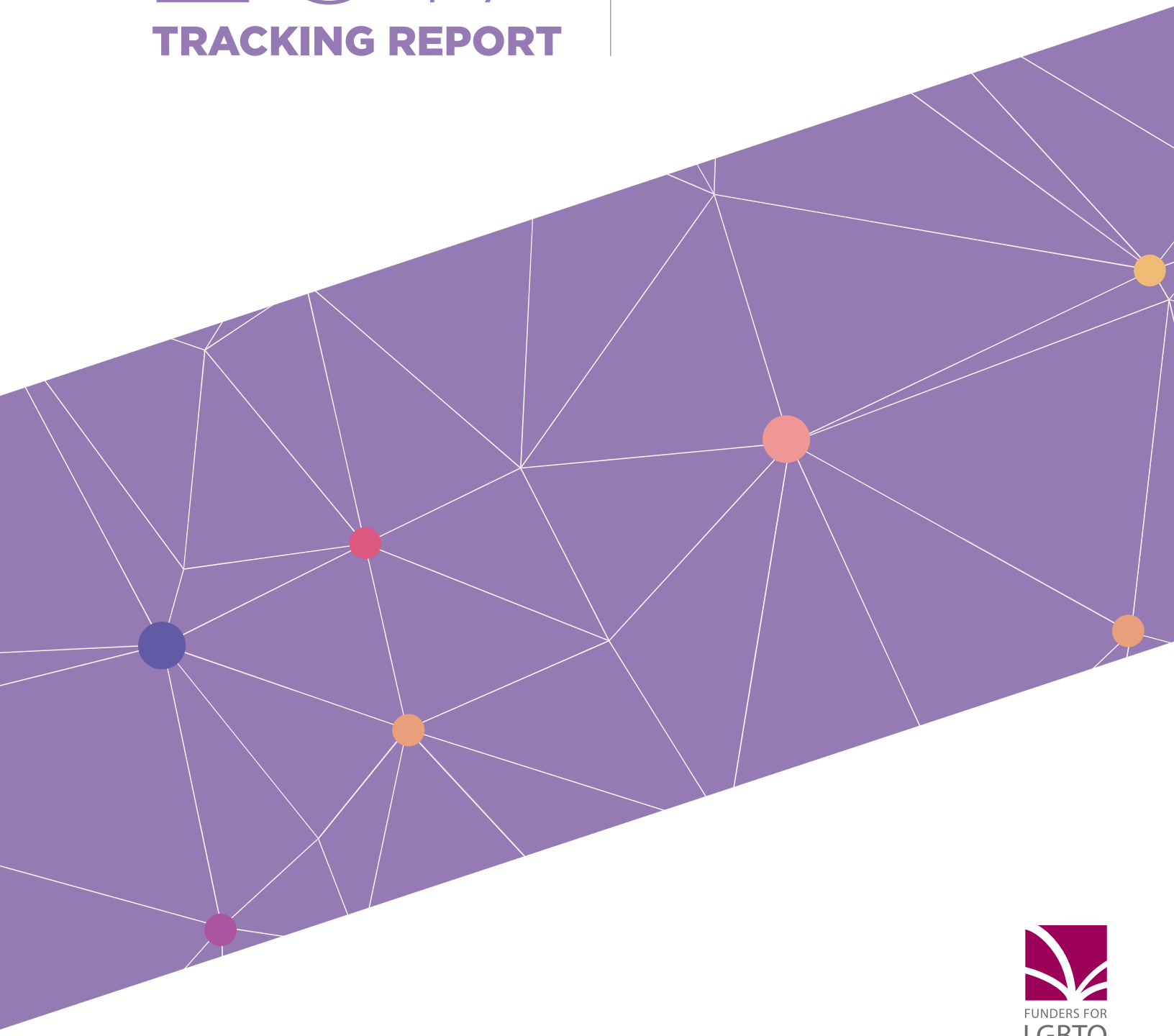
2017 TRACKING REPORT

LGBTQ Grantmaking by U.S. Foundations



FUNDERS FOR LGBTQ ISSUES

341 Foundations and Corporations Invested in LGBTQ Issues

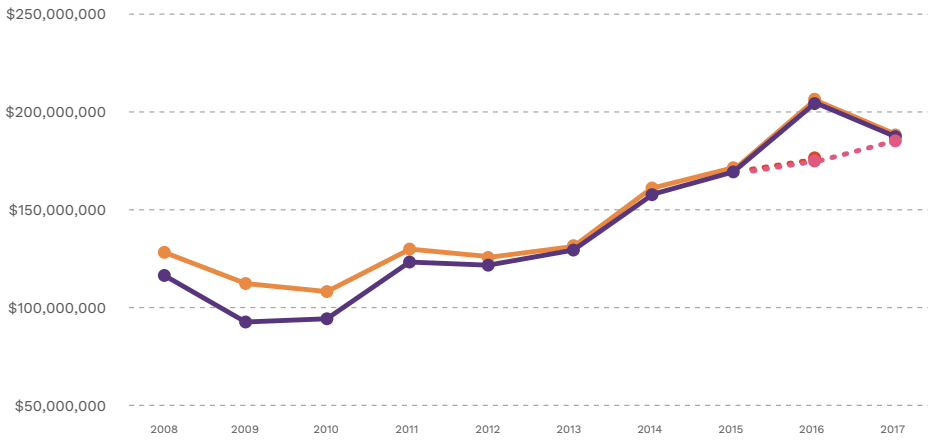
6,297 Grants

$185,841,930 Total Investment in LGBTQ issues

2,247 Grantees

Total Annual LGBTQ Grant Dollars, 2008-2017

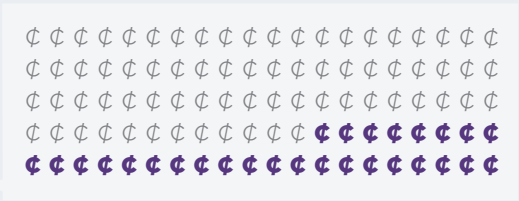
Foundation funding for LGBTQ issues totaled $185.8 million in 2017. While this represents a significant decrease of nearly $17 million, or 8 percent, from the $202.3 million in LGBTQ funding reported in 2016, this decline is almost entirely attributable to the philanthropic response to the Pulse Nightclub Massacre. **If we compare annual funding excluding OneOrlando Fund distributions, funding for LGBTQ increased by $10.8 million, or 6 percent.**



Nominal dollars (not adjusted)
2017 dollars (adjusted for inflation)
Total without OneOrlando grantmaking (not adjusted)
Total without OneOrlando grantmaking (adjusted for inflation)

2008	$116,181,019	$132,270,760
2009	$96,533,298	$110,294,457
2010	$96,829,756	$108,847,772
2011	$123,012,423	$134,048,809
2012	$121,412,490	$129,622,854
2013	$129,112,119	$135,853,237
2014	$153,248,693	$158,675,992
2015	$160,702,984	$166,197,005
2016	$202,312,772	$206,621,890
2016 (without One-Orlando grantmaking)	$172,802,772	$176,483,348
2017	$185,841,930	$185,841,930
2017 (without One-Orlando grantmaking)	$183,625,213	$183,625,213

*Inflation numbers are based on the Bureau of Labor Statistics Consumer Price Index.



For every $100 dollars awarded by U.S. foundations, **28 cents specifically supported LGBTQ issues.**

Top 10 Funders of LGBTQ Issues, by Total Dollar Amount

In 2017, **the top ten funders of LGBTQ issues awarded $86.2 million, accounting for 43 percent of all funding** for LGBTQ issues from U.S.-based foundations. Excluding funding awarded in response to the 2016 Pulse Nightclub Massacre, funding from the top ten funders increased by $1.2 million from 2016.

Arcus Foundation	Ford Foundation	Gilead Sciences	Gill Foundation	Open Society Foundations	Tides Foundation	Astraea Lesbian Foundation for Justice	Evelyn and Walter Haas, Jr. Fund	Elton John AIDS Foundation	M.A.C. AIDS Fund
$17.0M	$12.4M	$11.7M	$9.5M	$7.8M	$7.6M	$5.2M	$5.0M	$5.0M	$4.9M

Sources of LGBTQ Grant Dollars, by Funder Type*

While foundation giving to LGBTQ issues (not including OneOrlando Fund) increased in 2017, this growth was not uniform across foundation types. Community foundations and corporate funders had the biggest increases in 2017.

- **8%** Anonymous Funders — $15,570,000
- **6%** Community Foundations — $12,351,847
- **14%** Corporate Funders — $27,099,318
- **22%** LGBTQ Private Foundations — $42,478,374
- **26%** Non-LGBTQ Private Foundations — $50,985,257
- **10%** LGBTQ Public Foundations — $20,254,837
- **14%** Non-LGBTQ Public Foundations — $28,083,033

Distribution of LGBTQ Grant Dollars, by Geographic Focus*

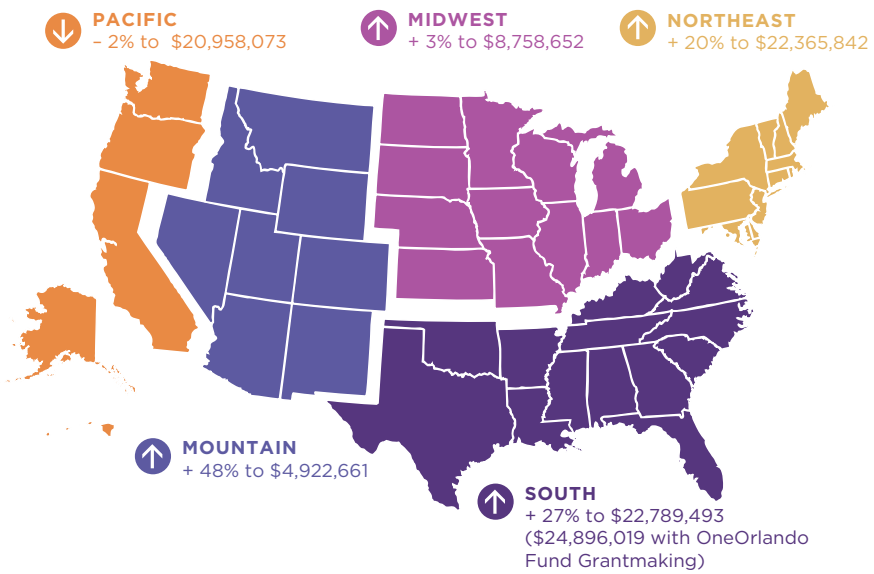
In 2017, approximately 73 percent of funding focused on LGBTQ communities in the United States, while approximately 26 percent focused on LGBTQ issues globally or outside the United States, excluding funding from OneOrlando.

- International (Global Focus) **$14,585,136**
- Outside the U.S. **$33,966,833**
- U.S. - National **$53,106,270**
- U.S. - Regional (Multi-State) **$9,245,146**
- U.S. - Statewide **$18,010,044**
- U.S. - Local **$54,726,476**

These sections exclude funding distributed by the OneOrlando Fund in 2017.

Local, State, and Regional Funding of LGBTQ Issues, by Regional Percentage Change

While the South received the largest share of grant dollars for the first time since we began tracking funding by region, with an increase of 27 percent, the region still receives less funding per LGBTQ adult than the Northeast and Pacific regions.



Notable Changes in 2017

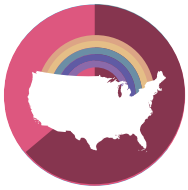
Funding for Trans Communities

2017 $22,564,755
2016 $16,976,892

+33%

Funding for trans communities in the United States continued to increase, reaching a record high of $22,564,755 in 2017 — a 33 percent increase from 2016.

Funding for LGBTQ Organizations



64%

The percentage of funding for domestic LGBTQ organizations decreased relative to funding to non-LGBTQ organizations, accounting for less than two-thirds of domestic funding.

INTRODUCTION

I am pleased to share with you the *2017 Tracking Report: Lesbian, Gay, Bisexual, Transgender, and Queer Grantmaking by U.S. Foundations*. This report captures foundation funding at a complicated moment, a year after we reported on the unprecedented philanthropic response to the Pulse Nightclub Massacre that propelled philanthropic support for LGBTQ issues to the highest level ever recorded, surpassing the $200-million mark for the first time.

In 2017, 341 foundations awarded 6,297 grants totaling $185.8 million in support of organizations and programs addressing lesbian, gay, bisexual, transgender, and queer issues. As expected, the more than $30 million in funds distributed in direct response to Pulse was highly focused in both scope and timing. In 2016, the OneOrlando Fund awarded about $30 million in direct support for approximately 300 survivors and families of victims of the massacre, and in 2017 the OneOrlando Fund gave out its remaining and final disbursements of $2.1 million. **Despite the overall decrease, excluding OneOrlando Fund grantmaking in 2016 and 2017, funding for LGBTQ issues by U.S. foundations actually increased by $10.8 million.** Given the extraordinary nature of the giving of the OneOrlando Fund, and for consistency with the 2016 report, this year's report again presents data both including and excluding OneOrlando Fund funding, particularly in those cases where OneOrlando makes up a disproportionately large amount of a particular sub-category of funding.

Given the changing funding landscape and that several key funders have scaled back support of LGBTQ issues, it is remarkable that funding increased by six percent in 2017. It is also encouraging that funding for LGBTQ issues in the South and for transgender communities reached record-breaking highs in 2017.

As always, the picture painted by the *2017 Tracking Report* is a mixed one. For the second year in a row, the percentage of funding for domestic LGBTQ organizations decreased relative to funding to non-LGBTQ organizations, accounting for less than two-thirds of domestic funding for the first time since we began tracking funding by organization type.

This year's report also sees significant shifts in both leading funders and leading grantees. Gilead Sciences climbed to the number three funder spot, awarding more than $11 million for LGBTQ communities. Funders such as Tides and The California Endowment also saw sharp increases. On the grantee side, the top three recipients were the New York LGBT Center, the Human Rights Campaign Foundation, and African Men for Sexual Health and Rights — none of which were among the top 15 recipients in 2016. As committed and new LGBTQ funders work to respond to a challenging and complex climate both in the U.S. and abroad, diligent tracking of trends and gaps in LGBTQ funding is more important than ever.

As a caveat, remember that this report only includes funding from foundations and corporations — not from individual donors or government agencies — and as such only captures a portion of all giving to LGBTQ issues. Note that the global section of this year's report once again only provides a brief summary, since we provide more detailed information on funding for LGBTQ issues internationally and outside the U.S. in our Global Resources Report, our biennial report series produced in collaboration with the Global Philanthropy Project.

It is my hope that this report continues to prove useful to funders, nonprofit leaders, and other stakeholders in identifying trends, gaps, and opportunities for LGBTQ grantmaking. As with all of our research, our goal is to provide accurate and user-friendly data on LGBTQ funding, so as to advance our mission of increasing the scale and impact of LGBTQ philanthropy.

Take Care,

Ben Francisco Maulbeck
President, Funders for LGBTQ Issues

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OVERVIEW

In 2017, United States-based foundations and corporations awarded 6,297 grants totaling $185.8 million in support for organizations and programs addressing lesbian, gay, bisexual, transgender, and queer issues. While this represents a significant decrease of nearly $17 million, or 8 percent from the $202.3 million in LGBTQ funding reported in 2016, this decline is almost entirely attributable to the philanthropic response to the Pulse Nightclub Massacre. In the aftermath of the most deadly and violent attack on our community in history, nearly $30 million dollars in direct support was distributed to survivors and the families of the victims through the OneOrlando Fund. As anticipated, this funding was highly focused in both scope and timing. In 2017, the OneOrlando Fund awarded a small fraction of what it awarded in 2016, with a second and final round of distributions to the survivors and families of the victims totalling $2.1 million. **If we compare annual funding excluding OneOrlando Fund distributions, funding for LGBTQ increased by $10.5 million, or 6 percent.** This rate of growth is similar to the growth we have reported in previous years.

In the *2016 Tracking Report*, we often reported two funding totals — one inclusive of OneOrlando Fund grantmaking and one excluding OneOrlando Fund grantmaking. For this Tracking Report, we have gone back to a single funding total, noting where necessary how OneOrlando Fund grantmaking significantly impacted a specific category (e.g., in local and statewide funding totals for the state of Florida).

The growth in funding that excludes OneOrlando Fund grantmaking was driven by several major funders significantly increasing their LGBTQ grantmaking. In particular, Gilead Sciences increased its LGBTQ funding by more than 50 percent — awarding a total of $11.7 million and rising to become the number three funder of LGBTQ issues. Several other corporate funders — ViiV Healthcare, Wells Fargo, and Google — all increased their LGBTQ funding by $1 million or more, buoying an overall increase in corporate funding.

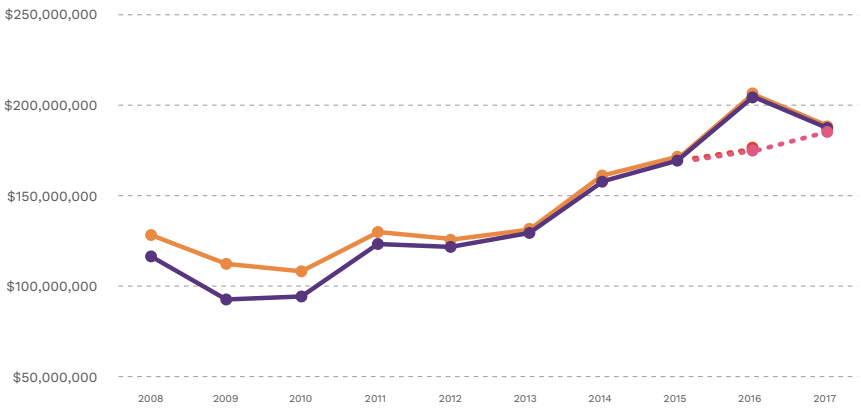
Several leading funders of LGBTQ issues also saw large increases in their LGBTQ funding. In particular, Foundation for a Just Society nearly doubled its LGBTQ grantmaking to $4.6 million. The California Endowment increased its LGBTQ funding by 73 percent, to nearly $3.8 million. Alphawood more than tripled its LGBTQ funding, exceeding $1.6 million and joining the top 20 funders of LGBTQ issues.

LGBTQ funding from mainstream community foundations grew by $5.5 million, an 80 percent increase buoyed in particular by $2.7 million in giving from the California Community Foundation. Several public foundations and intermediaries also saw increases in their LGBTQ funding in 2017, particularly Tides, Astraea Lesbian Foundation for Justice, and Borealis Philanthropy.

On the other hand, eight major LGBTQ funders decreased their support by $500,000 or more — for a total decrease in resources of more than $22 million. Without these losses, the net increase in LGBTQ funding would have been much higher. For several years, the list of top LGBTQ funders was fairly consistent from year to year, but it is now in a period of significant flux, with some funders scaling back support while others increase funding — and with new funders joining the movement to strengthen LGBTQ communities.

Total Annual LGBTQ Grant Dollars, 2008-2017

Not counting funding related to the 2016 Pulse nightclub tragedy, foundation funding for LGBTQ issues totaled $183.7 million in 2017, at a modest rate of growth of 6 percent.



**Inflation numbers are based on the Bureau of Labor Statistics Consumer Price Index.*

	Nominal dollars (not adjusted)	2017 dollars (adjusted for inflation)
		Total without OneOrlando grantmaking (not adjusted)
		Total without OneOrlando grantmaking (adjusted for inflation)
2008	$116,181,019	$132,270,760
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2010	$96,829,756	$108,847,772
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2017	$185,841,930	$185,841,930
2017 (without One-Orlando grantmaking)	$183,625,213	$183,625,213

TOP GRANTMAKERS

In 2017, the top ten funders of LGBTQ issues awarded nearly $86.2 million, accounting for 43 percent of all funding for LGBTQ issues from U.S.-based foundations. While this does represent a decrease of $48.3 million from 2016, if we exclude the nearly $40 million[1] in funding directly attributed to the 2016 Pulse Nightclub massacre reported in 2016 — funding from the top ten funders increased slightly, by $1.2 million from 2016.

The top twenty funders awarded $117 million, accounting for 59 percent of the year's total. Seven of the top twenty foundations were LGBTQ-specific funders, down from nine in 2016. In 2017, the top twenty list was comprised of six public foundations, ten private foundations, and four corporate funders.

TOP 20 FUNDERS OF LGBTQ ISSUES, BY TOTAL DOLLAR AMOUNT[2,3]

1 **Arcus Foundation**
$17,006,755
New York, NY

2 **Ford Foundation**
$12,445,000
New York, NY

3 **Gilead Sciences**
$11,730,648
Foster City, CA

4 **Gill Foundation**
$9,520,007
Denver, CO

5 **Open Society Foundations**
$7,769,598
New York, NY

6 **Tides Foundation**
$7,596,762
San Francisco, CA

7 **Astraea Lesbian Foundation for Justice**
$5,168,495
New York, NY

8 **Evelyn and Walter Haas Jr. Fund**
$5,038,200
San Francisco, CA

9 **Elton John AIDS Foundation**
$4,966,500
New York, NY

10 **M.A.C. AIDS Fund**
$4,963,389
New York, NY

11 **Foundation for a Just Society**
$4,640,000
New York, NY

12 **H. van Ameringen Foundation**
$4,349,500
New York, NY

13 **The California Endowment**
$3,780,111
New York, NY

14 **Wells Fargo**
$3,339,971
San Francisco, CA

15 **Borealis Philanthropy**
$3,181,800
Minneapolis, MN

16 **ViiV Healthcare**
$2,982,325
Research Triangle Park, NC

17 **California Community Foundation**
$2,778,807
Los Angeles, CA

18 **Strengthen Orlando — OneOrlando Fund**
$2,106,526
Orlando, FL

19 **American Jewish World Service**
$1,984,369
New York, NY

20 **Alphawood Foundation**
$1,686,500
Chicago, IL

TOP 10 FUNDERS OF LGBTQ ISSUES, BY NUMBER OF GRANTS

1	**Pride Foundation** Seattle, WA	348
2	**Horizons Foundation** San Francisco, CA	324
2	**Strengthen Orlando - OneOrlando Fund** Orlando, FL	302
4	**Astraea Lesbian Foundation for Justice** New York, NY	246
5	**Our Fund** Wilton Manors, FL	241
6	**Tides Foundation** San Francisco, CA	180
7	**Borealis Philanthropy** New York, NY	172
8	**Wells Fargo** San Francisco, CA	161
8	**Trans Justice Funding Project** New York, NY	154
10	**Arcus Foundation** New York, NY	147

[1] This $40 million total includes $29,510,000 in funding awarded through the OneOrlando fund as well as $9,445,045 awarded through the Equality Florida Institute in direct response to the Pulse Nightclub tragedy in 2016.

[2] In contrast to other sections of this report, this list of top funders includes dollars awarded for re-granting, so as to capture the full amount of funding flowing from (or through) each funder.

[3] In 2017, anonymous funders awarded a total of $15,570,000. If the anonymous funders appeared in the top twenty list as a single funder, they would rank as the number two U.S.-based foundation funder of LGBTQ issues.

TOP GRANT RECIPIENTS

In 2017, the top 20 recipients of LGBTQ funding received a total of $40.4 million, accounting for 22 percent of all LGBTQ dollars granted in 2017.

Nineteen of the top 20 grantees in 2017 are nonprofit organizations focused specifically on LGBTQ issues. The Southern AIDS Coalition, an advocacy coalition committed fighting AIDS in the U.S. South, was funded for work related to HIV/AIDS in the LGBTQ community. Eighteen of the 20 grant receipts are headquartered in the United States, with seven in California, five in New York City, and three in Washington, DC. Two top grantees are based outside the United States - AMSHER in South Africa and ISDAO in Kenya.

TOP 20 GRANTEES OF FOUNDATION FUNDING FOR LGBTQ ISSUES (EXCLUDES GRANT DOLLARS INTENDED FOR RE-GRANTING)[4]

1. **New York LGBT Center**
   $3,465,902
   New York, NY
2. **Human Rights Campaign (HRC)**
   $3,140,026
   Washington, DC
3. **African Men for Sexual Health and Rights (AMSHER)**
   $3,000,000
   Johannesburg, South Africa
4. **Transgender Law Center**
   $2,868,351
   Oakland, CA
5. **Genders & Sexualities Alliance Network**
   $2,848,955
   Oakland, CA
6. **All Out**
   $2,630,000
   New York, NY
7. **Astraea Lesbian Foundation for Justice**
   $2,200,505
   New York, NY
8. **University of California Los Angeles (UCLA) - Williams Institute**
   $1,926,400
   Los Angeles, CA
9. **Southern AIDS Coalition**
   $1,816,219
   Atlanta, GA
10. **Funders for LGBTQ Issues**
    $1,775,500
    New York, NY
11. **National Center for Lesbian Rights (NCLR)**
    $1,721,788
    San Francisco, CA
12. **Equality California Institute**
    $1,639,850
    Los Angeles, CA
13. **Los Angeles LGBT Center**
    $1,601,192
    Los Angeles, CA
14. **Initiative Sankofa d'Afrique de l'Ouest (ISDAO)**
    $1,500,000
    Nairobi, Kenya
15. **Equality Federation Institute**
    $1,443,500
    Portland, OR
16. **Movement Advancement Project (MAP)**
    $1,430,750
    Denver, CO
17. **LGBTQ Victory Institute**
    $1,397,612
    Washington, DC
18. **New York City Anti-Violence Project (AVP)**
    $1,372,000
    New York, NY
19. **Lambda Legal Defense & Education Fund**
    $1,371,655
    New York, NY
20. **National LGBTQ Task Force**
    $1,320,510
    Washington, DC

[4] In 2017, multiple anonymous grantees received a total of $6,414,363. This total includes individuals who received direct financial support in the form of scholarships or other direct financial assistance. If these anonymous grantees were to appear as a single entity on the top twenty list they would rank as the number one grant recipient of LGBTQ Funding.

SPECIAL UPDATE

THE PHILANTHROPIC RESPONSE TO THE PULSE TRAGEDY

On June 12, 2016, a gunman attacked the Pulse Nightclub, a gay club in Orlando, Florida, taking 49 lives, wounding 68 others, and forever changing the lives of countless more. It was Latin night, and the majority of victims and survivors were LGBTQ and Latinx.

More than $30 million was raised in response to the tragedy, the largest fundraising effort in history for a cause related to LGBTQ communities. Last year's 2016 Tracking Report provided a detailed report on the various philanthropic and government initiatives deployed in the aftermath of the tragedy. That year, the **OneOrlando Fund** provided $29.5 million in direct financial support for approximately 300 hundred survivors and families of victims of the shooting. This direct assistance was tightly focused in both scope and time, but constituted a full 15 percent of the year's total LGBTQ funding. As such, at several places in last year's report, we showed funding data both including and excluding OneOrlando Fund funding, so as to offer figures that were inclusive of the full scope of the year's giving but also that showed trends and comparisons with giving from other years.

While the vast majority of dollars related to the Pulse tragedy were given out in 2016, the philanthropic response continued in 2017 and beyond. The OneOrlando Fund distributed an additional $2 million to survivors and families of victims. For consistency with last year's report, this year's report shows figures both including and excluding OneOrlando Fund distributions in those cases where they make up a disproportionate share of a specific subcategory of funding.

Several other philanthropic initiatives awarded funding in 2017, particularly those seeking to address the long-term effects of the shooting — and the long-standing inequities that the tragedy brought to light. **The Better Together Fund** of the **Central Florida Foundation** awarded $406,054 for mental health and other social services, and to foster increased awareness and understanding across differences. **The Contigo Fund**, housed at **OurFund Foundation**, provided $614,824 for efforts to heal, educate and empower communities most affected by the tragedy and build bridges connecting all of Central Florida's diverse community groups.

The continuing needs and ongoing philanthropic efforts in response to the Pulse massacre are a demonstration of the long-term nature of the challenges presented by disasters and mass tragedies. While the bulk of funding related to Pulse was raised and awarded in the first six months of the tragedy, the philanthropic work in Central Florida's LGBTQ and Latinx communities carries on — with fewer resources but also with potential not only for healing but for fostering lasting change.

SOURCES OF LGBTQ FUNDING

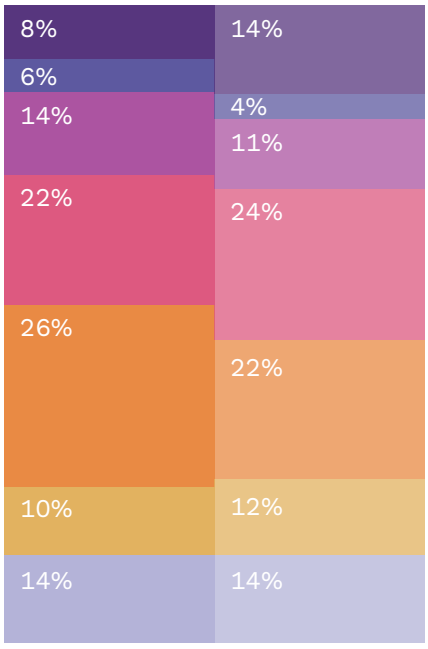
While foundation giving to LGBTQ issues (exclusive of OneOrlando Fund grantmaking) increased in 2017, this growth was not uniform across foundation types, and some foundation categories decreased their LGBTQ grant making in 2017.

Community Foundation giving saw the greatest increase, nearly doubling between 2016 and 2017 to account for 6 percent of all funding in 2017. This increase reflects the greater representation of community foundations in this report as well as significant growth in donor advised giving for LGBTQ issues reported at several institutions.

Corporate funding for LGBTQ issues also increased by $6.6 million, or 33 percent, to account for 14 percent of all giving in 2017. This rise was driven by substantial increases from Gilead Sciences and ViiV Healthcare for HIV/AIDS work in LGBTQ communities.

Anonymous foundations decreased funding by over 40 percent from a high of over $27 million in 2016 when anonymous foundations accounted for 11 percent of funding for LGBTQ Issues. Excluding funding from the OneOrlando Fund, the LGBTQ public foundations also decreased, falling by $4 million from 2016 to a three year low of $20.2 million, or 10 percent of funding for LGBTQ issues. This is due in large part to the end of the Weiland Bequest giving, which was administered by Pride Foundation. Giving from the Weiland Bequest typically accounted for $4-$5 million a year for the last eight years.

Sources of LGBTQ Grant Dollars by Funder Type[5]



	2017	2016
Anonymous Funders	$15,570,000	$27,013,706
	8%	14%
Community Foundations	$12,351,847	$6,853,988
	6%	4%
Corporate Funders	$27,099,318	$20,449,310
	14%	11%
LGBTQ Private Foundations	$42,478,374	$41,817,405
	22%	22%
Non-LGBTQ Private Foundations	$50,985,257	$46,582,150
	26%	24%
LGBTQ Public Foundations	$20,254,837	$24,146,411
	10%	12%
	$20,144,646 (including OneOrlando Fund)	$33,591,456 (including OneOrlando Fund)
Non-LGBTQ Public Foundations	$28,083,033	$27,410,044
	14%	14%
	$30,189,559 (including OneOrlando Fund)	$56,920,044 (including OneOrlando Fund)
Total	$196,822,666	$194,273,013
	$198,929,192 (including OneOrlando Fund)	$202,212,772 (including OneOrlando Fund)

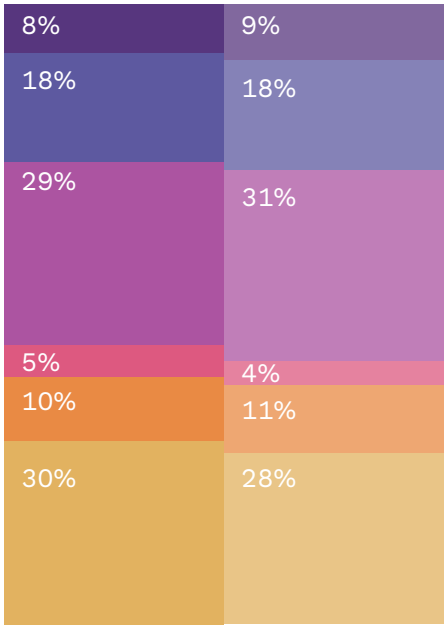
[5] In contrast to other sections of this report, this chart includes dollars awarded for re-granting, so as to capture the full amount of funding flowing from (or through) each type of funder.

GEOGRAPHIC FOCUS

In 2017, approximately 73 percent of funding focused on LGBTQ communities in the United States while approximately 26 percent focused on LGBTQ issues globally, or outside the United States.

Funding for LGBTQ communities in the United States totaled $134.8 million in 2017. The majority of the domestic funding focused on work at the local level — totaling $54.7 million, an increase of 14 percent from the $47.5 million reported in 2016, and accounting for 30 percent of all funding in 2017. Funding for work that was national in scope decreased by more than $500,000 but accounted for a similarly large share of domestic funding at 29 percent. Support for work at the state and regional level also remained relatively consistent in their share of funding, accounting for 10 and 5 percent of all funding, respectively.

Distribution of LGBTQ Grant Dollars by Geographic Focus



2017	2016
International (Global Focus)	
$14,585,136	**$14,696,231**
8%	9%
Outside the U.S.	
$33,966,833	**$30,816,851**
18%	18%
U.S. — National	
$53,106,270	**$53,884,827**
29%	31%
U.S. — Regional (Multi-State)	
$9,245,146	**$6,060,245**
5%	4%
U.S. — Statewide	
$18,010,044	**$19,808,569**
10%	11%
U.S. — Local	
$54,726,476	**$47,536,049**
30%	28%
$56,833,002 (including OneOrlando Fund)	**$77,046,049** (including OneOrlando Fund)
Total	**Total**
$183,350,213	**$172,802,772**
$185,841,930 (including OneOrlando Fund)	**$202,212,772** (including OneOrlando Fund)

TYPE OF SUPPORT

Consistent with established trends, funding for program or project specific support was the most common type of support in 2017, decreasing by 3 percent from 2016 but still accounting for 46 percent of all funding.

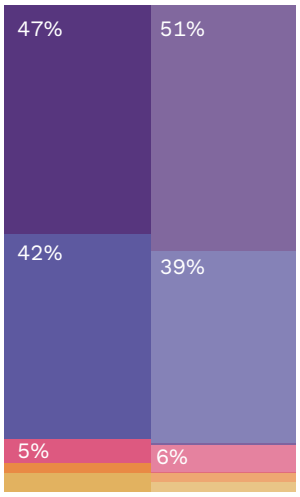
Funding for general operating support increased by 14 percent or nearly $10 million dollars to account for 42 percent of all funding, a record for this category.

Funding for direct victim support decreased substantially as distributions from the OneOrlando Fund to survivors and families of victims of the Pulse Nightclub tragedy were mostly disbursed in 2016.

Funding for capacity building remained level while scholarship and fellowship support declined slightly.

The 'other' category captures other types of funding, including: capital support, corporate matching gifts, emergency funding, endowment support, matching grants, prizes and awards, seed funding, sponsorships, as well as funds awarded to international intermediaries for the the purposes of regranting.

Distribution of LGBTQ Grant Dollars by Type of Support



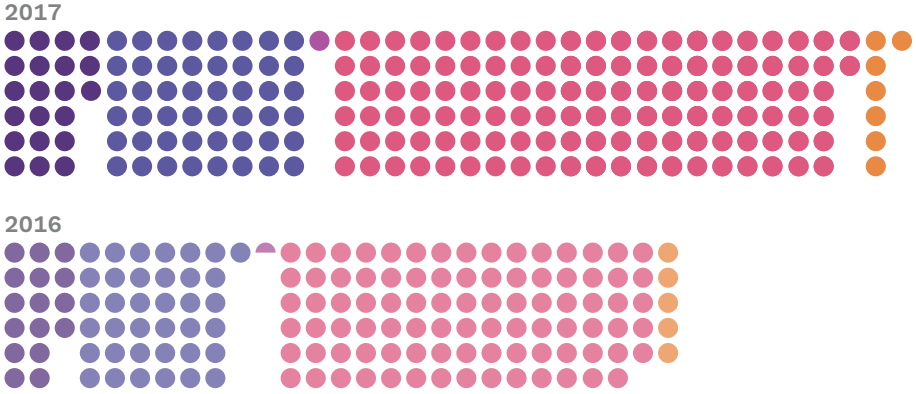
	2017	2016
Program/Project Support	$86,062,643	$88,073,569
	47%	51%
General Operating Support	$76,692,167	$67,003,518
	42%	39%
Direct Victim Support	$0	$0
	<1%	<1%
	$2,106,526 (including OneOrlando Fund)	$29,510,000 (including OneOrlando Fund)
Capacity-Building Support	$9,861,899	$9,628,993
	5%	6%
Scholarships and Fellowships	$3,598,538	$4,078,279
	2%	2%
Other	$7,520,158	$4,078,279
	4%	2%
Total	$183,735,404	$172,702,772
	$185,841,930 (including OneOrlando Fund)	$202,212,772 (including OneOrlando Fund)

POPULATION FOCUS

Consistent with previous reporting, the vast majority of LGBTQ grants in 2017, over $142.6 million or 73% of funding, targeted the LGBTQ community broadly. The data below looks at grants that specifically supported one segment of the LGBTQ community.

Trans funding increased by over 40 percent from a record high of $22.4 million in 2016 to over $32 million on 2017, to account for 17 percent of funding for LGBTQ issues. Funding for lesbians and queer women, bisexuals, and intersex people also saw modest increases in 2017.

Distribution of LGBTQ Grant Dollars by Sexual Orientation, Gender Identity, and Sex Characteristics



	2017	2016
Lesbians/Queer Women	$5,127,585	$4,029,117
	3%	2%
Gay Men/Queer Men/MSM	$11,937,066	$9,126,551
	6%	5%
Bisexual People	$210,776	$300
	<1%	<1%
Transgender People	$32,072,197	$22,434,839
	17%	11%
Intersex People	$1,737,605	$1,362,156
	1%	1%

● = $250,000

STRATEGIES FUNDED

Consistent with previous years, advocacy was again the most funded strategy in 2017, with 42 percent of LGBTQ funding supporting advocacy work.

In 2016, the victim support category was added to capture the nearly $30 million in funding to support the families of victims and survivors of the Pulse Nightclub Massacre in Orlando. In 2017, the OneOrlando Fund awarded an additional $2.1 million in direct victim support to families of victims and survivors.

Detailed Breakdown of Strategies Funded

Strategy	2017 Funding	%	2016 Funding	%
Advocacy	$78,471,664	42%	$77,999,796	39%
Advocacy (General)	$42,945,661	23%	$39,631,010	20%
Community Organizing	$16,094,242	9%	$12,447,844	6%
Intergovernmental Advocacy	$0	<1%	$5,000	<1%
Litigation	$9,189,784	5%	$11,476,421	6%
Public Education	$10,241,977	6%	$14,439,522	7%
Capacity-Building and Training	$22,259,175	12%	$23,429,941	11%
Conferences/Seminars/Travel Grants	$2,233,137	1%	$1,865,648	1%
Leadership Development	$6,054,590	3%	$8,451,762	4%
Organizational Capacity Building	$10,066,003	5%	$8,142,294	4%
Training/Technical Assistance	$3,905,445	2%	$4,970,237	2%
Culture and Media	$11,813,008	6%	$9,607,592	5%
Culture	$8,768,676	5%	$7,363,164	4%
Electronic Media/Online Services	$593,502	<1%	$749,640	<1%
Film/Video/Radio	$2,450,830	1%	$1,494,788	1%
Direct Service	$31,978,458	17%	$30,864,852	15%
Philanthropy and Fundraising	$20,590,368	11%	$14,119,724	7%
Fundraising Event	$1,198,854	1%	$1,166,645	1%
Matching Grant	$25,000	<1%	$10,250	<1%
Philanthropy	$19,366,515	10%	$12,942,830	6%
Research	$11,392,823	6%	$11,155,615	6%
Victim Support	$2,106,526	1%	$29,510,000	15%
Other	$7,430,320	4%	$5,625,252	3%
Multi-Strategy	$6,941,376	4%	$5,118,891	3%
Other	$488,944	<1%	$506,361	<1%
Total	**$185,841,930**		**$202,312,772**	

ISSUES ADDRESSED

Civil and human rights issues continued to receive the largest share of funding in 2017, accounting for nearly half of all LGBTQ funding. Funding for health and wellbeing increased to nearly 20 percent, driven largely by funding for HIV/AIDS.

Funding for issues related to violence, homophobia, and transphobia declined sharply, due to the sharp increase of funding reported in 2016 related to the Pulse Nightclub Massacre in Orlando.

Breakdown of Issues Addressed

Issue	2017 Funding	%	2016 Funding	%
Civil and Human Rights	$85,774,320	46%	$89,502,347	44%
Health and Wellbeing	$35,943,783	19%	$30,985,113	15%
Strengthening Communities, Families, and Visibility	$30,763,787	17%	$28,405,924	14%
Education and Safe Schools	$8,815,516	5%	$6,132,996	3%
Violence, Homophobia, and Transphobia	$6,673,023	4%	$31,900,337	16%
Economic Issues	$6,629,890	4%	$6,216,616	3%
Other Issues	$11,432,022	6%	$9,169,439	5%
Total	**$185,841,930**		**$202,312,772**	

DOMESTIC FUNDING OF LGBTQ ISSUES

In 2017, funding for LGBTQ issues in the United States totaled, $137 million - down slightly from last year's record high of $157.1 million that included nearly $30 million in direct victim support for those affected by the Pulse Nightclub Massacre. With dollars for re-granting included, total domestic funding was $146.5 million in 2017.

Local and statewide funding also dipped slightly for the same reason, totaling $83.9 million. Down from the record high of $102.9 million in 2016, but higher than the $73.4 million in 2016 without OneOrlando Fund grantmaking.

TOP 10 DOMESTIC FUNDERS[6]

1. **Gilead Sciences**
   $10,097,801
   Foster City, CA
2. **Arcus Foundation**
   $9,729,000
   New York, NY
3. **Gill Foundation**
   $9,520,007
   Denver, CO
4. **Evelyn & Walter Haas, Jr. Fund**
   $5,038,200
   San Francisco, CA
5. **Ford Foundation**
   $5,030,000
   New York, NY
6. **H. van Ameringen Foundation**
   $4,319,500
   New York, NY
7. **Elton John AIDS Foundation**
   $4,080,500
   New York, NY
8. **The California Endowment**
   $3,775,111
   Los Angeles, CA
9. **Tides Foundation**
   $3,508,122
   San Francisco, CA
10. **Wells Fargo**
    $3,214,971
    San Francisco, CA

TOP 10 DOMESTIC GRANTEES[7]

1. **New York LGBT Center**
   $3,465,902
   New York, NY
2. **Human Rights Campaign (HRC) Foundation**
   $3,080,026
   Washington, DC
3. **Transgender Law Center**
   $2,868,351
   Oakland, CA
4. **Genders & Sexualities Alliance Network**
   $2,848,955
   Oakland, CA
5. **Southern AIDS Coalition**
   $1,816,219
   Atlanta, GA
6. **Funders for LGBTQ Issues**
   $1,775,500
   New York, NY
7. **National Center for Lesbian Rights (NCLR)**
   $1,721,788
   San Francisco, CA
8. **Equality California Institute**
   $1,639,850
   Los Angeles, CA
9. **Los Angeles LGBT Center**
   $1,601,192
   Los Angeles, CA
10. **Equality Federation Institute**
    $1,443,500
    Portland, OR

[6] In 2017, anonymous funders awarded a total of $9,210,000 to support LGBTQ issues in the United States. If the anonymous funders appeared in the top ten list as a single funder, they would rank as the number four funder of LGBTQ issues domestically.

[7] In 2017, multiple anonymous grantees received a total of $4,901,944 for work benefiting LGBTQ communities in the United States. This includes the individuals who received victim support in the aftermath of the Pulse Nightclub Massacre in Orlando. If the multiple anonymous grantees appeared in the top twenty list as a single grantee, they would rank as the number one grant recipient of domestic LGBTQ funding.

TOP 10 FUNDERS OF LOCAL AND STATE-LEVEL WORK

1 **Gilead Sciences**
$5,646,283
Foster City, CA

2 **Gill Foundation**
$4,276,007
Denver, CO

3 **The California Endowment**
$3,772,111
Los Angeles, CA

4 **Arcus Foundation**
$3,433,000
New York, NY

5 **Elton John AIDS Foundation**
$3,198,000
New York, NY

6 **Tides Foundation**
$2,483,622
San Francisco, CA

7 **H. van Ameringen Foundation**
$2,380,000
New York, NY

8 **Borealis Philanthropy**
$2,357,250
Minneapolis, MN

9 **ViiV Healthcare**
$2,188,732
Research Triangle, NC

10 **Strengthen Orlando — OneOrlando Fund**
$2,106,526
Orlando, FL

TOP 10 LOCAL AND STATE-LEVEL GRANTEES[8]

1 **New York LGBT Center**
$3,465,902
New York, NY

2 **Southern AIDS Coalition**
$1,816,219
Atlanta, GA

3 **Equality California Institute**
$1,639,850
Los Angeles, CA

4 **Los Angeles LGBT Center**
$1,586,192
Los Angeles, CA

5 **Freedom for All Americans**
$1,190,000
Washington, DC

6 **Pride Foundation**
$1,119,638
Seattle, WA

7 **Desert AIDS Project**
$1,084,775
Palm Springs, CA

8 **Hetrick-Martin Institute (HMI)**
$1,017,672
New York, NY

9 **Genders & Sexualities Alliance Network**
$1,009,955
Oakland, CA

10 **Women With A Vision**
$979,559
New Orleans, LA

[8] In 2017, multiple anonymous grantees received a total of $3,598,271 for the benefit of local and state-wide LGBTQ communities. This includes the individuals who received victim support in the aftermath of the Pulse Nightclub Massacre in Orlando. If the multiple anonymous grantees appeared in the top ten list as a single grantee, they would rank as the number one grant recipient of local and state-level funding.

LOCAL, STATE, AND REGIONAL FUNDING OF LGBTQ ISSUES

Funding for local, statewide, and regional LGBTQ work in the United States totaled $84 million in 2017, down for the record high of $102.9 million in 2016. That record high was made possible by the OneOrlando Fund giving. Without OneOrlando Fund grantmaking, the total was $73.4 million 2016 and $81.9 million in 2017.

The South received the largest share of grant dollars for the first time since we began tracking funding by region. The South received $22.7 million in funding — $24.8 million if you include final disbursements from the OneOrlando Fund for the survivors and the families of the victims of the Pulse Nightclub Massacre — representing a 27 percent increase in funding.

The Northwest region received the second largest share of grant dollars with $22.4 million in funding, representing a 20 percent increase in funding. Meanwhile **the Pacific** region saw a 3 percent decrease in funding, with $21 million in 2017. **The Midwest** posted a modest three percent increase with $8.8 million in funding. Meanwhile, **the Mountain** region saw the biggest percentage increase, 48 percent, but received the smallest share of grant dollars at just $4.9 million.

In 2017, funding for **Puerto Rico** increased by 75 percent to $341,644. There was also $1.8 million awarded for local or regional work that cut across regions or was otherwise anonymous.

California and **New York** were once again the top funded states in 2017, at $16.4 million and $15.7 million respectively. This represents a slight dip for California and a record high for New York. With a $4.8 million increase in funding in 2017, New York experienced the most significant increase in local and statewide funding. If you exclude OneOrlando Fund grantmaking, California and New York were the only states to receive more than $5 million in funding. **Florida**, **Georgia**, **Illinois**, and **Texas** all received more than $2.5 million in funding.

In 2017, 28 states saw an increase in local and statewide funding while 22 states and the District of Columbia experienced a decrease. Eighteen states and the District of Columbia received more than $1 million in LGBTQ funding, up from 14 in 2016. No state that received more than $1 million in funding in 2016 dropped below that level. The states joining the "million dollar club" in 2017 included returning states **Colorado** and **Ohio** and first-timers **Arizona** and **New Mexico**.

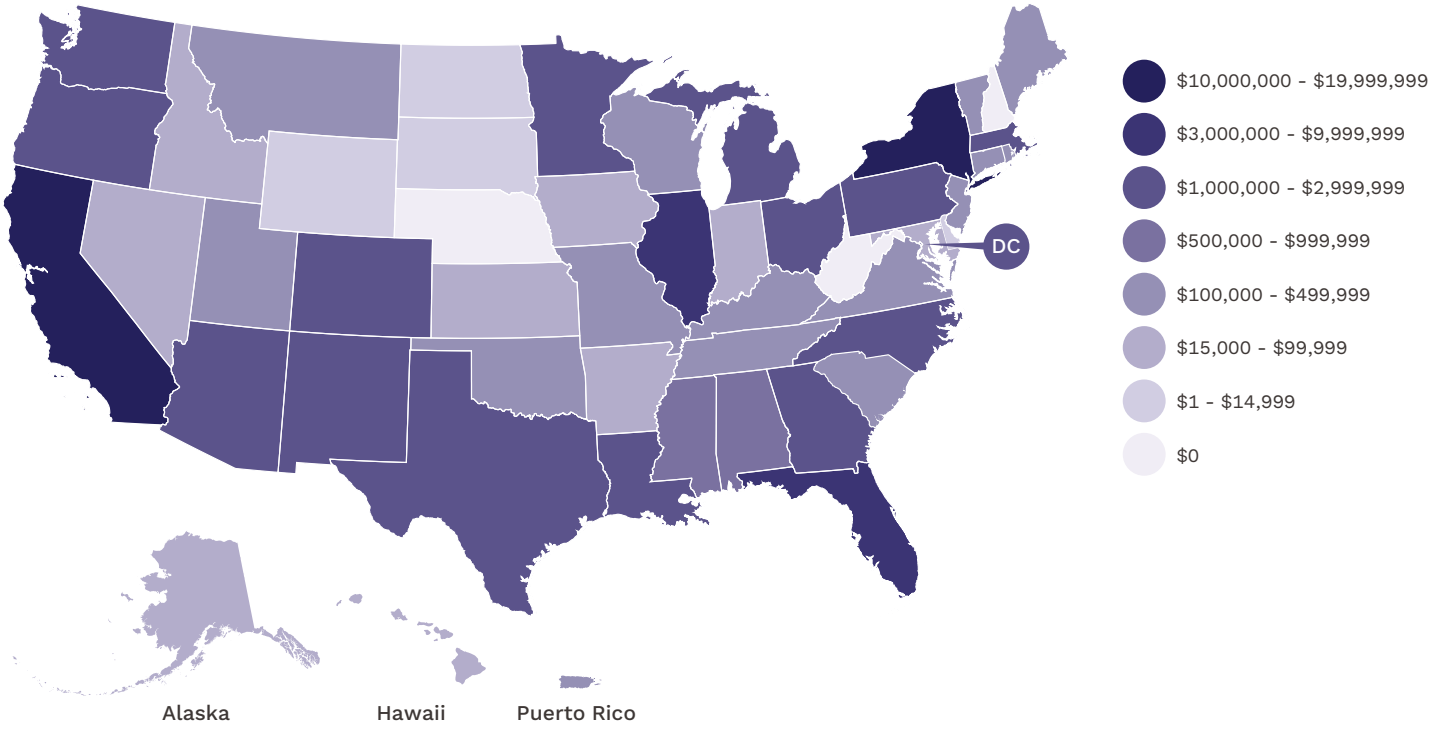
Most of the decreases were moderate, with only 5 states and the District of Columbia seeing decreases of $250,000 or more. **Washington** — the state to experience the biggest decrease in 2017 — was the only state to witness a decrease of more than $500,000.

There were three states where we could not identify any LGBTQ funding in 2017: **Nebraska**, **New Hampshire**, and **West Virginia**.

Local, State, and Regional LGBTQ Funding, By Region

Region	2017	2016	Percent Change
Midwest	$8,758,652	$8,483,928	▲ 3%
Mountain	$4,922,661	$3,321,748	▲ 48%
Northeast	$22,365,842	$18,630,833	▲ 20%
Pacific	$20,958,073	$21,341,571	▼ 2%
South	$22,789,493 ($24,896,019 with OneOrlando Fund Grantmaking)	$17,882,284 ($47,392,284 with OneOrlando Fund Grantmaking)	▲ 27%
U.S. Territories (Puerto Rico)	$341,644	$195,000	▲ 75%
Multi-Region/Unspecified	$1,845,300	$3,548,000	▼ 48%
Total	**$81,981,666 ($84,088,192 with OneOrlando Fund Grantmaking)**	**$73,404,863 ($102,914,863 with OneOrlando Fund Grantmaking)**	▲ **11%**

Local, State, and Regional Funding of LGBTQ Issues, by State (Density Map)



Midwest	$8,758,652
Illinois	$3,182,681
Indiana	$40,920
Iowa	$22,975
Kansas	$25,000
Michigan	$1,168,242
Minnesota	$1,758,361
Missouri	$349,525
Nebraska	$-
North Dakota	$2,500
Ohio	$1,286,148
South Dakota	$25,800
Wisconsin	$392,000
Midwest Region (General)	$504,500

Mountain	$4,922,661
Arizona	$1,740,003
Colorado	$1,188,375
Idaho	$53,650
Montana	$320,538
Nevada	$19,600
New Mexico	$1,227,050
Utah	$364,945
Wyoming	$8,500
Mountain Region (General)	$10,000

Northeast	$22,365,842
Connecticut	$108,205
Delaware	$10,000
District of Columbia	$1,422,093
Maine	$171,100
Maryland	$858,972
Massachusetts	$1,615,174
New Hampshire	$-
New Jersey	$78,700
New York	$15,739,488
Pennsylvania	$1,088,225
Rhode Island	$249,052
Vermont	$210,458
Northeast Region (General)	$814,375

Pacific	$20,958,073
Alaska	$73,500
California	$16,441,044
Hawaii	$74,666
Oregon	$1,825,265
Washington	$1,105,721
Pacific Region (General)	$1,437,877

U.S. Territories	$341,644
Puerto Rico	$341,644

Multi-Regional / Unspecified	$1,845,300

South (Including OneOrlando Fund)	$24,896,019
South (Not Including OneOrlando Fund)	$22,789,493
Alabama	$624,832
Arkansas	$15,500
Florida*	$4,759,082
Florida (with OneOrlando Fund Grantmaking)	$6,865,608
Georgia	$2,573,326
Kentucky	$185,714
Louisiana	$1,634,888
Mississippi	$696,300
North Carolina	$1,567,957
Oklahoma	$282,729
South Carolina	$380,466
Tennessee	$479,300
Texas	$2,623,766
Virginia	$277,240
West Virginia	$-
South Region (General)	$6,688,394

Total	**$81,981,666**
Total (with OneOrlando Fund Grantmaking)	**$84,088,192**

FUNDING PER LGBT ADULT

Our metric of GDQ, or "Grant Dollars per Queer," analyzes the total local and statewide LGBTQ grant dollars awarded per state or region divided by the estimated number of adults in said state or region who identify as lesbian, gay, bisexual, or transgender. The goal of the GDQ is to assess the level of funding for each state relative to its population.

In 2016, the overall GDQ decreased slightly to $7.36, partially on account of more LGBT adults coming out in the Gallup surveys and a subsequent increase in the estimated number of LGBT adults in the United States.

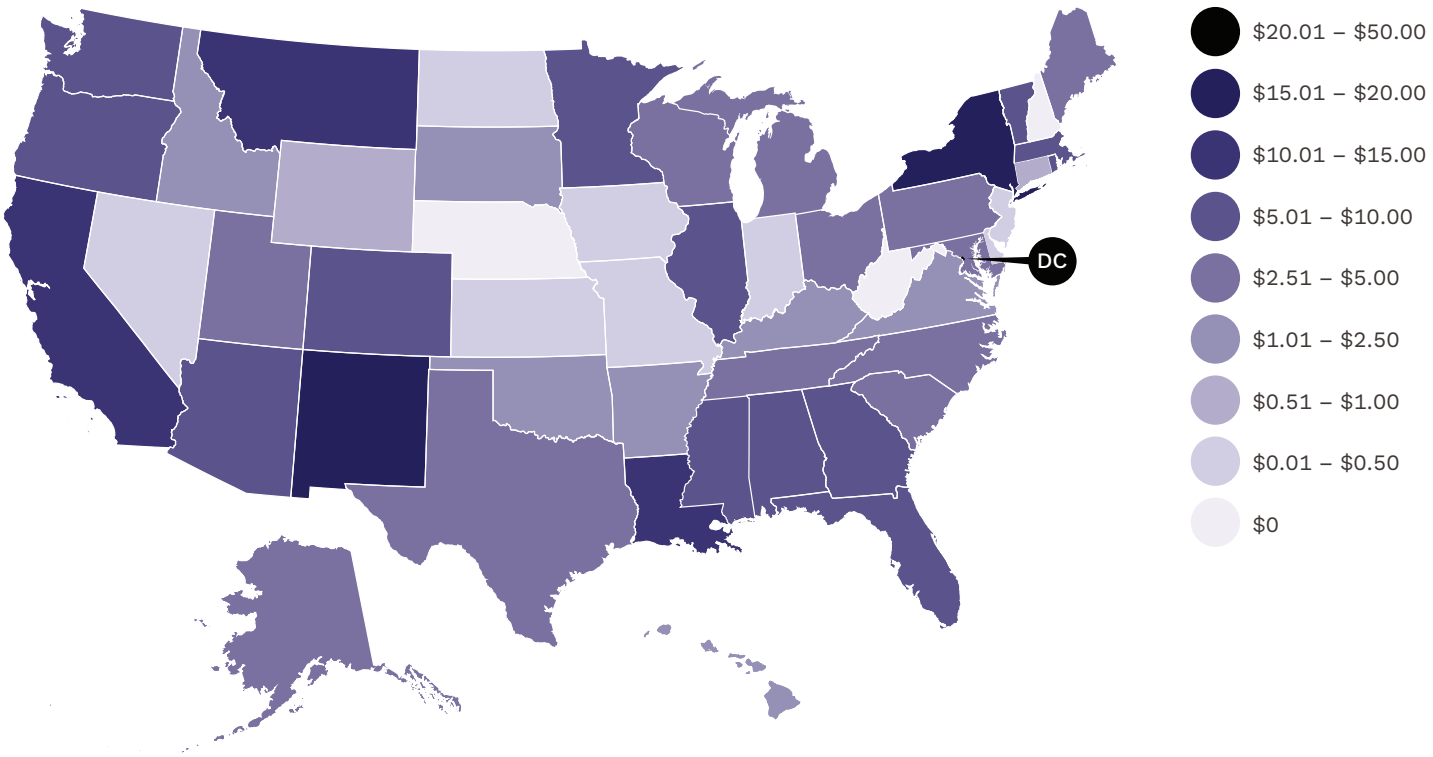
Despite the increase in LGBT adults and the decrease in the overall GDQ, both the average GDQ and the median GDQ increased. In 2017, the average GDQ for states and the District of Columbia was $4.77, up from $4.68 in 2016. In 2017, the median GDQ for the 50 states and the District of Columbia was $3.21, up from $2.92 in 2016.

In 2017, 27 states saw their GDQ increase, while the other 23 states and the District of Columbia witnessed a decrease in GDQ. **New Mexico** had the largest increase, with a $6.79 increase, while the **District of Columbia** had the biggest decrease, with a $11.20 decrease.

The **District of Columbia**, **New York**, and **New Mexico** had the three highest GDQs, in that order. They join **California**, **Louisiana**, and **Montana** as the only six states with GDQ's over $10.

While the South has become the most funded region, it still has a much lower GDQ than the Pacific or Northeast, at $6.25 compared to $9.60 and $9.48, respectively. The Midwest has the lowest GDQ at $4.09. It is the lowest GDQ for any region in last three years.

LGBTQ Funding per LGBT Adult, by State



LGBTQ Funding per LGBT Adult, by State

Midwest	$4.09
Illinois	$7.49
Indiana	$0.18
Iowa	$0.26
Kansas	$0.34
Michigan	$3.73
Minnesota	$9.95
Missouri	$1.94
Nebraska	$–
North Dakota	$0.16
Ohio	$3.29
South Dakota	$1.29
Wisconsin	$2.27

Mountain	$6.06
Arizona	$6.99
Colorado	$5.83
Idaho	$1.47
Montana	$13.27
Nevada	$0.15
New Mexico	$16.90
Utah	$4.43
Wyoming	$0.58

Pacific	$9.60
Alaska	$3.59
California	$10.15
Hawaii	$1.45
Oregon	$9.83
Washington	$3.62

South	$6.25
South (with OneOrlando Fund Grantmaking)	$6.38
Alabama	$5.31
Arkansas	$0.20
Florida	$6.06
Florida (with OneOrlando Fund Grantmaking)	$8.74
Georgia	$7.14
Kentucky	$1.58
Louisiana	$11.76
Mississippi	$8.72
North Carolina	$4.85
Oklahoma	$2.49
South Carolina	$2.73
Tennessee	$2.60
Texas	$3.00
Virginia	$1.07
West Virginia	$–

Northeast	$9.48
Connecticut	$0.98
Delaware	$0.29
District of Columbia	$25.24
Maine	$3.21
Maryland	$4.35
Massachusetts	$5.40
New Hampshire	$–
New Jersey	$0.28
New York	$19.94
Pennsylvania	$2.61
Rhode Island	$6.50
Vermont	$7.93

LGBTQ Funding, by Region

Region	2017	2016	Percent Change
Midwest	$4.09	$4.38	▼ 7%
Mountain	$6.06	$4.64	▲ 31%
Northeast	$9.48	$8.86	▼ 7%
Pacific	$9.60	$10.92	▼ 12%
South	$6.28 ($6.86 with OneOrlando Fund Grantmaking)	$5.64 ($14.96 with OneOrlando Fund Grantmaking)	▲ 11%
Total	**$7.36 ($7.55 with OneOrlando Fund Grantmaking)**	**$7.43 ($10.42 with OneOrlando Fund Grantmaking)**	▼ 1%

SPECIAL UPDATE
GROWTH IN FUNDING FOR LGBTQ ISSUES IN THE SOUTH

In 2017, LGBTQ funding for the South exceeded $22 million (excluding OneOrlando Funding), an increase of 27 percent over 2016. Since we began tracking funding at the regional level and launched our Out in the South Initiative, LGBTQ funding for the South has nearly quintupled. As of this tracking report, the region now receives more LGBTQ funding than any other region in the U.S., followed closely by the Northeast and Pacific. Nevertheless, when accounting for the fact that the South is home to more than one-third of the country's LGBTQ adult population, the region still lags behind the Northeast and the Pacific in LGBTQ funding per LGBT adult.

The growth in Southern LGBTQ funding is the result of the shared efforts of national and Southern funders to increase resources for advancing LGBTQ justice in the region. While this increase in funding is a positive step forward, it is also highly dependent on a small number of funders and spread unevenly across the region. As shown in the section on Local, State, and Regional Funding, only five of fourteen Southern states have surpassed $1 million in LGBTQ funding: Florida, Georgia, Louisiana, North Carolina, and Texas. States such as Arkansas, Kentucky, Oklahoma, Virginia, and West Virginia receive LGBTQ funding ranging from $0 to less than $300,000.

In addition, the increase in funding has been highly dependent on a small number of funders, largely based outside the South.

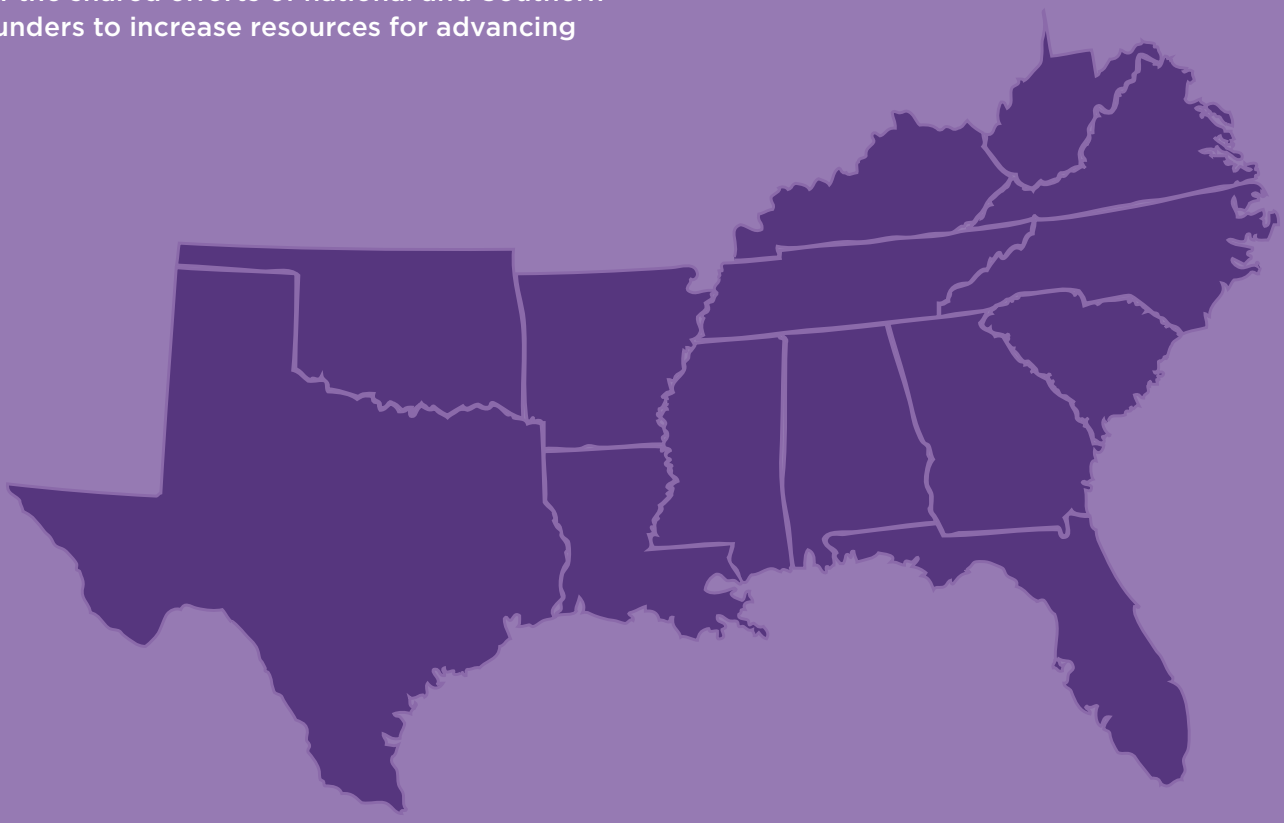


EXHIBIT D-27d

TOP 10 FUNDERS FOR LGBTQ ISSUES IN THE SOUTH

1	**Gilead Sciences** Foster City, CA	$3,527,697
2	**Elton John AIDS Foundation** New York, NY	$1,974,000
3	**Gill Foundation** Denver, CO	$1,666,007
4	**Arcus Foundation** New York, NY	$1,339,500
5	**Evelyn & Walter Haas, Jr. Fund** San Francisco, CA	$963,833
6	**Astraea Lesbian Foundation for Justice** New York, NY	$840,000
7	**Amy Mandel and Katina Rodis Fund** Asheville, NC	$810,820
8	**Borealis Philanthropy** Minneapolis, MN	$743,250
9	**ViiV Healthcare** Research Triangle, NC	$693,000
10	**Ford Foundation** New York, NY	$600,000

The top 10 funders of LGBTQ issues in the South collectively awarded about half of all funding for the region. Of these funders, only two were based in the South pointing to the need for cultivating locally driven, sustainable resources for the region's LGBTQ movement. Much of the increase in funding was also driven by a rise in HIV funding for LGBTQ funding in the South, driven largely by Gilead Sciences and the Elton John AIDS Foundation. In part, this reflects the philanthropic response to the alarming incidence of HIV in the region, which accounts for half of new HIV infections.

As Funders for LGBTQ Issues and its members continue to advance the work of the Out in the South Initiative, these data indicate both significant progress as well as the need to address the continued under-resourcing of the region's needs.

ISSUES ADDRESSED IN DOMESTIC FUNDING

In the year after the Pulse Nightclub Massacre, Addressing Violence, Homophobia, Biphobia, and Transphobia went from being the second most funded issue area to its normal spot as the least funded issue area.

Civil Rights continued its run as the most funded issue area, but saw no growth in the actual funding. Health and Wellbeing was the second most funded issue area, while Strengthening Communities, Families, and Visibility was the third most funded issue area.

LGBTQ funding focused on education, gender identity rights, HIV/AIDS, religion, religious exemptions, safe schools, sexual and reproductive rights and justice, and visibility increased, with each issue area seeing an increase of $1 million or more.

Detailed Breakdown of Issues Addressed in Domestic Funding

Issue	2017	%	2016	%
Civil Rights	$52,694,352	38%	$55,254,503	35%
Civil Rights (General)	$25,603,813	19%	$32,709,734	21%
Criminalization and Criminal Justice Reform	$4,171,178	3%	$3,686,398	2%
Gender Identity Rights	$9,064,300	6%	$6,310,272	4%
Immigration and Refugee Issues	$2,902,150	2%	$2,844,901	2%
Marriage and Civil Unions	$105,000	<1%	$4,100	<1%
Military Inclusion	$870,000	<1%	$821,053	1%
Nondiscrimination Protections	$5,577,256	4%	$7,422,833	5%
Religious Exemptions	$1,480,500	<1%	$460,200	<1%
Sexual and Reproductive Rights/Justice	$2,898,155	2%	$992,012	1%
Health and Wellbeing	$27,645,366	20%	$25,612,314	16%
Cancer	$64,750	<1%	$602,497	<1%
Cultural Competence and Data Collection	$595,224	<1%	$1,245,916	1%
General Health Services and Health Promotion	$6,314,473	5%	$5,908,916	4%
HIV/AIDS	$17,634,537	13%	$15,912,711	10%
Insurance Coverage	$62,665	<1%	$95,000	<1%
Mental Health, Substance Abuse, and Suicide Prevention	$1,919,956	1%	$1,512,605	1%
Primary Care	$129,012	<1%	$130,478	<1%
Sexual and Reproductive Health	$924,750	1%	$204,191	<1%
Strengthening Communities, Families, and Visibility	$27,106,304	20%	$24,996,864	16%
Community Building and Empowerment	$11,748,930	9%	$12,080,027	8%
Religion	$3,483,607	3%	$1,882,940	1%
Strengthening Families	$1,028,295	1%	$2,502,577	2%
Visibility	$10,845,472	8%	$8,481,320	5%
Education and Safe Schools	$8,785,516	6%	$6,105,406	6%
Education	$4,301,487	3%	$2,879,025	2%
Safe Schools	$4,484,029	3%	$3,226,381	4%

Detailed Breakdown of Issues Addressed in Domestic Funding (cont.)

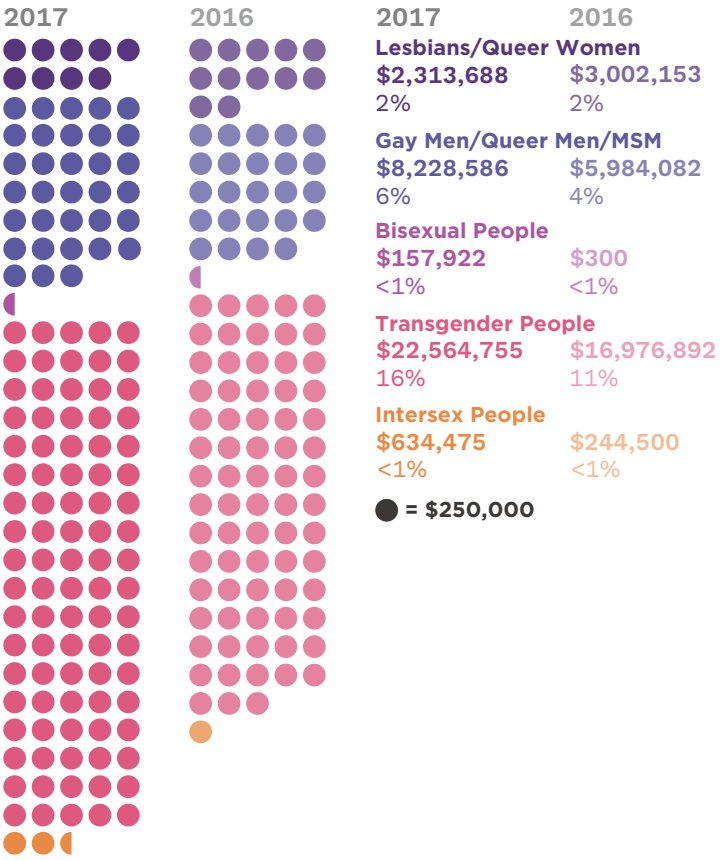
Economic Issues	$6,616,290	5%	$6,028,559	4%
Food Security	$289,075	<1%	$531,800	<1%
Housing and Homelessness	$5,164,531	4%	$4,105,736	3%
Labor and Employment	$1,162,684	1%	$1,391,023	1%
Addressing Violence, Homophobia, Biphobia, and Transphobia	$6,258,023	5%	$31,564,421	20%
Anti-Violence	$4,534,791	3%	$30,610,939	19%
Gun Control	$0	0%	$26,500	<1%
Homophobia, Biphobia, and Transphobia	$1,723,232	1%	$926,982	1%
Other Issues	$8,088,611	6%	$7,237,623	5%
Multi-Issue	$4,411,454	3%	$2,938,478	3%
Philanthropy	$3,666,520	3%	$4,299,145	2%
Unspecified	$10,636	<1%	$0	<1%
Total	**$137,194,461**		**$156,799,690**	

DOMESTIC POPULATION FOCUS

As in previous years, the vast majority of domestic grant dollars were awarded to organizations and programs that serve LGBTQ people generally. Only 24 percent of grant dollars singled out a specific segment of the LGBTQ population.

Funding for trans communities in the United States reached another record high in 2017. At $22.6 million, funding for U.S. trans communities increased by 33 percent.

Distribution of Domestic Grant Dollars by Sexual Orientation, Gender Identity, and Sex Characteristics



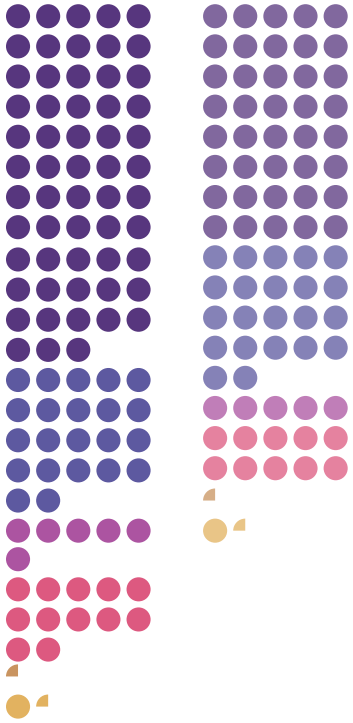
In 2017, funding for LGBTQ communities of color totaled $26.6 million. If you exclude OneOrlando Fund grantmaking from the last two years, this year would represent a new record high in funding for LGBTQ communities of color - going from $20 million without OneOrlando Fund grantmaking in 2016 to $24.5 million without OneOrlando Fund grantmaking in 2016.

This increase was driven by a nearly $4 million increase in funding for communities of color in general and a more $500,000 increase in funding for LGBTQ Latinx communities.

Excluding OneOrlando Fund, the top ten funders of LGBTQ communities of color in 2017 were: Borealis Philanthropy, Gilead Sciences, Arcus Foundation, Ford Foundation, Astraea Lesbian Foundation for Justice, The California Endowment, ViiV Healthcare, Elton John AIDS Foundation, Groundswell Fund, and Tides Foundation. Together they awarded $13.8 million, or 52 percent of all funding for LGBTQ communities of color.

HIV/AIDS was the most funded issue, with 16 percent of all funding for LGBTQ communities of color focused on HIV/AIDS.

Distribution of Domestic Grant Dollars Among People of Color



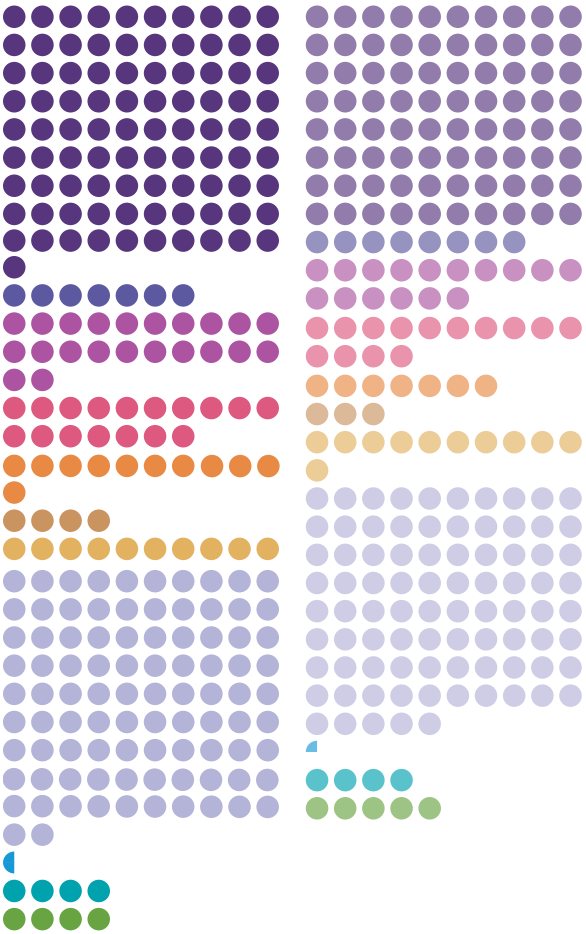
	2017	2016
People of Color (General)	$14,424,956	$10,656,780
	11%	7%
African American/Black	$5,404,187	$5,376,926
	4%	3%
Asian American/Pacific Islander	$1,389,895	$1,153,582
	1%	1%
Latinx	$2,961,139	$2,463,603
	2%	2%
	$5,067,665 (including OneOrlando Fund)	$31,973,693 (including OneOrlando Fund)
Middle Eastern	$7,000	$11,000
	<1%	<1%
Native American	$272,500	$311,750
	<1%	<1%

● = $250,000

Funding for LGBTQ children and youth, which is historically the most funded subpopulation, reached a new record high in 2017 of $25.2 million after a $5.1 million or 26 percent increase.

Funding for LGBTQ people who are homeless or marginally housed, immigrants or refugees, currently or formerly incarcerated, or living with HIV/AIDS also increased by more than $500,000 across each sub-population.

Distribution of Domestic Grant Dollars Among Other Populations

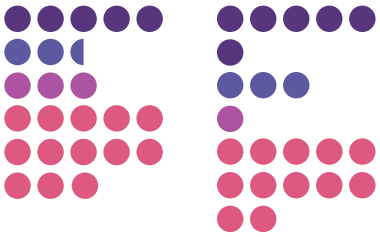


	2017	2016
Children and Youth	$25,517,935	$20,108,727
	19%	13%
Economically Disadvantaged People	$1,705,081	$1,914,296
	1%	1%
Homeless and Marginally Housed People	$5,445,734	$4,032,873
	4%	3%
Immigrants and Refugees	$4,208,250	$3,505,247
	3%	2%
Incarcerated/Formerly Incarcerated People	$2,791,300	$1,857,686
	2%	1%
Military Service Members and Veterans	$1,012,750	$848,553
	1%	1%
Older Adults	$2,413,704	$2,839,532
	2%	2%
People Living with HIV/AIDS (PLWHA)	$23,204,417	$21,357,679
	17%	14%
People with Disabilities	$125,370	$85,000
	1%	<1%
Sex Workers	$990,950	$953,580
	1%	1%
Survivors of Violence	$897,793	$1,362,951
	1%	1%
Survivors of Violence (Including OneOrlando Fund)	$3,004,319	$30,872,951

● = $250,000

In 2017, funding for people of faith increased 10 percent to $5.9 million, up from $5.4 million in 2016. Noticeably, funding for LGBTQ Muslims more than tripled, but still is less than $1 million a year. The Arcus Foundation and the Evelyn and Walter Haas, Jr. Fund were the top two funders of LGBTQ people of faith, collectively providing 56 percent of the funding.

Distribution of Domestic Grant Dollars Among People of Faith



	2017	2016
Christians	$1,302,443 1%	$1,447,972 1%
Jewish People	$647,064 <1%	$746,579 <1%
Muslims	$723,500 <1%	$191,500 <1%
People of Faith (General)	$3,240,937 2%	$2,981,256 2%

● = $250,000

DOMESTIC FUNDING BY TYPE OF ORGANIZATION

LGBTQ ORGANIZATIONS VS. NON-LGBTQ ORGANIZATIONS

Of the $137 million in domestic funding for LGBTQ communities, $132 million was awarded to organizations and $5 million supported individuals. LGBTQ organizations, those whose missions explicitly focus on LGBTQ issues, were awarded $85.2 million or 64 percent of funding for domestic organizations. Non-LGBTQ organizations that received funding for an LGBTQ-specific campaign, program, project, or outreach effort were awarded $46.3 million or 35 percent of funding for domestic organizations.

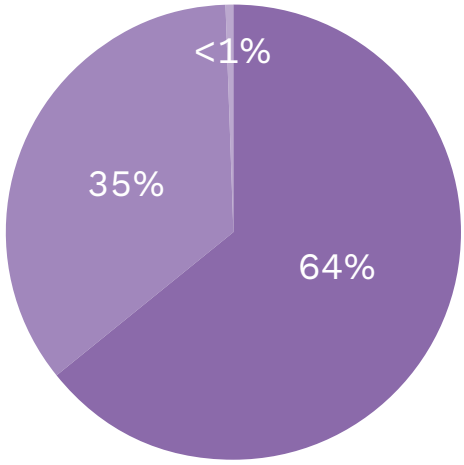
Examples of non-LGBTQ organizations receiving significant funding for LGBTQ work in 2017 include HIV/AIDS service providers such as the Southern AIDS Coalition and Desert AIDS Project, as well as non-profits such as Media Matters for America and Forward Together.

Funding for LGBTQ organizations increased by approximately $3.3 million, while funding for non-LGBTQ organizations increased by $3.5 million. Funding for unnamed or anonymous organizations increased in 2017 but continued to account for less than one percent of funding to domestic organizations.

For the second year in a row, the percentage of funding for domestic LGBTQ organizations decreased relative to funding to non-LGBTQ organizations, accounting for less than two-thirds of domestic funding for the first time since we began tracking funding by organization type.

NOTE: All figures in this section exclude the $5 million awarded to individuals. That funding includes ongoing direct victim support for individuals affected by the Pulse Nightclub Massacre as well as scholarships and fellowships.

Breakdown of Domestic Grant Dollars by Recipient Type: LGBTQ vs. Non-LGBTQ



LGBTQ Organizations
$85,241,996

Non-LGBTQ Organizations
$46,370,521

Unspecified
$609,659

BREAKDOWN OF DOMESTIC FUNDING FOR LGBTQ ORGANIZATIONS

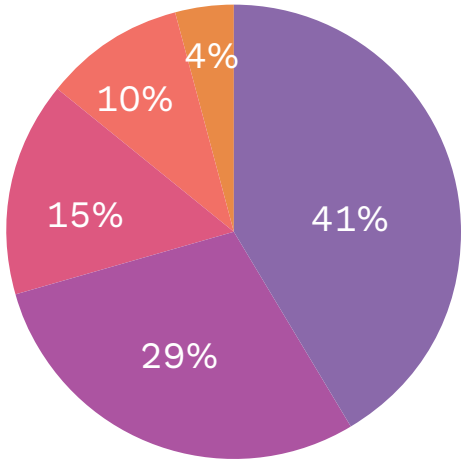
While advocacy organizations continue to capture the largest share of funding for LGBTQ organizations in the United State, the percentage of funding for LGBTQ **advocacy organizations** decreased slightly to 41 percent, down from 45 percent reported in 2016. LGBTQ advocacy organizations with a national scope receive over 20 percent of this funding, followed by organizations focusing on litigation and legal services and state-based advocacy organizations, receiving 10 and 9 percent of funding respectively. Funding for local advocacy organizations increased in 2017, from $1.7 million in 2016 to nearly $3 million, or 3 percent of funding for advocacy organizations.

Service providers received the second highest share of funding for domestic LGBTQ organizations, accounting for just over $25.2 million or nearly 30 percent of funding in 2017, a total consistent with 2016 funding levels. Of this funding, twelve percent was directed towards community centers, which received the largest share of funding to service providers. Funding for community centers increased to $10.5 million, up from $8.4 million in 2016.

Funding for **infrastructure organizations** increased from $9 million in 2016 to nearly $13 million in 2017, to account for 15 percent of all funding for domestic LGBTQ organizations. This growth was driven largely by increases in funding to LGBTQ public foundations as well as funding for research institutes such as the Williams Institute.

Funding remained consistent for the remaining categories of LGBTQ domestic organizations, with only minor fluctuations. **Grassroots community groups**—including faith-based groups, GSA networks, and pride organizations—captured 10 percent of funding for domestic LGBTQ organizations, followed by **arts and culture organizations**, which received 4 percent of funding.

Domestic Grant Dollars for LGBTQ Organizations, by Recipient Organization Type



Advocacy Organizations
41%

Service Providers
29%

Infrastructure Organizations
15%

Grassroots Community Groups
10%

Arts and Culture Organizations
4%

Breakdown of Domestic Grant Dollars for LGBTQ Organizations, By Recipient Organization Type and Sub-Type

Organization Type / Sub-Type	2017	%	2016	%
Advocacy Organizations	**$35,112,584**	**41%**	**$36,843,312**	**45%**
National Advocacy Organizations	$14,468,217	17%	$16,303,941	20%
Regional Advocacy Organizations	$1,653,414	2%	$1,395,147	2%
State Advocacy Organizations	$7,668,465	9%	$7,286,035	9%
Local Advocacy Organizations	$2,813,725	3%	$1,750,085	2%
Litigation & Legal Services Organizations	$8,508,764	10%	$10,108,103	12%
Arts and Culture Organizations	**$3,614,910**	**4%**	**$3,362,793**	**4%**
Grassroots Community Groups	**$8,352,224**	**10%**	**$6,786,702**	**8%**
Athletic Groups	$158,810	<1%	$315,630	<1%
Business/Professional Networks	$1,149,137	1%	$431,450	1%
Faith-based Groups	$1,228,046	1%	$1,617,548	2%
Family Groups	$204,615	<1%	$850,082	1%
GSA Networks or Campus Groups	$2,849,505	3%	$1,974,420	2%
Pride Organizations	$487,615	1%	$241,230	<1%
Social and Recreational Groups	$0	<1%	$6,000	<1%
Infrastructure Organizations	**$12,841,285**	**15%**	**$9,094,742**	**11%**
Philanthropic Networks	$1,865,650	2%	$1,011,677	1%
Public Foundations	$4,891,525	6%	$3,404,168	4%
Research Institutes	$3,970,970	5%	$2,813,153	3%
Technical Assistance Provider and Networks	$2,113,140	2%	$1,865,744	2%
Service Providers	**$25,016,312**	**29%**	**$25,634,977**	**31%**
Aging Service Providers	$1,304,069	2%	$2,091,843	3%
Community Centers	$10,186,827	12%	$8,404,747	10%
Health Centers	$2,808,980	3%	$3,041,375	4%
HIV/AIDS Service Providers	$3,367,640	4%	$5,272,270	6%
Other Service Providers	$2,896,454	3%	$2,329,546	3%
Support Groups	$81,050	<1%	$72,275	<1%
Youth Service Providers	$4,371,292	5%	$4,422,922	5%
Universities and Post-Secondary Schools	**$29,680**	**<1%**	**$89,971**	**<1%**
Campus Groups	$500	<1%	$23,160	<1%
High Schools	$25,180	<1%	$66,811	<1%
Unspecified	**$0**	**<1%**	**$188,313**	**<1%**
Grand Total	**$85,241,996**		**$81,813,997**	

BREAKDOWN OF DOMESTIC FUNDING FOR NON-LGBTQ ORGANIZATIONS

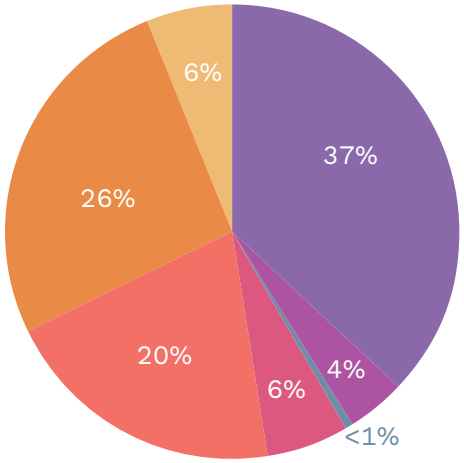
Advocacy organizations continued to capture the largest share of funding for non-LGBTQ organizations, accounting for almost $17 million or 37 percent of all funding for non-LGBTQ organizations in 2017. This represents an increase of over $4 million from 2016.

Funding for non-LGBTQ **service providers** takes the second largest share of funding, accounting for 26 percent or $12.1 million dollars in 2017, representing a slight increase from the $10.6 million reported in 2016. This category is carried by the $5.4 million for non-LGBTQ HIV/AIDS service providers funded for targeted work with LGBTQ populations.

Infrastructure organizations continue to receive a significant portion of funds for non-LGBTQ organizations in the United States. These organizations — including public foundations, research institutes, and philanthropic networks — collectively received $9.2 million, or 20 percent of funding for non-LGBTQ organizations in 2017.

While funding for non-LGBTQ organizations increased overall, some categories of organizations did see a decrease in funding in 2017. Support for non-LGBTQ **arts and culture organizations**, **grassroots community groups**, and **universities and schools** all saw modest decreases.

Domestic Grant Dollars for Non-LGBTQ Organizations, by Recipient Organization Type



- **Advocacy Organizations** 37%
- **Arts and Culture Organizations** 4%
- **Government/Intergovernmental Agencies** <1%
- **Grassroots Community Groups** 6%
- **Infrastructure Organizations** 20%
- **Service Providers** 26%
- **Universities and Schools** 6%

Breakdown of Domestic Grant Dollars for Non-LGBTQ Organizations, By Recipient Organization Type and Sub-Type

Organization Type / Sub-Type	2017	%	2016	%
Advocacy Organizations	**$16,955,696**	**37%**	**$12,892,866**	**30%**
National Advocacy Organizations	8,469,464	18%	$7,101,007	17%
Regional Advocacy Organizations	$2,194,219	5%	$520,081	1%
State Advocacy Organizations	$1,608,951	3%	$1,222,939	3%
Local Advocacy Organizations	$2,770,647	6%	$1,684,532	4%
Litigation & Legal Services Organizations	$1,912,415	4%	$2,358,307	6%
Arts and Culture Organizations	**$2,044,167**	**4%**	**$3,698,477**	**9%**
Government Agencies (Including Public School Systems)	**$5,000**	**<1%**	**$62,850**	**<1%**
Grassroots Community Groups	**$2,946,312**	**6%**	**$3,002,681**	**7%**
Athletic Groups	$0	<1%	$1,000	<1%
Business/Professional Networks	$555,800	1%	$916,700	2%
Faith-based Groups	$1,213,237	3%	$738,695	2%
Social and Recreational Groups	$5,000	<1%	$1,000	<1%
Infrastructure Organizations	**$9,296,762**	**20%**	**$9,404,028**	**22%**
Philanthropic Networks	$825,367	2%	$966,991	2%
Public Foundations	$4,799,995	10%	$3,869,872	9%
Research Institutes	$1,679,200	4%	$3,290,200	8%
Technical Assistance Provider and Networks	$1,992,200	4%	$1,276,965	3%
Service Providers	**$12,199,142**	**26%**	**$10,664,612**	**25%**
Aging Service Providers	$67,5850	<1%	$20,100	<1%
Community Centers	$349,274	1%	$144,537	<1%
Health Centers	$2,175,436	5%	$1,815,087	4%
HIV/AIDS Service Providers	$5,534,735	12%	$5,166,619	12%
Other Service Providers	$1,973,446	4%	$2,221,276	5%
Support Groups	$35,000	0%	$35,000	<1%
Youth Service Providers	$2,054,667	4%	$1,277,593	3%
Universities and Post-Secondary Schools	**$2,899,992**	**6%**	**$3,148,968**	**7%**
Campus Groups	$62,552	<1%	$6,250	<1%
High Schools	$9,650	<1%	$6,250	<1%
Universities	$2,827,790	6%	$3,148,968	7%
Grand Total	**$46,370,521**		**$42,874,483**	

GLOBAL FUNDING FOR LGBTQ ISSUES

In 2017, U.S.-based foundations awarded 754 grants totaling $48.5 million to support international LGBTQ issues and LGBTQ communities outside the U.S. This figure does not include an additional 17 grants totaling $3.6 million awarded to intermediaries for international re-granting. This represents an increase of 6 percent from the $45.5 million awarded in 2016, setting a new record for grantmaking for LGBTQ issues outside the United States by U.S.-based foundations for the second year in a row.

Grantmaking outside of the United States accounted for approximately 26 percent of grantmaking by U.S. foundations.

NOTE: This section explores funding from foundations, corporations, and nonprofit grantmakers based in the United States. It does not include LGBTQ funding from foundations and funding institutions outside the U.S. or governments and multilateral organizations. The *2015-2016 Global Resources Report,* published in April of 2018 by Funders for LGBTQ Issues in partnership with the Global Philanthropy Project, tracks philanthropic support for LGBTQ issues globally and includes those grantmakers.

NOTE: The list of top grant recipients excludes dollars awarded for re-granting purposes. Multi-year grants are counted for the full amount in the year they are awarded.

TOP 10 U.S.-BASED GLOBAL LGBTQ FUNDERS[9]

1. **Ford Foundation**
   $7,415,000
   New York, NY
2. **Arcus Foundation**
   $7,277,755
   New York, NY
3. **Open Society Foundations**
   $6,961,001
   New York, NY
4. **Tides Foundation**
   $4,088,640
   San Francisco, CA
5. **Foundation for a Just Society**
   $3,800,000
   New York, NY
6. **M.A.C. AIDS Fund**
   $2,846,389
   New York, NY
7. **Astraea Lesbian Foundation for Justice**
   $2,324,879
   New York, NY
8. **American Jewish World Service**
   $1,924,369
   New York, NY
9. **Gilead Sciences**
   $1,632,847
   Foster City, CA
10. **Andrew W. Mellon Foundation**
    $1,159,000
    New York, NY

TOP 10 GLOBAL LGBTQ GRANTEES OF U.S.-BASED FUNDERS[10]

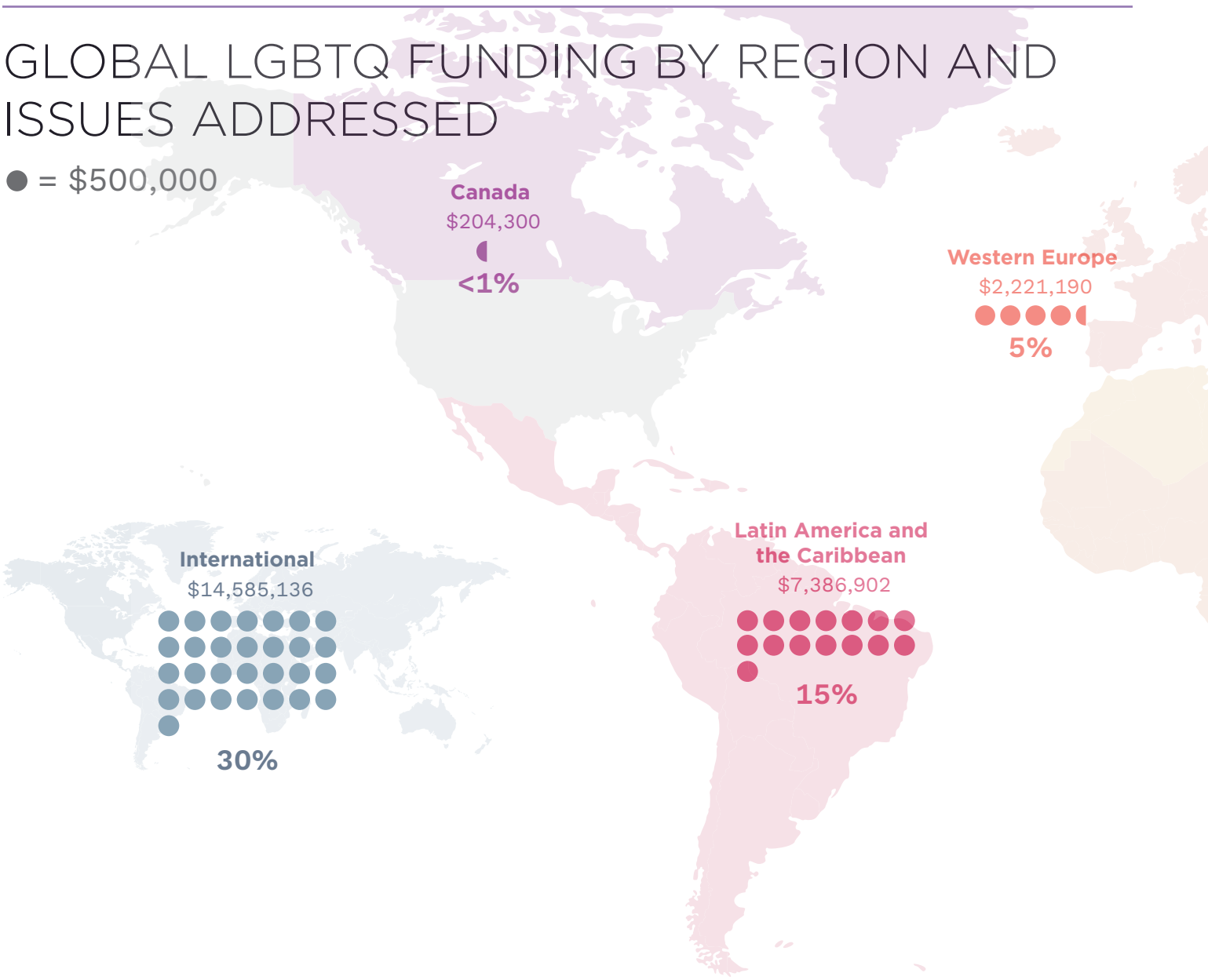
1. **African Men for Sexual Health and Rights (AMSHER)**
   $3,000,000
   Johannesburg, South Africa
2. **All Out**
   $2,630,000
   New York, NY
3. **Astraea Lesbian Foundation for Justice**
   $1,580,005
   New York, NY
4. **Initiative Sankofa d'Afrique de l'Ouest (ISDAO)**
   $1,500,000
   Nairobi, Kenya
5. **University of the Western Cape**
   $1,159,000
   Cape Town, South Africa
6. **Collective Foundation AIDS Accountability International**
   $1,150,000
   Södermalm, Sweden
7. **Tharthi Myay Foundation**
   $750,000
   Yangon, Myanmar
8. **Partners Asia**
   $750,000
   Oakland, CA
9. **Transgender Europe (TGEU)**
   $700,000
   Berlin, Germany
10. **The Council for Global Equality**
    $665,000
    Washington, DC

[9] In 2017, one anonymous funders awarded a total of $6,360,000 to support LGBTQ issues outside of the United States. If the multiple anonymous funders appeared in the top ten list, they would rank as the fourth largest funder.

[10] In 2016, multiple anonymous grantees received $1,416,919.00 for work benefiting LGBTQ communities outside the United States. If these multiple anonymous grantees appeared in the top ten list, they would rank as the number five grantee.

GLOBAL LGBTQ FUNDING BY REGION AND ISSUES ADDRESSED

● = $500,000



International

TOP FUNDER
Arcus Foundation $4,161,755

TOP STRATEGY
Advocacy (57%)

TOP ISSUE ADDRESSED
Civil and Human Rights (79%)

Canada

TOP FUNDER
Elton John AIDS Foundation $337,000

TOP STRATEGY
Direct Service (49%)

TOP ISSUE ADDRESSED
Civil and Human Rights (98%)

Latin America and the Caribbean[11]

TOP FUNDER
M.A.C. AIDS Fund $927,889

TOP STRATEGY
Advocacy (33%)

TOP ISSUE ADDRESSED
Civil and Human Rights (57%)

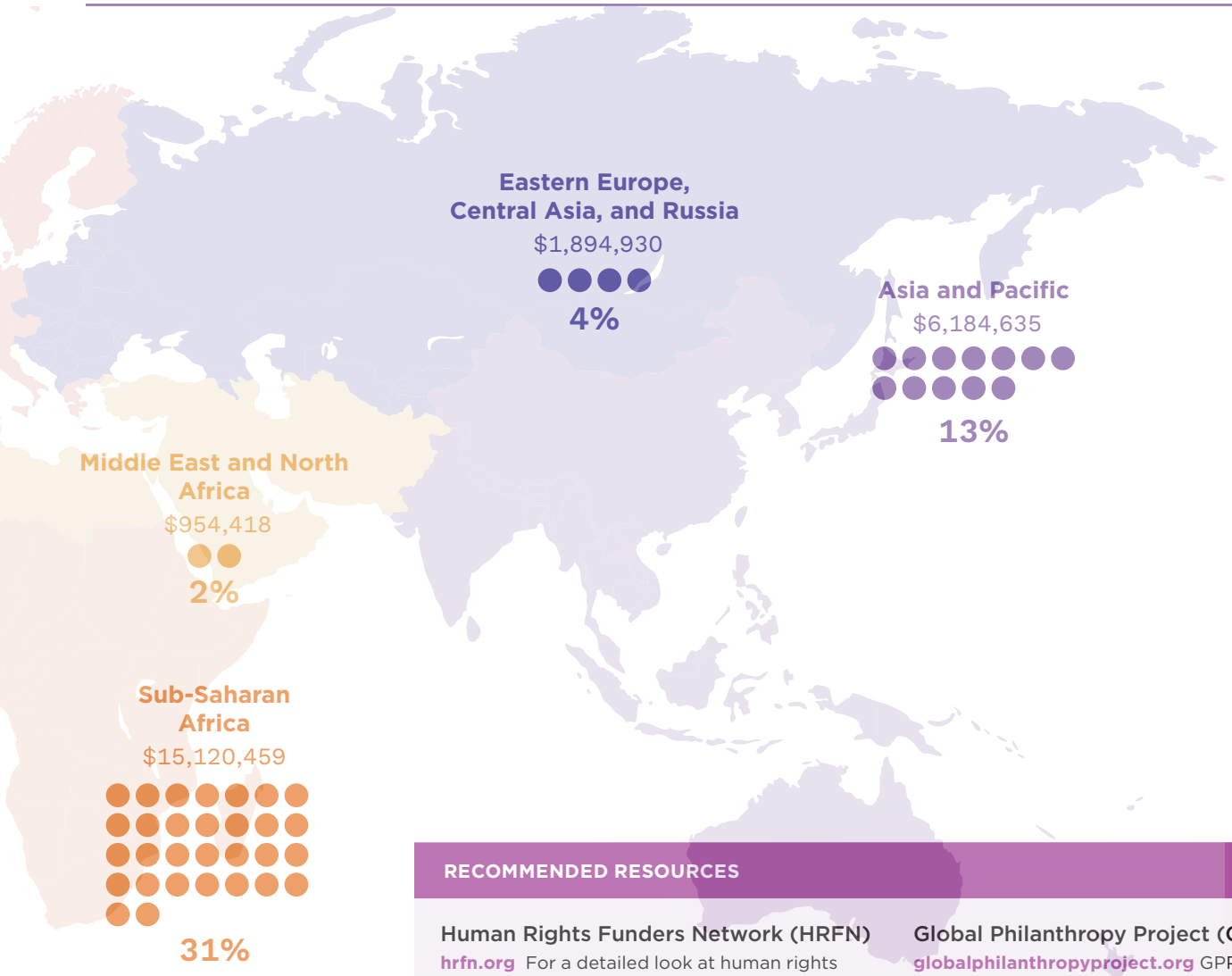
Western Europe

TOP FUNDER
M.A.C. AIDS Fund $830,000

TOP STRATEGY
Advocacy (28%)

TOP ISSUE ADDRESSED
Health and Wellbeing (75%)

[11] In 2017, multiple anonymous funders awarded a total of $2,080,000 to support LGBTQ issues in Latin America and The Caribbean. If the multiple anonymous funders appeared as one funder, they would rank as the number one funder.



RECOMMENDED RESOURCES

Human Rights Funders Network (HRFN)

hrfn.org For a detailed look at human rights funding around the world, see "Advancing Human Rights: The State of Global Foundation Grantmaking," produced by HRFN and the Foundation Center. The most recent report found that foundations awarded $2.4 billion for human rights in 2015, of which about 4 percent ($101.8 million) focused on LGBT populations. Interactive data is available at **humanrightsfunding.org.**

Global Philanthropy Project (GPP)

globalphilanthropyproject.org GPP is a global network of funders and philanthropic advisors working to expand global philanthropic support to advance the human rights of lesbian, gay, bisexual, transgender and intersex (LGBTI) people in the Global South and East. GPP's website, **globalphilanthropyproject.org**, provides an array of resources on grantmaking for LGBTI issues around the world.

Sub-Saharan Africa[12]

TOP FUNDER
Ford Foundation
$6,200,00

TOP STRATEGY
Advocacy (62%)

TOP ISSUE ADDRESSED
Civil and Human Rights (68%)

Middle East and North Africa

TOP FUNDER
Arcus Foundation
$300,000

TOP STRATEGY
Philanthropy and Fundraising (31%)

TOP ISSUE ADDRESSED
Civil and Human Rights (49%)

Eastern Europe, Central Asia, and Russia

TOP FUNDER
Open Society Foundations
$736,000

TOP STRATEGY
Advocacy (78%)

TOP ISSUE ADDRESSED
Civil and Human Rights (80%)

Asia and Pacific

TOP FUNDER
Foundation for a Just Society $1,950,000

TOP STRATEGY
Advocacy (42%)

TOP ISSUE ADDRESSED
Civil and Human Rights (74%)

[12] In 2016, multiple anonymous funders awarded a total of $3,230,000 to support LGBTQ issues in Sub-Saharan Africa. If the multiple anonymous funders appeared as one funder, they would rank as the number one funder.

GLOBAL FUNDING BY LOCATION OF GRANTEE

In 2017, 25 percent of all funding for global LGBTQ issues was awarded to a grantee physically located in the United States. Another 12 percent of funding for global LGBTQ work was awarded to grantees physically located in Western Europe. Over 60 percent of global funding by U.S. foundations reached organizations that were physically located outside of Western Europe and the United States.

This chart shows the country locations of grantees that received U.S. foundation funding for LGBTQ issues in 2017. For each geographic area, the chart shows the amount of funding for each country in the region. It also shows the funding for work focused on the region, but conducted by organizations based outside the region. Some funding was devoted to organizations in undisclosed locations, and that total amount is listed for each region.

Global Funding by Location of Grantee

Asia and Pacific	$6,184,635
Regional Funding for Organizations Based Within Asia and Pacific	
Australia	$288,975
Bangladesh	$30,000
Cambodia	$40,000
China	$20,000
Fiji	$21,000
Hong Kong	$20,000
India	$1,059,381
Indonesia	$106,000
Japan	$117,700
Mongolia	$80,000
Myanmar	$1,215,000
Nepal	$74,560
New Zealand	$30,000
Pakistan	$65,480
Philippines	$258,134
Samoa	$22,500
Singapore	$162,000
South Korea	$24,545
Sri Lanka	$25,000
Taiwan	$179,000
Thailand	$696,540
Timor Leste	$1,000
Regional Funding for Organizations Based Outside Asia and Pacific	
Switzerland	$195,620
United Kingdom	$25,000
USA	$1,057,800
Regional Funding for Organizations Based in Undisclosed Countries	
Unspecified	$369,400

Eastern Europe, Central Asia and Russia	$1,894,930
Regional Funding for Organizations Based Within Eastern Europe, Central Asia and Russia	
Armenia	$10,000
Bosnia and Herzegovina	$101,800
Bulgaria	$40,000
Croatia	$102,000
Czech Republic	$100,986
Georgia	$98,700
Hungary	$38,000
Kazakhstan	$28,000
Kyrgyzstan	$216,800
Latvia	$30,000
Lithuania	$90,000
Moldova	$80,000
Montenegro	$40,000
Poland	$101,200
Romania	$50,000
Russia	$236,744
Serbia	$257,000
Slovenia	$32,000
Turkey	$10,000
Ukraine	$132,000
Uzbekistan	$4,700
Regional Funding for Organizations Based Outside Eastern Europe, Central Asia and Russia	
Austria	$20,000
Belgium	$55,000
Regional Funding for Organizations Based in Undisclosed Countries	
Unspecified	$20,000

Latin America and the Caribbean	$7,386,902
Regional Funding for Organizations Based Within Latin America and the Caribbean	
Argentina	$360,000
Belize	$26,800
Brazil	$1,623,000
Chile	$554,500
Colombia	$540,666
Costa Rica	$12,000
Dominican Republic	$226,700
Ecuador	$80,000
El Salvador	$136,600
Grenada	$75,000
Guatemala	$33,000
Guyana	$15,000
Haiti	$88,000
Honduras	$104,500
Jamaica	$792,389
Mexico	$1,524,500
Nicaragua	$286,770
Paraguay	$28,000
Peru	$254,477
St. Lucia	$190,000
Trinidad and Tobago	$10,000
Uruguay	$40,000
Regional Funding for Organizations Based Outside Latin America and the Caribbean	
Switzerland	$50,000
USA	$330,000
Regional Funding for Organizations Based in Undisclosed Countries	
Unspecified	$5,000

Global Funding by Location of Grantee (cont.)

Sub-Saharan Africa	$15,120,459
Regional Funding for Organizations Based Within Sub-Saharan Africa	
Botswana	$127,000
Burkina Faso	$197,000
Burundi	$23,000
Cameroon	$10,000
Democratic Republic of the Congo (DRC)	$32,182
Ghana	$65,000
Ivory Coast	$15,000
Kenya	$4,441,997
Liberia	$102,200
Malawi	$190,000
Namibia	$185,000
Nigeria	$456,500
Rwanda	$65,000
Sénégal	$13,000
South Africa	$5,720,862
Swaziland	$50,000
Sweden	$1,150,000
Tanzania	$80,000
Togo	$200,000
Uganda	$788,219
Zambia	$162,000
Zimbabwe	$69,500
Regional Funding for Organizations Based Outside Sub-Saharan Africa	
United Kingdom	$100,000
USA	$846,999
Regional Funding for Organizations Based in Undisclosed Countries	
Unspecified	$30,000

Middle East and North Africa	$954,418
Regional Funding for Organizations Based Within Middle East and North Africa	
Algeria	$13,700
Egypt	$115,000
Israel	$183,000
Jordan	$5,000
Lebanon	$167,000
Morocco	$67,267
Tunisia	$30,000
Turkey	$73,451
Regional Funding for Organizations Based Outside Middle East and North Africa	
The Netherlands	$300,000

United States and Canada	$137,420,261
Regional Funding for Organizations Based Within the United States and Canada	
Canada	$204,300
United States of America	$137,215,961
Regional Funding for Organizations Based in Undisclosed Countries	
Unspecified	$3,873,444

Western Europe	$2,221,190
Regional Funding for Organizations Based Within Western Europe	
Austria	$7,000
Belgium	$11,935
Denmark	$6,000
France	$138,900
Germany	$582,000
Iceland	$10,000
Ireland	$48,890
Italy	$165,000
Norway	$3,632
Spain	$256,122
The Netherlands	$210,000
United Kingdom	$781,711

International	$14,585,136
International Funding for Organizations Based Around The World	
Australia	$6,000
Austria	$92,000
Belgium	$561,935
Canada	$100,000
Denmark	$6,000
Fiji	$5,200
France	$188,900
Germany	$1,282,000
Iceland	$10,000
Ireland	$48,890
Italy	$165,000
Mexico	$5,000
Namibia	$125,000
Norway	$3,632
Pakistan	$1,451
Russia	$1,638
South Africa	$1,682,000
Spain	$256,122
Sweden	$15,000
Switzerland	$534,163
The Netherlands	$430,000
United Kingdom	$207,854
United Kingdom - England	$942,648
USA	$9,808,893
International Funding for Organizations Based in Undisclosed Countries	
Unspecified	$327,000

COMMUNITY FOUNDATION GRANTMAKING FOR LGBTQ ISSUES

In 2017, community foundations awarded $12.4 million to LGBTQ issues (or $11.7 million after dollars awarded for re-granting are excluded). This is a increase from 2016, when community foundations awarded $6.9, driven in part by increased donor advised grantmaking at community foundations as well as new foundations entering the field. Donor advised funds accounted for 27.5 percent of community foundation grantmaking for LGBTQ issues in 2017.

NOTE: This section includes funding awarded by community foundations from their discretionary funds as well as from their donor-advised funds, which are often driven by recommendations from the donor who originally established the fund.

TOP 10 COMMUNITY FOUNDATIONS

1. **California Community Foundation**
   $2,778,807
   Los Angeles, CA
2. **Greater Kansas City Community Foundation**
   $1,404,750
   Kansas City, Missouri
3. **Silicon Valley Community Foundation**
   $936,112
   Mountain View, CA
4. **The New York Community Trust**
   $815,250
   New York, NY
5. **Arizona Community Foundation**
   $658,276
   Phoenix, AZ
6. **Boston Foundation**
   $625,800
   Boston, MA
7. **Community Foundation for Northeast Florida**
   $545,900
   Jacksonville, FL
8. **Community Foundation of Broward**
   $485,820
   Fort Lauderdale, FL
9. **The Cleveland Foundation**
   $480,250
   Cleveland, OH
10. **Miami Foundation**
    $360,675
    Miami, FL

TOP 10 COMMUNITY FOUNDATION GRANTEES

1. **Human Rights Campaign (HRC) Foundation**
   $2,146,623
   Washington, DC
2. **Desert AIDS Project**
   $1,001,500
   Palm Springs, CA
3. **ONE Community Media, LLC**
   $423,249
   Phoenix, AR
4. **San Francisco AIDS Foundation**
   $378,814
   San Francisco, CA
5. **Lambda Legal Defense and Education Fund**
   $339,708
   New York, NY
6. **Los Angeles LGBT Center**
   $309,457
   Los Angeles, CA
7. **Equality Ohio Education Fund**
   $286,000
   Columbus, OH
8. **The Trevor Project**
   $268,747
   West Hollywood, CA
9. **The Boston Foundation**
   $255,000
   Boston, MA
10. **Jacksonville Area Sexual Minority Youth Network (JASMYN)**
    $245,250
    Jacksonville, FL

CORPORATE GRANTMAKING FOR LGBTQ ISSUES

In 2017, corporate foundation support for LGBTQ issues totaled a record-breaking $27.1 million (or $23.8 million after dollars awarded for re-granting are excluded). This marks a $1.2 million - or 5 percent - increase over last year's record high of $25.9 million. While the 2016 high mark was driven by $9.4 million awarded in response to the Pulse Nightclub Massacre, the 2017 increase is fueled by substantial increases in giving by Gilead Sciences and ViiV Healthcare for HIV/AIDS work in LGBTQ communities.

NOTE: The Committee Encouraging Corporate Philanthropy estimates that corporate foundation giving only accounts for 34 percent of all corporate giving, with direct cash accounting for 48 percent and in-kind giving accounting for 18 percent. Currently, our corporate data only includes corporate foundation grantmaking and employee matching gift programs run through corporate foundations with some direct cash included if the company self reports. It does not include all of the generous support from corporations giving without an official foundation or philanthropic office or in-kind gifts.

TOP 10 CORPORATE FUNDERS

1. **Gilead Sciences**
   $11,730,648
   Foster City, CA
2. **M.A.C. AIDS Fund**
   $4,963,389
   New York, NY
3. **Wells Fargo**
   $3,339,971
   San Francisco, CA
4. **ViiV Healthcare**
   $2,982,325
   Research Triangle, NC
5. **Levi Strauss Foundation**
   $1,045,500
   San Francisco, CA
6. **Google**
   $1,000,000
   Mountain View, CA
7. **Bank of America Charitable Foundation**
   $289,488
   Charlotte, NC
8. **Citi Foundation**
   $250,000
   Long Island City, NY
9. **Polk Bros. Foundation**
   $243,500
   Chicago, IL
10. **Blue Shield of California Foundation**
    $227,000
    San Francisco, CA

TOP 10 CORPORATE GRANTEES

1. **Southern AIDS Coalition**
   $1,751,219
   Atlanta, GA
2. **New York LGBT Center**
   $1,040,583
   New York, NY
3. **Los Angeles LGBT Center**
   $800,124
   Los Angeles, CA
4. **Annenberg Center for Health Sciences at Eisenhower**
   $756,250
   Rancho Mirage, CA
5. **Casa Ruby**
   $600,000
   Washington, DC
6. **Elton John AIDS Foundation**
   $587,500
   New York, NY
7. **San Francisco AIDS Foundation**
   $521,339
   San Francisco, CA
8. **Point Foundation**
   $510,500
   Los Angeles, CA
9. **Elton John AIDS Foundation (UK)**
   $500,000
   London, England
10. **Fund for Public Health in New York, Inc.**
    $500,000
    New York, NY

RECOMMENDED RESOURCE

Committee Encouraging Corporate Philanthropy

A great resource for a more detailed look at corporate philanthropy is ***Giving in Numbers: 2018 Edition*** by the Committee Encouraging Corporate Philanthropy. The report and more can be found at **www.cecp.co**.

PRIVATE FOUNDATION GRANTMAKING FOR LGBTQ ISSUES

In 2017, private foundations awarded $93.4 million to LGBTQ issues (or $87.3 million after dollars for re-granting are excluded). This represents a $4.7 million increase from the record high reported in 2016. Non-LGBTQ private foundations increased their grantmaking by $4.3 million while LGBTQ private foundations increased their grantmaking only slightly, by less than one million dollars.

Consistent with historical trends, private foundations continue to represent the largest slice of LGBTQ funding, accounting for nearly half of all foundation funding in 2017.

TOP 10 LGBTQ PRIVATE FOUNDATIONS

1. **Arcus Foundation**
   $17,006,755
   New York, NY
2. **Gill Foundation**
   $9,520,007
   Denver, CO
3. **H. van Ameringen Foundation**
   $4,349,500
   New York, NY
4. **Alphawood Foundation**
   $1,686,500
   Chicago, IL
5. **Tawani Foundation**
   $1,648,000
   Chicago, IL
6. **David Bohnett Foundation**
   $1,393,481
   Los Angeles, CA
7. **Amy Mandel and Katina Rodis Fund**
   $1,185,210
   Asheville, NC
8. **Palette Fund**
   $1,114,325
   New York, NY
9. **Calamus Foundation**
   $647,000
   New York, NY
10. **Bastian Foundation, B. W.**
    $625,070
    Oren, UT

TOP 10 NON-LGBTQ PRIVATE FOUNDATIONS

1. **Ford Foundation**
   $12,445,000
   New York, NY
2. **Open Society Foundations**
   $7,769,598
   New York, NY
3. **Evelyn & Walter Haas, Jr. Fund**
   $5,038,200
   San Francisco, CA
4. **Foundation for a Just Society**
   $4,640,000
   New York, NY
5. **The California Endowment**
   $3,780,111
   Los Angeles, CA
6. **John D. and Catherine T. MacArthur Foundation**
   $1,425,000
   Chicago, IL
7. **Andrew W. Mellon Foundation**
   $1,159,000
   New York, NY
8. **William and Flora Hewlett Foundation**
   $1,125,000
   Menlo Park, CA
9. **Meyer Memorial Trust**
   $955,856
   Portland, OR
10. **Marguerite Casey Foundation**
    $822,500
    Seattle, WA

TOP 10 PRIVATE FOUNDATION GRANTEES[13]

1. **African Men for Sexual Health and Rights (AMSHER**
   $3,000,000
   Johannesburg, South Africa
2. **Genders & Sexualities Alliance Network**
   $2,580,455
   Oakland, CA
3. **National Center for Lesbian Rights (NCLR)**
   $1,545,000
   San Francisco, CA
4. **Astraea Lesbian Foundation for Justice**
   $1,510,200
   New York, NY
5. **Initiative Sankofa d'Afrique de l'Ouest (ISDAO)**
   $1,500,000
   Nairobi, Kenya
6. **Freedom for All Americans**
   $1,205,000
   Washington, DC
7. **Equality California Institute**
   $1,177,500
   Los Angeles, CA
8. **University of the Western Cape**
   $1,159,000
   Cape Town, South Africa
9. **Equality Federation Institute**
   $1,152,500
   San Francisco, CA
10. **Collective Foundation AIDS Accountability International**
    $1,150,000
    Södermalm, Sweden

[13] NOTE: Anonymous grantees received a total of $1,448,968 from private foundations. If they were one grantee, they would appear in the top ten list at number six.

PUBLIC FUNDER GRANTMAKING FOR LGBTQ ISSUES

In 2017, public foundations awarded $50.4 million to LGBTQ issues (or $49.8 million after dollars awarded for regranting are excluded). This represents a significant decrease of $36.8 million from 2016, when nearly $40 million in direct victim support following the Pulse Nightclub massacre elevated public foundation LGBTQ giving to an all time high of nearly $90 million.

The percentage of donor advised grantmaking from public foundations increased from eleven percent in 2016 to 20 percent in 2017.

TOP 10 LGBTQ PUBLIC FUNDERS

1. **Astraea Lesbian Foundation for Justice**
   $5,168,495
   New York, NY
2. **Elton John AIDS Foundation**
   $4,966,500
   New York, NY
3. **Horizons Foundation**
   $1,644,979
   San Francisco, CA
4. **Pride Foundation**
   $1,200,468
   Seattle, WA
5. **Black Tie Dinner**
   $1,154,999
   Dallas, TX
6. **Point Foundation**
   $818,668
   Los Angeles, CA
7. **Our Fund**
   $738,207
   Wilton Manors, FL
8. **Our Fund – Contigo Fund**
   $614,824
   Orlando, FL
9. **Funders for LGBTQ Issues**
   $505,000
   New York, NY
10. **Trans Justice Funding Project**
    $500,500
    New York, NY

TOP 10 NON-LGBTQ PUBLIC FUNDERS

1. **Tides Foundation**
   $7,596,762
   San Francisco, CA
2. **Borealis Philanthropy**
   $3,181,800
   Minneapolis, MN
3. **Strengthen Orlando - OneOrlando Fund**
   $2,106,525
   Orlando, FL
4. **American Jewish World Service**
   $1,984,369
   New York, NY
5. **NEO Philanthropy**
   $1,319,985
   New York, NY
6. **Groundswell Fund**
   $1,171,554
   Oakland, CA
7. **Robin Hood Foundation**
   $1,109,500
   New York, NY
8. **Broadway Cares/Equity Fights AIDS**
   $1,061,263
   New York, NY
9. **New York Women's Foundation**
   $959,500
   New York, NY
10. **amfAR, Foundation for AIDS Research**
    $950,122
    New York, NY

TOP 10 PUBLIC FUNDER GRANTEES[14]

1. **All Out**
   $2,330,000
   New York, NY
2. **New York LGBT Center**
   $1,297,580
   New York, NY
3. **Transgender Law Center**
   $941,098
   Oakland, CA
4. **Human Rights Campaign (HRC) Foundation**
   $595,225
   Washington, DC
5. **GMHC**
   $536,269
   New York, NY
6. **Gay and Lesbian Leadership Institute (Victory Institute)**
   $509,212
   Washington, DC
7. **International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA)**
   $496,163
   Geneva, Switzerland
8. **Hetrick-Martin Institute (HMI)**
   $465,472
   New York, NY
9. **BreakOUT!**
   $457,500
   New Orleans, LA
10. **Southerners On New Ground (SONG)**
    $412,922
    Atlanta, GA

[14] Anonymous grantees received a total of $4,886,665 from public funders - which includes $2.1 million in victim support distributed in a second round of payments following the Pulse Nightclub Massacre in Orlando. If they were one grantee, they would appear in the top ten list in the top spot.

APPENDIX: 2017 LIST OF LGBTQ GRANTMAKERS IN THE U.S.

FOUNDATION NAME	Total Grants	Direct Grant Dollars	Regranting Dollars	Total Dollars
AARP Foundation	1	$15,000		$15,000
AbbVie Foundation	1	$10,000		$10,000
Abelard Foundation	1	$10,500		$10,500
Adams Memorial Fund, Frank W. & Carl S.	2	$15,400		$15,400
Advocates for Youth	3	$52,480		$52,480
Aetna Foundation	1	$ 1,000		$ 1,000
Ahmanson Foundation	1	$ 7,500		$ 7,500
AHS Foundation	4	$81,000		$81,000
AIDS Foundation of Chicago	7	$52,185		$52,185
AIDS Funding Collaborative	6	$136,021		$136,021
AIDS United	17	$567,500		$567,500
Akron Community Foundation	2	$ 6,000		$ 6,000
Allstate Foundation	1	$ 1,000		$ 1,000
Ally Financial	1	$ 1,575		$ 1,575
Alphawood Foundation	29	$1,686,500		$ 1,686,500
Altman Foundation, Jeffrey A.	1	$ 5,000		$ 5,000
Amalgamated Bank	1	$ 2,500		$ 2,500
American Express Foundation	1	$100,000		$100,000
American Institute of Bisexuality	8	$200,776		$200,776
American Jewish World Service	90	$1,984,369		$ 1,984,369
amfAR, Foundation for AIDS Research	12	$950,122		$950,122
Andersen Foundation, Hugh J.	3	$29,000		$29,000
Andrus Family Fund	4	$256,000		$256,000
Annenberg Foundation	1		$12,500	$12,500
Anonymous Donors	51.5	$13,070,000	$2,500,000	$ 15,570,000

FOUNDATION NAME	Total Grants	Direct Grant Dollars	Regranting Dollars	Total Dollars
Anschutz Family Foundation, The	2	$12,500		$12,500
Anschutz Foundation, The	1	$ 5,000		$ 5,000
Appalachian Community Fund	3	$51,200		$51,200
Arabella Advisors	1	$ 2,500		$ 2,500
Arcus Foundation	147	$13,434,755	$3,572,000	$17,006,755
ARIA Foundation	8	$319,989		$319,989
Arizona Community Foundation	63	$658,276		$658,276
Asian Americans/Pacific Islanders in Philanthropy (AAPIP)	26	$60,000	$10,000	$70,000
Astraea Lesbian Foundation for Justice	246	$5,168,495		$5,168,495
AT&T Foundation	1	$10,000		$10,000
Auchincloss Foundation, Lily	1	$60,000		$60,000
Babson Charitable Foundation, Susan A. and Donald P.	10	$38,624		$38,624
Babson Foundation, Paul and Edith	5	$27,000		$27,000
Bank of America Charitable Foundation	44	$289,488		$289,488
Baron & Blue Foundation	1	$15,000		$15,000
Barr Foundation	1	$225,000		$225,000
Barra Foundation, The	2	$100,000		$100,000
Bastian Foundation, B. W.	46	$625,070		$625,070
Bernstein Memorial Foundation, Morey	1	$ 3,000		$ 3,000
Black Tie Dinner	20	$1,154,999		$1,154,999
Blandin Foundation	1	$180,000		$180,000
Blue Cross and Blue Shield of Minnesota Center for Prevention	1	$100,000		$100,000
Blue Shield of California Foundation	7	$227,000		$227,000
Bohnett Foundation, David	95	$1,392,981	$500	$1,393,481
Booth Ferris Foundation	2	$400,000		$400,000
Borealis Philanthropy	172	$3,181,800		$3,181,800
Boston Foundation	85	$610,050	$15,750	$625,800
Bread and Roses Community Fund	13	$72,376		$72,376
Bremer Foundation, Otto	7	$360,000		$360,000
Bristol-Myers Squibb Company	5	$33,500		$33,500
Broadway Cares/Equity Fights AIDS	58	$1,061,263		$1,061,263
Brother Help Thyself	34	$75,000		$75,000
Buffett Foundation, Susan Thompson	2	$300,000		$300,000
Bush Foundation	2	$110,000		$110,000
Cafritz Foundation, Morris and Gwendolyn	1	$42,400		$42,400
Calamus Foundation (Delaware)	15	$135,000	$50,000	$185,000
Calamus Foundation (New York)	16	$647,000		$647,000

FOUNDATION NAME	Total Grants	Direct Grant Dollars	Regranting Dollars	Total Dollars
California ChangeLawyers	1	$65,000		$65,000
California Community Foundation	116	$2,775,807	$3,000	$2,778,807
California Endowment, The	64	$3,780,111		$3,780,111
California Wellness Foundation	4	$815,000		$815,000
Calvin Klein Family Foundation	2		$20,000	$20,000
Campaign for Southern Equality	97	$53,151		$53,151
Campbell Foundation, The	5	$30,000		$30,000
CareOregon	4	$ 5,750		$ 5,750
Carmody Trust, The Kathrine C.	1	$10,000		$10,000
Casey Foundation, Annie E.	6	$87,500		$87,500
Casey Foundation, Marguerite	6	$822,500		$822,500
Celanese Foundation	1	$10,000		$10,000
Central Florida Foundation	18	$401,054	$ 5,000	$406,054
Chanin Foundation, Marcy and Leona	1	$ 2,000		$ 2,000
Charities Aid Foundation of America	1	$ 6,379		$ 6,379
Chernow Trust, Michael	1	$ 1,000		$ 1,000
Chicago Community Trust	2	$220,000		$220,000
Chicago Foundation for Women	5	$39,000		$39,000
Citi Foundation	1	$250,000		$250,000
Cleveland Foundation, The	13	$480,250		$480,250
Coca-Cola Foundation, The	3	$166,667		$166,667
COIL Foundation	5	$63,398		$63,398
Collins Foundation, The	7	$414,000		$414,000
Columbus Foundation	6	$42,799		$42,799
Comer Family Foundation	6	$32,000	$40,000	$72,000
Common Stream	2	$35,000		$35,000
Community Foundation for Greater Atlanta	1	$60,000		$60,000
Community Foundation for Northeast Florida	31.5	$515,900	$30,000	$545,900
Community Foundation for Southeast Michigan	30	$306,074		$306,074
Community Foundation for Southern Arizona	22	$66,835		$66,835
Community Foundation of Broward	15	$285,409	$200,411	$485,821
Community Foundation of Greater Birmingham	15	$110,580		$110,580
Community Foundation of Greater Fort Wayne	1	$ 2,420		$ 2,420
Community Foundation of Greater Greensboro	6	$123,703		$123,703
Community Foundation of Lorain County	1	$23,472		$23,472
Community Foundation of Louisville	2	$18,756		$18,756
Community Foundation of Middle Tennessee	4	$37,750	$45,000	$82,750
Community Foundation of Santa Cruz County	36	$128,850		$128,850

FOUNDATION NAME	Total Grants	Direct Grant Dollars	Regranting Dollars	Total Dollars
Community Foundation of Sarasota County	19	$126,188		$126,188
Community Foundation San Luis Obispo County	1	$ 5,000		$5,000
Community Foundation Serving Boulder County	35	$89,450		$89,450
Con Alma Health Foundation	1	$ 1,000		$1,000
Consumer Health Foundation	1	$30,000		$30,000
Core Health Foundation	1	$122,898		$122,898
Cream City Foundation	35	$123,500		$123,500
CREDO	1	$40,644		$40,644
Dallas Bears	1	$17,250		$17,250
Dallas Women's Foundation	1	$30,000		$30,000
DeCamp Foundation, Ira W.	2	$180,000		$180,000
deKay Foundation	1	$ 5,000		$5,000
Delaware Valley Legacy Fund	4	$ 9,600		$9,600
Design Industries Foundation Fighting AIDS (DIFFA)	15	$185,500		$185,500
District of Columbia Bar Foundation	1	$75,000		$75,000
Dollgener Memorial AIDS Fund, Greg	1	$ 1,000		$1,000
Doris Duke Charitable Foundation	2	$200,000		$200,000
Dwight Stuart Youth Fund	9	$226,000		$226,000
Dyson Foundation	4	$99,500		$99,500
Elizabeth Taylor AIDS Foundation	13	$144,700		$144,700
Elton John AIDS Foundation	74	$4,891,500	$75,000	$4,966,500
Esmond Harmsworth 1997 Charitable Foundation	9	$335,000		$335,000
Fels Fund, Samuel S.	3	$100,000		$100,000
Ford Foundation	32	$11,935,000	$510,000	$12,445,000
Foundation for a Just Society	13	$4,200,000	$440,000	$4,640,000
Foundation for Healthy St. Petersburg	3	$57,000		$57,000
Foundation for Louisiana	4	$79,500		$79,500
Foundation for the Carolinas - Charlotte Lesbian and Gay Fund	4	$45,300		$45,300
Fox Family Foundation, Frieda C.	1	$ 1,000		$1,000
Frameline	14	$36,817		$36,817
Freeman Foundation	14	$271,000	$65,000	$336,000
Fry Foundation, Lloyd A.	3	$105,000		$105,000
FSG	1	$ 2,500		$2,500
Fund For Global Human Rights	34	$482,466		$482,466
Funders for LGBTQ Issues	13	$235,000	$270,000	$505,000
Gamma Mu Foundation	37	$165,700		$165,700
Gates Foundation, Bill and Melinda	1	$15,000		$15,000

FOUNDATION NAME	Total Grants	Direct Grant Dollars	Regranting Dollars	Total Dollars
Gay Asian Pacific Alliance (GAPA) Foundation	13	$29,135		$29,135
GE Company	1	$10,000		$10,000
Geffen Foundation, David	1	$25,000		$25,000
Gerbic Family Foundation, Edward and Verna	1	$1,000		$1,000
Gilead Sciences	101	$8,930,648	$2,800,000	$11,730,648
Gill Foundation	80	$9,120,007	$400,000	$9,520,007
Gilmour-Jirgens Fund	1	$1,000		$1,000
GLMA: Health Professionals Advancing LGBT Equality	3	$50,005		$50,005
Global Fund for Women	23	$454,700		$454,700
Google	1	$1,000,000		$1,000,000
Grand Foundation, Richard	2	$35,000		$35,000
Grand Rapids Community Foundation	14	$83,000		$83,000
Grant Foundation, William T.	1	$25,000		$25,000
Grants for the Arts/San Francisco Hotel Tax Fund	17	$484,800		$484,800
Greater Barrington Foundation	1	$20,000		$20,000
Greater Kansas City Community Foundation	5	$1,203,950	$200,800	$1,404,750
Greater Milwaukee Foundation	2	$26,000		$26,000
Greater New Orleans Foundation	18	$95,722		$95,722
Greater Seattle Business Association	45	$350,000		$350,000
Greater Twin Cities United Way	2	$120,000		$120,000
Groundswell Fund	38	$1,126,554	$45,000	$1,171,554
Guilford Green Foundation	2	$20,000		$20,000
Gund Foundation, George	3	$250,000		$250,000
Haas Fund, Walter and Elise	5	$245,000		$245,000
Haas Jr. Fund, Evelyn and Walter	69	$5,038,200		$5,038,200
Hagedorn Fund	1	$30,000		$30,000
Haring Foundation, Keith	15	$380,000		$380,000
Harter Charitable Trust, John Burton	5	$87,500		$87,500
Hartford Foundation for Public Giving	10	$87,500		$87,500
Hayden Foundation, Charles	1	$100,000		$100,000
Hazen Foundation, Edward W.	2	$29,000		$29,000
Headwaters Fund for Justice	2	$34,000		$34,000
Health Foundation of Greater Indianapolis	1	$20,000		$20,000
Heinz Endowments, The	1	$13,050		$13,050
Hersh Foundation	1	$ 5,000		$ 5,000
Hewlett Foundation, William and Flora	9	$1,125,000		$1,125,000
Higginson Trust, Corina	1	$10,000		$10,000
Hill-Snowdon Foundation	2	$60,000		$60,000

FOUNDATION NAME	Total Grants	Direct Grant Dollars	Regranting Dollars	Total Dollars
Hoblitzelle Foundation	1	$54,315		$54,315
Hofmann Foundation, Kent Richard	2	$9,166		$9,166
Horizons Foundation	324	$1,632,479	$12,500	$1,644,979
Hormel Trust, James	1	$60,000		$60,000
Horwitz Foundation, Redlich	1	$25,000		$25,000
Human Rights Campaign	15	$180,850		$180,850
Hunt Foundation, Roy A.	1	$5,000		$5,000
Hyde and Watson Foundation	1	$15,000		$15,000
International Trans Fund	29	$500,000		$500,000
Intuit Foundation	15	$17,011		$17,011
Irvine Foundation, James	1	$50,000		$50,000
James Charitable Endowment Fund, Raymond	1	$5,000		$5,000
Jewish Communal Fund of New York	15	$906,917		$906,917
Jewish Community Federation of San Francisco, The Peninsula, Marin and Sonoma	4	$134,500		$134,500
Johnson & Johnson Family of Companies	1	$25,000	$100,000	$125,000
Johnson Family Foundation	30	$748,200	$50,000	$798,200
Johnson Foundation, Robert Wood	6	$71,800		$71,800
Junior League of Dallas	1	$5,000		$5,000
Just Fund Kentucky	18	$42,208		$42,208
Kaiser Permanente	4	$91,000		$91,000
Kalamazoo Community Foundation	1	$30,000		$30,000
Keith Founation Trust, Ben E.	2	$ 2,600		$ 2,600
Kellett Foundation, John Steven	6	$18,900		$18,900
Kerr Foundation, William A.	5	$67,500		$67,500
King Cole, Inc.	1		$19,500	$19,500
Knight Family Foundation	1		$37,500	$37,500
Knistrom Foundation, Fanny and Svante	1	$5,000		$5,000
Koffman, Betsy and Bates, Lorraine Family Fund	1	$25,000		$25,000
Kors Le Pere Foundation	1	$105,336		$105,336
LA84 Foundation	1	$2,500		$2,500
Langeloth Foundation, Jacob and Valeria	1	$2,500		$2,500
Larsen Foundation, John	4	$85,000		$85,000
Laughing Gull Foundation	6	$105,000	$50,000	$155,000
Leeway Foundation	14	$82,500		$82,500
Legg Mason Charitable Foundation	1	$700		$700
Levi Strauss Foundation	12	$1,045,500		$ 1,045,500
Liberty Hill Foundation	60	$604,960		$604,960

FOUNDATION NAME	Total Grants	Direct Grant Dollars	Regranting Dollars	Total Dollars
Lightner Sams Foundation	1	$15,000		$15,000
M.A.C. AIDS Fund	85	$4,803,389	$160,000	$4,963,389
MacArthur Foundation, John D and Catherine T.	5	$1,425,000		$ 1,425,000
Maine Community Foundation	8	$121,600		$121,600
Maine Health Access Foundation	3	$22,000		$22,000
Maine Women's Fund	2	$3,000		$3,000
Mandel, Amy and Rodis, Katina Fund	37	$1,037,710	$147,500	$1,185,210
Marguerite Casey Foundation	1	$7,500		$7,500
Marks Foundation, Carl	1	$1,000		$1,000
Masto Foundation	6	$15,500	$40,000	$55,500
McCarthy Foundation, Brian A.	7	$305,000		$305,000
McDermott Foundation, Eugene	1	$5,000		$5,000
McGregor Fund	2	$385,000		$385,000
McKenzie River Gathering	1	$10,000		$10,000
Mellon Foundation, Andrew W.	1	$1,159,000		$1,159,000
MetLife Foundation	9	$162,265		$162,265
Meyer Memorial Trust	14	$955,856		$955,856
Miami Foundation	46	$360,675		$360,675
Michaels Foundation, Howard and Jennifer	1		$6,250	$6,250
Miller Foundation, Herman and Frieda L.	1	$50,000		$50,000
Minneapolis Foundation	44	$89,394	$14,778	$104,172
Mirapaul Foundation	1		$12,500	$12,500
Missouri Foundation for Health	1	$209,688		$209,688
Moody Foundation	1	$20,000		$20,000
Moonwalk Fund, Silva Watson	14	$230,000		$230,000
Moriah Fund	2	$70,000		$70,000
Morrison and Foerster Foundation	11	$70,135		$70,135
Ms. Foundation for Women	3	$75,311		$75,311
Mukti Fund	3	$96,000	$1,000	$97,000
NEO Philanthropy	18	$1,319,985		$1,319,985
New York Community Trust, The	20	$803,250	$12,000	$815,250
New York Women's Foundation	19	$959,500		$959,500
New Yorkers for Children	1	$30,000		$30,000
Newpol Foundation	3	$35,000	$1,250	$36,250
Nordson Corporation Foundation, The	1	$13,000		$13,000
Nordstrom	1	$10,000		$10,000
Norris Preyer Fund, Marry	1	$5,000		$5,000
North Star Fund	21	$201,750		$201,750

FOUNDATION NAME	Total Grants	Direct Grant Dollars	Regranting Dollars	Total Dollars
Northrop Grumman	1	$2,500		$2,500
Northwest Area Foundation	4	$65,000	$60,000	$125,000
NoVo Foundation	7	$597,500	$165,000	$762,500
Ohio Transformation Fund	1	$40,000		$40,000
Omomuki Foundation	4	$25,940	$12,122	$38,062
Open Society Foundations	92	$7,577,998	$191,600	$ 7,769,598
Oregon Community Foundation	51	$341,983	$500	$342,483
Orlando City Soccer Club Foundation	2	$50,000		$50,000
Our Fund	236	$687,207	$51,000	$738,207
Our Fund - Contigo Fund	26	$614,824		$614,824
OUT Miami Foundation	5	$39,000		$39,000
Overbrook Foundation, The	14	$606,000	$155,000	$761,000
Packard Foundation, David and Lucile	1	$50,000		$50,000
Palette Fund	24	$1,114,325		$1,114,325
Parsons Foundation, Bob and Renee	1	$275,000		$275,000
Parsons Foundation, Ralph M.	1	$35,000		$35,000
Peace Development Fund	3	$132,431		$132,431
Pfund Foundation	33	$62,900		$62,900
Philadelphia Foundation	35	$347,252		$347,252
Pittsburgh Foundation, The	1	$10,000		$10,000
Point Foundation	97	$818,668		$818,668
Polk Bros. Foundation	6	$243,500		$243,500
Pride Foundation	348	$1,200,468		$1,200,468
Proteus Fund	9	$905,000		$905,000
Reynolds Babcock Foundation, Mary	1	$150,000		$150,000
Reynolds Foundation, Z. Smith	3	$105,000		$105,000
Richardson Fund, Anne S.	1	$30,000		$30,000
Richmond Memorial Health Foundation	2	$22,500		$22,500
Roaring Fork Gay and Lesbian Community Fund	1	$5,000		$5,000
Robin Hood Foundation	7	$1,109,500		$ 1,109,500
Roblee Foundation, Joseph H. and Florence A.	3	$50,000		$50,000
Rochester Area Community Foundation	14	$40,700		$40,700
Rockefeller Brothers Fund	1	$25,000		$25,000
Rockefeller Foundation	3	$300,000		$300,000
Rockefeller Philanthropy Advisors	1	$500		$500
Rohr Foundation, Mark & Rachel	1	$10,000		$10,000
Rolland Foundation, Ian and Mimi	1	$12,500		$12,500
Rorie Foundation, Ryan	1	$1,000		$1,000

FOUNDATION NAME	Total Grants	Direct Grant Dollars	Regranting Dollars	Total Dollars
Rosenberg Foundation	1	$750		$750
Rubin Foundation, Shelley and Donald	2	$30,000		$30,000
Rudin Family Foundation, May and Samuel	2	$75,000		$75,000
Samsara Foundation	1	$7,000		$7,000
San Diego Foundation	2	$36,350		$36,350
San Diego Human Dignity Foundation	18	$92,200	$300	$92,500
San Diego Pride	1	$6,000		$6,000
San Francisco Foundation	11	$186,857		$186,857
Santa Fe Community Foundation	22	$72,050		$72,050
Schott Foundation for Public Education	4	$105,000		$105,000
Seattle Foundation, The	5	$36,500		$36,500
Silicon Valley Community Foundation	10	$936,112		$936,112
Simmons Foundation, The	7	$240,000		$240,000
Skolnick Family Charitable Trust, The	1	$1,000		$1,000
Small Change Foundation	21	$501,000		$501,000
Snowdon Foundation, Ted	10	$277,000	$35,000	$312,000
Snyder Fund, Valentine Perry	2	$100,000		$100,000
Social Justice Fund Northwest	19	$183,906		$183,906
Southern Vision Alliance	5	$3,750		$3,750
Southwest Florida Community Foundation	1	$18,000		$18,000
Spartanburg County Foundation	5	$46,500		$46,500
Stonewall Community Foundation	142	$494,133		$494,133
Storr Family Foundation, The	1	$5,000		$5,000
Strengthen Orlando - OneOrlando Fund	302	$2,106,526		$2,106,526
Surdna Foundation	8	$66,100		$66,100
Tawani Foundation	18	$1,648,000		$ 1,648,000
TEGNA Foundation	1	$5,000		$5,000
Texas Pride Impact Funds	1	$11,000		$11,000
The LGBTQ Focus Foundation	5	$140,500		$140,500
Third Wave Fund	39	$391,800		$391,800
Tides Foundation	180	$7,524,762	$72,000	$ 7,596,762
TJX Foundation, The	6	$70,000		$70,000
Tov Adama Foundation	1	$2,500		$2,500
Trans Justice Funding Project	154	$500,500		$500,500
TurningPoint Foundation	1	$50,000		$50,000
Unitarian Universalist Program Veatch Program at Shelter Rock	7	$260,000	$70,000	$330,000
Unitarian Universalist Service Committee	4	$105,000		$105,000

FOUNDATION NAME	Total Grants	Direct Grant Dollars	Regranting Dollars	Total Dollars
United Way of Cleveland	1	$7,767		$7,767
United Way of Greater Cincinnati	1	$32,000		$32,000
United Way of Greater St. Louis	1		$60,000	$60,000
United Way of Metro Dallas	2	$180,000		$180,000
United Way of Tucson and Southern Arizona	1	$8,616		$8,616
Urgent Action Fund	38	$127,066		$127,066
van Ameringen Foundation, H	86	$4,349,500		$4,349,500
Vermont Community Foundation	23	$47,550	$36,000	$83,550.00
ViiV Healthcare	39	$2,742,325	$240,000	$2,982,325
Wallis Foundation	1	$5,000		$5,000
Warhol Foundation for the Visual Arts, Andy	2	$20,000		$20,000
Washington AIDS Partnership	5	$198,500		$198,500
Washington Area Women's Foundation	1	$500		$500
Washington Forrest Foundation	1	$3,000		$3,000
Weinberg Foundation, Harry and Jeanette	1	$200,000		$200,000
Wells Fargo	161	$3,339,971		$ 3,339,971
Wild Geese Foundation	21	$246,600		$246,600
Women's Foundation of California, The	11	$235,000		$235,000
Women's Foundation of Minnesota	1	$8,500		$8,500
Zarrow Family Foundation, Maxine & Jack	3	$4,000		$4,000
Zarrow Family Foundations	2	$6,500		$6,500
Zarrow Foundation, Anne and Henry	2	$45,000		$45,000
Zarrow Family Foundation, Maxine & Jack	1	$1,500		$1,500
Zarrow Foundation, Anne and Henry	2	$155,000		$155,000
Total	**6,297**	**$185,841,930**	**$13,087,261**	**$198,929,192**

METHODOLOGY & ACKNOWLEDGMENTS

METHODOLOGY

We surveyed the 2017 grantmaking activity of nearly 1,000 philanthropic entities in search of LGBTQ funding. All types of foundations were surveyed—private, public, community and corporate—as well as nonprofit organizations with grantmaking programs. Information was obtained predominantly through self-reporting by grantmakers, as well as through a review of 990s and annual reports. This report includes all information received as of December 20, 2018.

Our overarching research goal was to ensure that the data we collected focused specifically on LGBTQ issues and organizations. Therefore, the data set does not include grants to organizations or projects that are generally inclusive of LGBTQ people unless they explicitly address an LGBTQ issue or population. For example, a women's organization awarded a grant to develop a sex education curriculum for girls, open and welcoming to all girls, including LBTQ girls, would not have been included in the data. If that same organization was funded to provide sex education specifically to LBTQ girls, it would have been included.

We have included all re-granting dollars in charts that rank individual grantmakers and in the appendix to accurately show the overall level of LGBTQ funding provided by each grantmaker, regardless of whether those dollars are provided in the form of direct grants or through an intermediary that then re-grants those dollars to other organizations and individuals. As a result, the charts that rank grantmakers and the appendix "double-count" re-granting when aggregated. However, for all other tabulations and charts, we have not included dollars awarded for the purpose of re-granting, so as to avoid double counting.

ACKNOWLEDGMENTS

None of this work would be possible without our members and the other philanthropic entities who generously shared data on their grantmaking for LGBTQ communities. We are especially appreciative to our friends at Funders Concerned About AIDS (FCAA)—John Barnes, Sarah Hamilton, and Caterina Gironda—for sharing their LGBTQ-specific HIV/AIDS grantmaking data and for consistently being outstanding collaborative partners in our research efforts.

MISSION

Funders for LGBTQ Issues works to increase the scale and impact of philanthropic resources aimed at enhancing the well-being of lesbian, gay, bisexual, transgender and queer communities, promoting equity and advancing racial, economic and gender justice.

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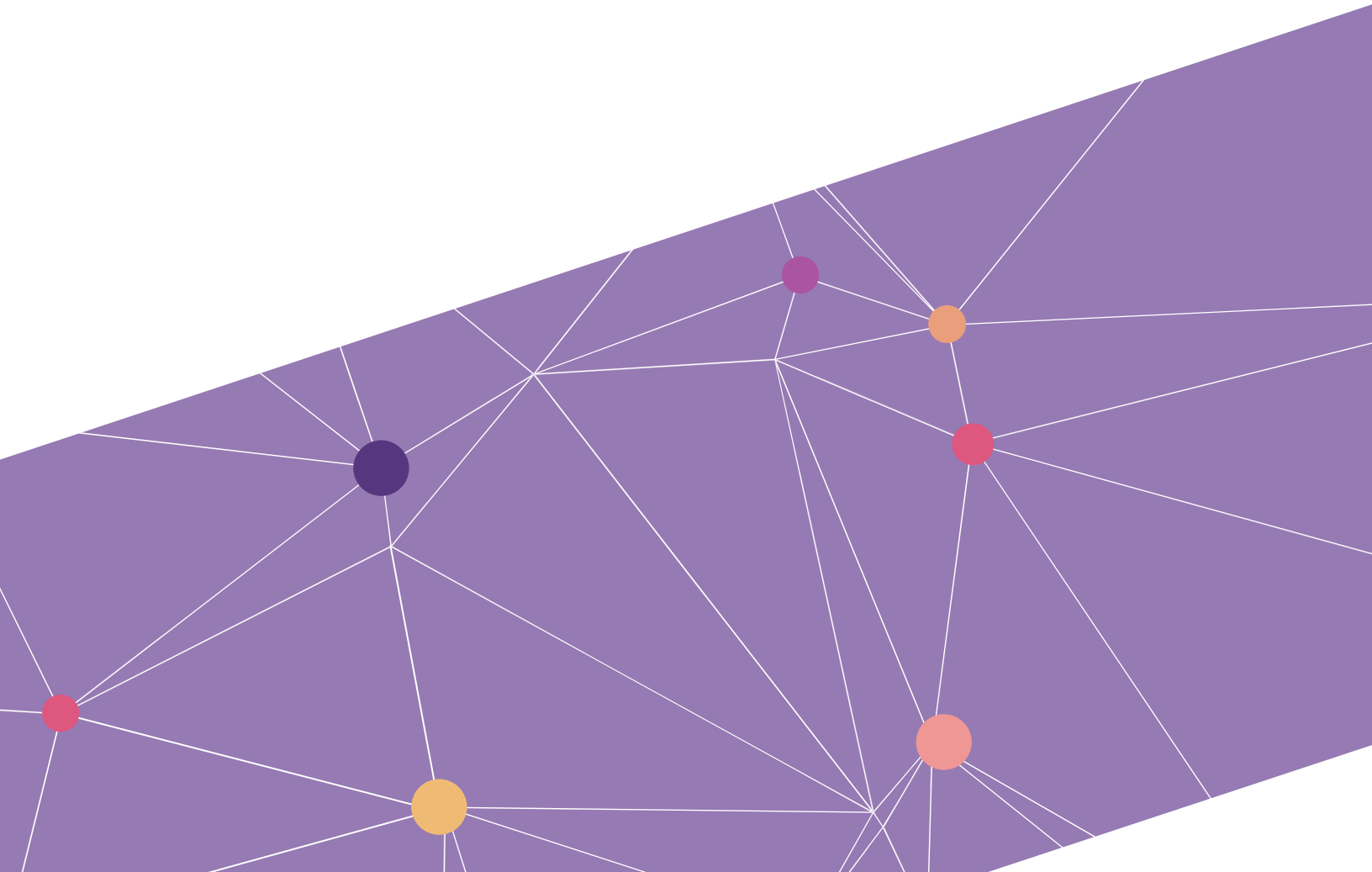


ADULT LGBT POPULATION IN THE UNITED STATES

UCLA School of Law Williams Institute

March 2019

Estimated number of LGBT adults in the US and by state

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

EXHIBIT D-27e

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

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

Suggested Citation: Adult LGBT Population in the United States. (February 2019). The Williams Institute, UCLA, Los Angeles, CA.

Methodological Notes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

UCLA School of Law Williams Institute

March 2019
Updated April 2019

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

KEY FINDINGS

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

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

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

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

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

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

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

EMPLOYMENT

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

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

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

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

PUBLIC ACCOMMODATIONS

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

RACE/ETHNICITY

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

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

SEX

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

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

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

METHODOLOGICAL NOTES

LGBT Workers

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

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

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

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

LGBT Students

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LGBT People

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

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

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

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

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

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

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

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

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

LGBT Adults (18+)

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

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

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

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

LGBT workers in public and private sector employment

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

Public accommodations by race/ethnicity and sex

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

RACE/ETHNICITY

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

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

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

SEX

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

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

PATHWAYS FORWARD

FOUNDATION FUNDING FOR LGBTQ IMMIGRATION ISSUES

BY DANILO MACHADO AND
BEN FRANCISCO MAULBECK

JULY 2014

FUNDERS FOR LGBTQ ISSUES

PATHWAYS FORWARD

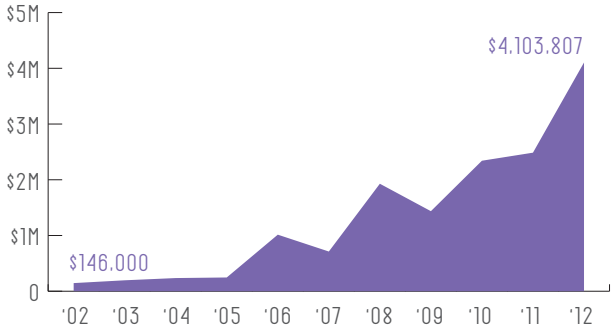
LGBTQ IMMIGRANT RIGHTS ARE MAKING PROGRESS ...

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

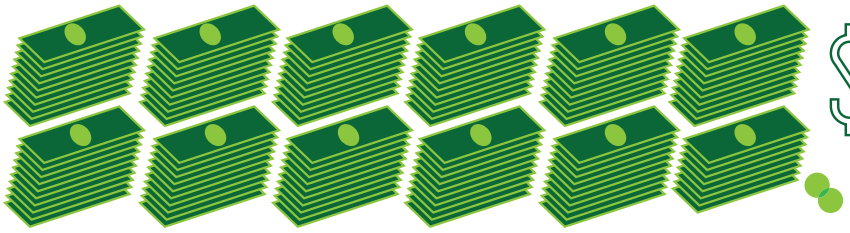
2008
BAN ON HIV-POSITIVE PEOPLE ENTERING THE U.S. IS LIFTED.

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

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



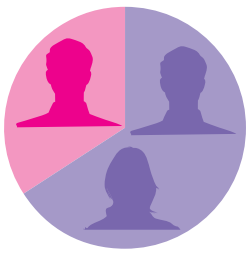
EVEN SO, LESS THAN ONE HALF OF ONE PERCENT OF ALL IMMIGRATION FUNDING SPECIFICALLY TARGETS LGBTQ IMMIGRANTS.



$99.50 VS. 50¢

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

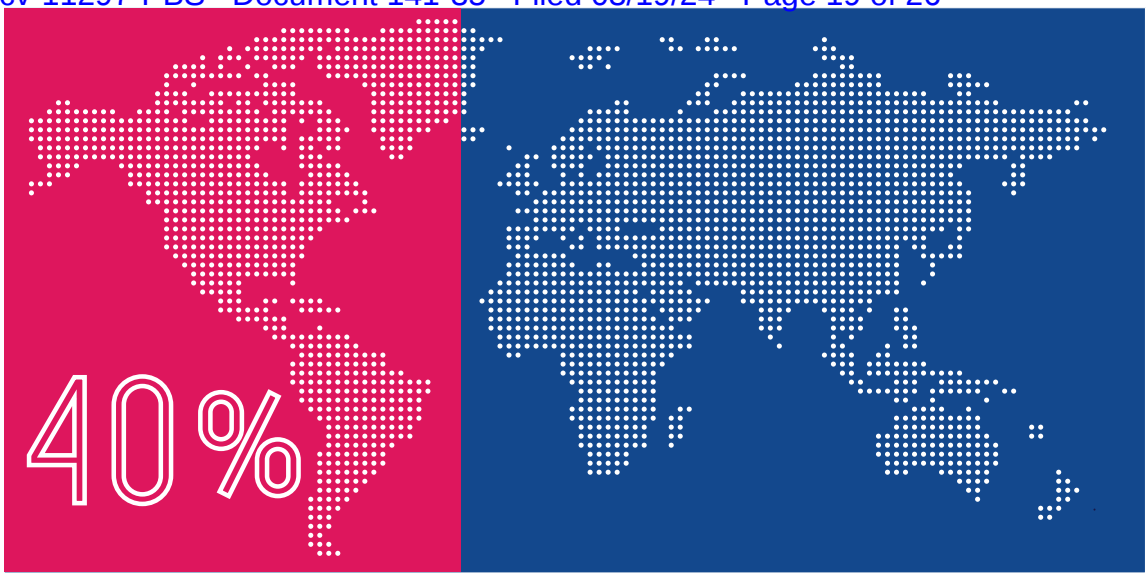
BUT MANY LGBTQ IMMIGRANTS ARE STILL LIVING IN THE SHADOWS. NEARLY A THIRD OF ALL LGBT ADULT IMMIGRANTS IN THE U.S. ARE UNDOCUMENTED.



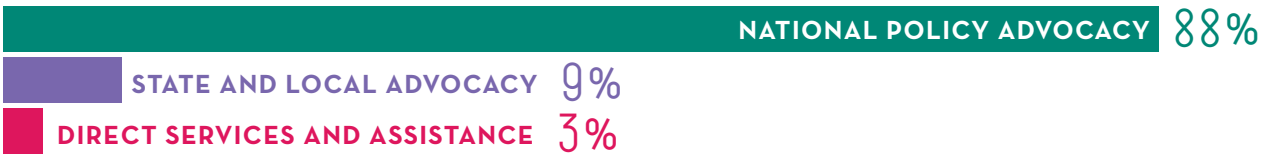
13X

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

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



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



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

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

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

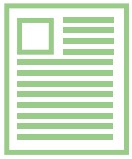
Fund advocacy and coalition-building around LGBTQ/ Immigration issues for the long term.

Support and develop LGBTQ immigrant leaders.

Strengthen state and local LGBTQ immigration advocacy.

Strengthen agencies and networks serving LGBTQ asylum seekers and immigrants.

Increase LGBTQ cultural competence of immigration service systems.



Provide financial assistance for immigration applications.

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INTRODUCTION

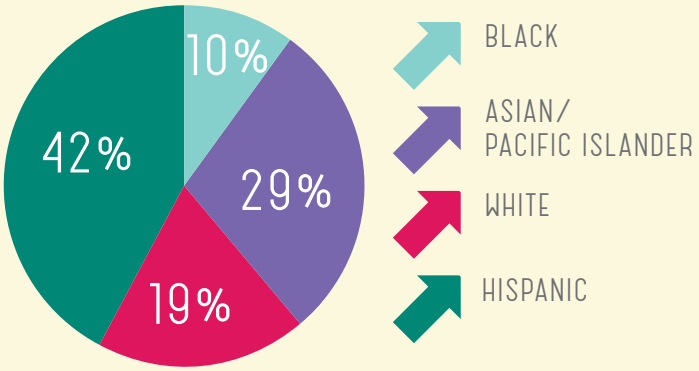
For most of the twentieth century, anyone who openly identified as gay, lesbian, bisexual, or transgender (LGBT) was banned from immigrating to the United States. HIV-positive people were also barred from entry. Until 2013, the immigration system denied recognition of LGBT families: the so-called Defense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

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

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

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

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



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

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

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

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

HIGHLIGHTS OF LGBTQ IMMIGRANT RIGHTS

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

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

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

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

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

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

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

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

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

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

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

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

LGBTQ ASYLUM SEEKERS

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

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

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

DETENTION

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

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

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

THE FUNDING

LGBTQ IMMIGRATION FUNDING: OVERVIEW AND CONTEXT

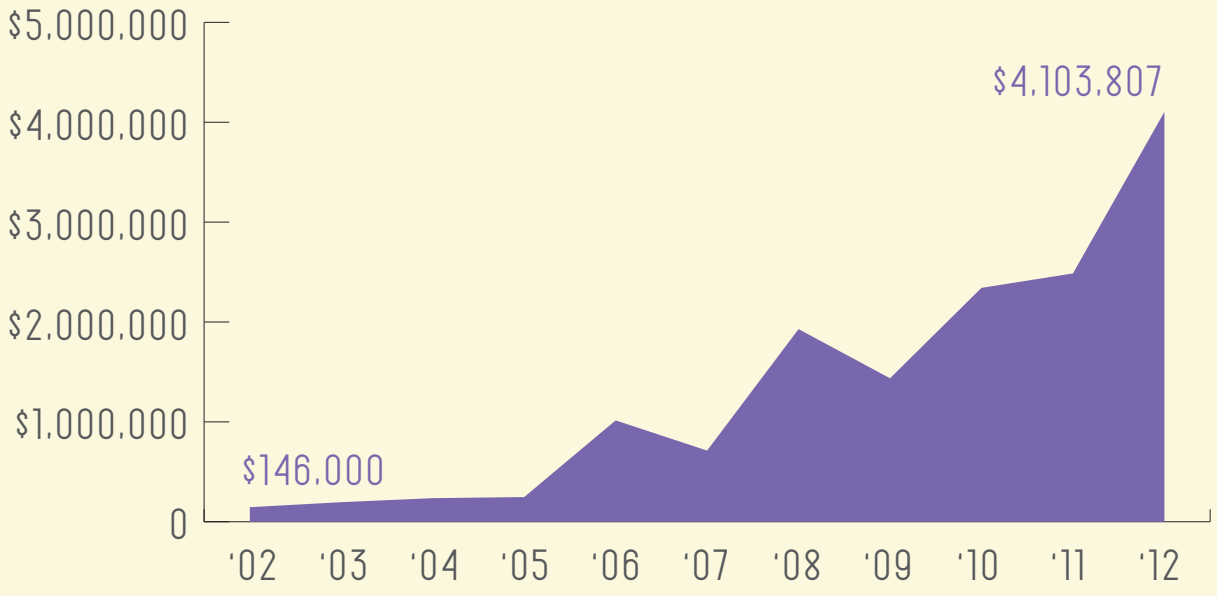
U.S. foundation funding for LGBTQ immigrants, refugees, and asylees around the globe has historically been modest, only recently exceeding $1 million annually. Nevertheless, it has grown rapidly—from barely $150,000 in 2002 to more than $4 million in 2012—an increase of more than 20-fold in just a decade.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

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

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

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

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



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

EXHIBIT D-27f

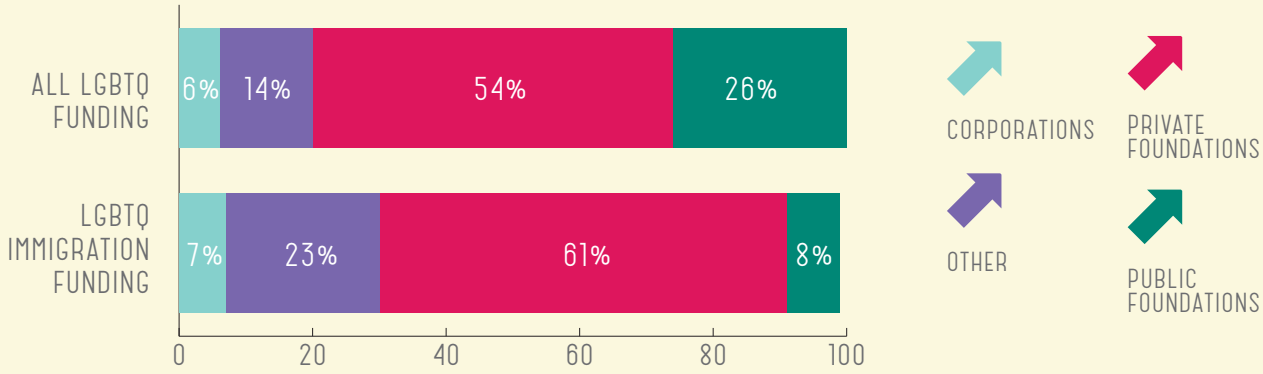
TOP TEN LGBTQ IMMIGRATION FUNDERS (2011-2012)

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

TOP TEN LGBTQ IMMIGRATION GRANTEES (2011-2012)

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

SOURCES OF FUNDING BY FOUNDATION TYPE (2011-2012)



THE ASSETS

THE ECOLOGY OF ORGANIZATIONS ADDRESSING LGBTQ IMMIGRATION ISSUES

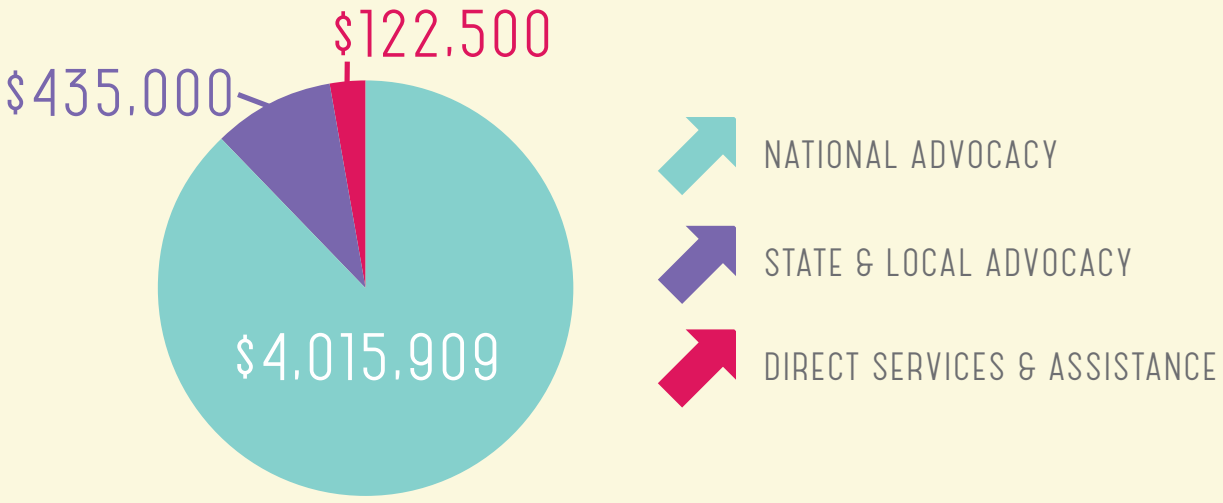
A range of organizations are working to address the needs of LGBTQ immigrants and asylum seekers in the U.S. Organizations working on LGBTQ immigration largely focus on one of three areas: (1) national policy advocacy; (2) state and local advocacy; and (3) direct services and assistance for LGBTQ immigrants.

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

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

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

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



INFRASTRUCTURE FOR NATIONAL ADVOCACY ON LGBTQ/IMMIGRATION ISSUES

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

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

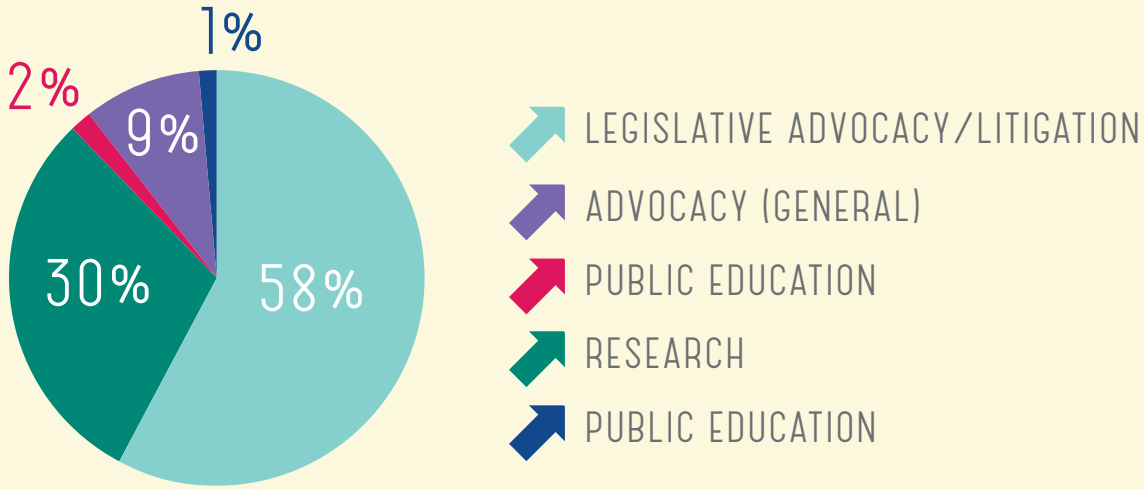
At the international level, the Organization for Refuge, Asylum, & Migration (ORAM), has played a leading role in educating and training non-governmental organizations and governments to be more inclusive and responsive to the needs of LGBTI refugees and asylum seekers. The International Gay & Lesbian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

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

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

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

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



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

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

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

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

WHAT IS DACA?

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

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

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

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

INFRASTRUCTURE FOR STATE AND LOCAL ADVOCACY ON LGBTQ/IMMIGRATION ISSUES

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

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

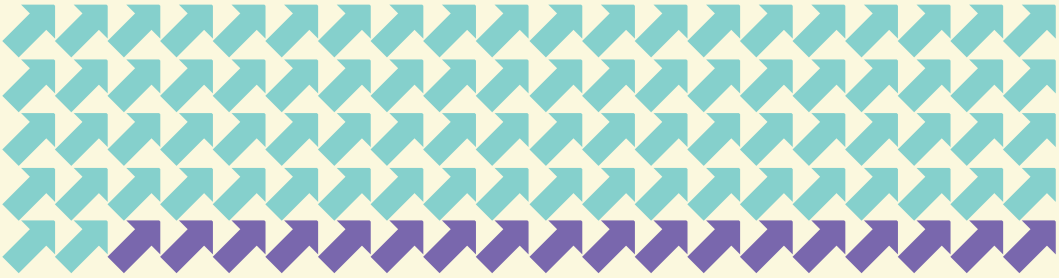
STATE ADVOCACY ORGANIZATIONS AND COALITIONS: In some states, state-level LGBTQ, Latino, or immigrant advocacy organizations have effectively advanced policies that benefit LGBTQ immigrants. In Oregon, Basic Rights Oregon, the state LGBT equality organization; Causa, the state Latino immigrant advocacy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

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

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

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

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



82%
STATE-LEVEL ADVOCACY

18%
LOCAL GRASSROOTS ORGANIZING

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

SERVICES INFRASTRUCTURE FOR LGBTQ IMMIGRANTS

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

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

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

FUNDER COLLABORATION ON LGBTQ IMMIGRATION ISSUES

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS

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

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

2. SUPPORT AND DEVELOP LGBTQ IMMIGRANT LEADERS.

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

3. STRENGTHEN STATE AND LOCAL LGBTQ IMMIGRATION ADVOCACY.

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

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

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

5. INCREASE CULTURAL COMPETENCE OF IMMIGRATION SERVICE SYSTEMS.

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

6. PROVIDE FINANCIAL ASSISTANCE FOR IMMIGRATION APPLICATIONS.

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

METHODOLOGY

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

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

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

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

ACKNOWLEDGEMENTS

Our sincere appreciation goes out to the Evelyn & Walter Haas, Jr. Fund, a leading funder on both LGBTQ and immigrant rights, whose support made this report possible. We also extend our gratitude to The Dream Summer National Internship Program of the UCLA Labor Center's Dream Resource Center, which allowed co-author Danilo Machado to conduct research for this report as an intern at Funders for LGBTQ Issues.

Many thanks to the many experts and leaders who took the time to be interviewed for our research: Robert Bray, Four Freedoms Fund; Monica Enriquez, Astraea Foundation; Sharita Gruberg, Center for American Progress; Jorge Gutierrez, Familia: Trans Queer Liberation Movement; Alice Hom, Asian-American/Pacific Islanders in Philanthropy; Sergio Lopez, Freedom to Marry; Rachel Tiven, former executive director of Immigration Equality; and Geoffrey Winder, GSA Network.

We would also like to acknowledge several board members and members who served as initial readers of early drafts of the report, and provided helpful feedback and edits: Surina Khan, Andrew Lane, and Cindy Rizzo. Finally, we are deeply grateful to Max Niedzwiecki of the LGBT Faith and Asylum Network, Marco Quiroga and Trystan Reese of Immigration Equality, and Felipe Sousa-Rodriguez of United We Dream for offering thoughtful advice, expertise, and resources at several points during the research and writing of this report.

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Ben Francisco Maulbeck has served as president of Funders for LGBTQ issues since December 2012. He has more than a decade of experience as a leader, grantmaker, and fundraiser for LGBT rights, racial equity, and social change. From 2007 through 2012, he worked at Hispanics in Philanthropy (HIP), most recently serving as Vice President. Prior to that, Maulbeck served as director of programs for the William Way LGBT Community Center and as a program associate at the Philadelphia Foundation. He previously chaired the board of GALAEI, a queer Latino social justice organization in Philadelphia, and has degrees from Swarthmore College and the Harvard Kennedy School of Government.

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LYLE MATTHEW KAN

Lyle Matthew Kan is Director of Communications and Education at Funders for LGBTQ Issues. Lyle is also a part of the grants review committee for the Queer Youth Fund at Liberty Hill Foundation, which has invested more than $4.6 million in innovative and effective leadership development and organizing projects that empower LGBTQ youth. From 2011-2013, Lyle led development and communications efforts at Stonewall Community Foundation. Prior to that, Lyle worked at the Foreign Policy Association and in the private sector specializing in business development and branding. Lyle holds a B.A. from New York University and a M.Sc. from the London School of Economics and Political Science.

MISSION

Funders for LGBTQ Issues works to mobilize the philanthropic resources that enhance the well-being of lesbian, gay, bisexual, transgender and queer communities, promote equity and advance racial, economic and gender justice.

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August 13, 2019

Department of Health and Human Services
Office for Civil Rights
Attention: Section 1557 NPRM, RIN 0945–AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Re: Comments on HHS Proposed Rule on Nondiscrimination in Health and Health Education Programs or Activities (RIN 0945–AA11)

Dear OCR Director Roger Severino:

On behalf of the Massachusetts Medicaid and CHIP programs (MassHealth), I am writing to provide comments on the HHS Proposed Rule[1] on Nondiscrimination in Health and Health Education Programs or Activities, and its associated proposed conforming changes, as published in the Federal Register on June 14, 2019. 84 FR 27860 (the Proposed Rule). The Proposed Rule substantially revises HHS' regulations under Section 1557 of the Patient Protection and Affordable Care Act (ACA § 1557), codified at 45 CFR part 92 (the 1557 Regulations). MassHealth opposes the Proposed Rule and respectfully requests that it be withdrawn.

MassHealth provides comprehensive, affordable health insurance coverage to approximately 1.8 million residents of the Commonwealth, including 40% of all Massachusetts children and 60% of all residents with disabilities. MassHealth's mission is to improve the health outcomes of our diverse members, their families and communities by providing access to integrated health care services that sustainably promote health, well-being, independence and quality of life.

[1] https://www.govinfo.gov/content/pkg/FR-2019-06-14/pdf/2019-11512.pdf

MassHealth strongly opposes the Proposed Rule because it exposes vulnerable populations to potential discrimination, erodes access to language assistance for individuals with limited English proficiency (LEP), and limits the ability of individuals to seek assistance when they have experienced discrimination.

Such revisions are likely to result in both increased barriers to care for some of our most vulnerable members, and ultimately higher health care costs if such individuals are discouraged from seeking primary and preventive care services. Further, these changes are likely to create considerable confusion among state agencies, Medicaid managed care programs (as well as integrated care programs such as PACE), and other entities who have already taken substantial steps to ensure their programs comply with the current regulations.

Proposed Changes could Lead to Discrimination in Vulnerable Communities, including against the LGBTQ Community

HHS proposes to eliminate the definitions set forth at section 45 CFR 92.4, which include, among other important clarifying definitions, additional detail on what constitutes discrimination on the basis of sex. MassHealth is strongly opposed to the removal of these definitions. If finalized, HHS' proposed changes would eliminate the current regulation's prohibition of discrimination on the basis of gender identity and sex stereotyping, which will likely lead to increased barriers to care for members of LGBTQ communities.

LGBTQ individuals and others with diverse sexual orientations and gender identities experience significant health challenges and higher rates of illness when compared to other groups,[2] making access to equitable treatment and care for these populations especially important. For instance, LGBTQ individuals are at increased risk for adverse health outcomes, including[3] increased risk for suicide, HIV and other sexually transmitted diseases (STDs), and are less likely to seek care for behavioral health services, cancer, depression, and smoking. Higher rates of chronic diseases such as lifetime asthma, arthritis, and obesity are of major concern especially among lesbians and bisexual women.[4] Beyond adverse health outcomes for individuals, increased barriers to care for LGBTQ communities can also lead to negative public health outcomes including higher rates of HIV and STDs, and other serious consequences.[5]

At the same time, LGBTQ individuals can also face discrimination when trying to access needed care. For example, among transgender individuals who had visited a doctor or health care provider's office in the past year, 29% reported that a doctor or other health care provider refused to see them because of their gender identity.[6] Further, LGBTQ individuals also experience discrimination in accessing housing and are at increased risk for homelessness, which has also been shown to lead to poor health outcomes. These health disparities are often compounded for LGBTQ individuals of

[2] https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health?topicid=25
[3] www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3490559/pdf/AJPH.2011.300379.pdf
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3490559/pdf/AJPH.2011.300379.pdf
[6] https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/

color, and/or LGBTQ individuals living with disabilities.[7] The results from a study reported in the *American Journal of Public Health* suggest that disparities in chronic health conditions, health risk behaviors, and poor physical and mental health among LGBTQ adults may contribute to the heightened prevalence of disability. Higher mental distress prevalence among all of the groups and higher poor physical health among gay men and bisexual women and men are also significant indicators of disability.[8]

The proposed changes to this rule would allow providers and plans to discriminate against individuals on the basis of sex, including gender identity and sexual orientation, by denying or limiting health care coverage for LGBTQ individuals, and/or requiring higher cost sharing amounts for their care. Such actions could range from excluding coverage or denying care for medically necessary, gender-affirming care to transgender individuals, to refusing to serve LGBTQ individuals altogether, even for routine preventive care such as primary care visits or flu shots.

Adverse health outcomes for this population are also likely to lead to higher costs for MassHealth, other state Medicaid programs and Medicare, particularly if groups of members facing discrimination are unable to access, or are discouraged from accessing, primary or preventive health services, and must ultimately resort to more expensive urgent or emergency care.

The Proposed Rule's Religious and Abortion Exemptions for Providers Could Harm Public Health

The Proposed Rule would allow health care providers and other covered entities to invoke blanket abortion and religious objection exemptions from the regulation's general prohibition on sex discrimination. These exemptions could allow providers to create barriers for individuals, particularly women who may be stigmatized for their medical history, seeking medically necessary care, potentially jeopardizing their health. The Proposed Rule could result in situations where members seeking health care services (including abortion or other health care services) are denied, delayed, or discouraged from seeking necessary care, placing them at risk of serious or life-threatening results in emergencies and other circumstances, especially when the individual's choice of health care provider is limited. For example, the Proposed Rule allows health care staff and providers to refuse women reproductive care, such as an emergency abortion to protect the life or health of the mother. Furthermore, an individual's choice of health care provider may be limited, especially in rural areas, to hospitals or other provider sites that are run by religious institutions.

In the event that HHS elects to finalize those exemptions, it should adopt additional safeguards to protect members seeking necessary services. Specifically, MassHealth urges HHS to require covered providers declining to provide services because of religious or moral objections to inform the patient about alternative means for accessing health care services which they are entitled to receive under federal Medicaid law.

[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3490559/pdf/AJPH.2011.300379.pdf
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3490559/

Access to Language Assistance Improves Health and Lowers Costs

The 1557 Regulations required covered entities to provide language assistance services, multi-language "taglines," and nondiscrimination notices to ensure meaningful access for *each* limited English proficiency (LEP) individual. The Proposed Rule requires "reasonable steps to provide meaningful access" to LEP individuals, in general and not to each specific individual, as required by the current rule. The Proposed Rule would relax the current requirement to provide meaningful access to each individual by adopting a four-part balancing test which would allow covered entities to potentially deny language assistance services to an LEP member who needs them when a covered entity decides the costs of doing so outweigh the benefits. MassHealth recommends that HHS should continue to require providers and plans to provide meaningful access to such interpretation and translation services for each LEP individual.

Additionally, HHS' Proposed Rule would also repeal the current rule's requirement that covered entities develop, post, and/or provide prescribed notices and taglines. Because such notices and taglines facilitate communication for LEP individuals within the health care system, MassHealth recommends that HHS should also continue to require their use.

Relaxing the current standards could limit access to necessary care, jeopardize patient safety and incur higher costs. LEP patients who do not receive professional interpretation at admission and discharge have longer lengths of stay and higher readmission rates compared to patients who receive professional interpretation services.[9] Studies show that LEP patients experience high rates of medical errors with worse clinical outcomes than English-proficient patients and receive lower quality of care by other metrics.[10] Patient safety can be impacted by poor patient comprehension of their medical condition, treatment plan, discharge instructions, complications, and follow-up; inaccurate and incomplete medical history; ineffective or improper use of medications or serious medication errors; improper preparation for tests and procedures; and poor or inadequate informed consent.

In fact, research has shown this issue extends beyond the patient's ability to communicate with their doctors. In a recent survey of 15,800 physicians about the topic of bias, 32% of physicians (both male and female) admitted they held specific bias towards patients for whom there was a language difference.[11] Despite evidence and professional standards that call for interpreter services, health care providers often try to "get by" with their own limited language skills or with ad hoc interpreters such as accompanying family members. Easing access to language services has been shown to improve patient care.[12]

While there may be potential cost savings to Medicaid agencies associated with changes to translated member communications as a result of the relaxed requirements in the Proposed Rule, HHS should balance these potential savings against the potentially increased costs incurred when members are unable to communicate with, or understand information provided by, their providers,

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3445680/
[10] AMA J Ethics. 2017;19(3):263-271. doi: 10.1001/journalofethics.2017.19.3.medu1-1703.
[11] https://connectwithpartners.org/2016/09/07/tackling-lep-issues-at-mgh
[12] https://www.ncbi.nlm.nih.gov/books/NBK43719/

health plans, or insurers. This is especially true if individuals are unable to access primary/preventive care services and ultimately require urgent or emergency care.

Grievance Process Helps Vulnerable Members

The 1557 Regulations required larger covered entities, including state Medicaid agencies, to develop a grievance procedure and designate a compliance coordinator to investigate grievances alleging violation of the 1557 Regulations. The Proposed Rule would eliminate these requirements.

MassHealth urges HHS to retain the requirements that larger covered entities (1) designate a responsible employee to coordinate efforts to comply with the 1557 Regulations and (2) adopt grievance procedures that guide the resolution of such grievances. Investigations conducted by Section 1557 Compliance Coordinators may prompt corrective measures for individuals who experience discrimination within entities such as hospitals, managed care plans and doctors' offices, including dual eligible members (who are especially vulnerable by virtue of being low income, elderly and/or disabled).

HHS Request for Comments: Access and Accommodation Standards for Persons with Disabilities

HHS seeks comment on whether to maintain current access standards for persons with disabilities, although the agency has not proposed changes to those standards at this time. MassHealth strongly urges HHS to maintain existing standards to ensure access to care and reasonable accommodations for persons with disabilities. A significant portion of MassHealth members have disabilities, and the existing access and accommodations requirements are critical to ensuring that these members are able to apply for and maintain MassHealth coverage to properly access the benefits and services they need to maintain health and independence. This includes the provision of auxiliary aids and services to ensure effective communication, requiring compliance with ADA construction and architectural standards, and providing reasonable modification in policies, practices and procedures to prevent discrimination. Further, Massachusetts has worked closely with CMS, its members, and other stakeholders on the State Demonstration to Integrate Care for Dual Eligible Individuals (known as One Care), which is explicitly designed to improve care and reduce costs for dual eligible individuals ages 21 to 64 who are living with disabilities. As with the other proposed changes to this rule, removing these protections for individuals with disabilities could lead to increased barriers to care and reduced access to benefits and services, resulting in poorer health outcomes and increased costs for dual eligible populations. These impacts could jeopardize the potential of innovative initiatives, like One Care, which are expressly designed to improve the lives and health care experiences of these communities but which depend on the ability of members to access critical benefits and services to be successful.

Conclusion

The proposed revisions to the 1557 Regulations would negatively impact the lives of the diverse communities that make up the Commonwealth and would perpetuate inequality among some of MassHealth's most vulnerable groups of members. The proposed revisions are also in direct conflict with MassHealth's goals promoting health equity and reducing health disparities.

For these reasons, and the reasons detailed above, MassHealth respectfully requests that HHS withdraw the Proposed Rule and revert to the 1557 Regulations. Massachusetts appreciates the opportunity to comment on this Proposed Rule and looks forward to continuing to work with the Administration to strengthen and improve the Medicaid program and public health. Thank you for consideration of these comments.

Sincerely,

Daniel Tsai
Assistant Secretary for MassHealth and Medicaid Director

cc: Marylou Sudders, Secretary, Executive Office of Health and Human Services

EXHIBIT D-29

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

August 6, 2019

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

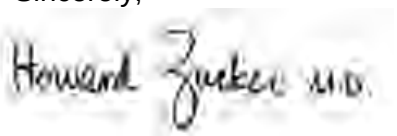
Re: Center for Medicare & Medicaid Services' Notice of Proposed Rulemaking (Docket No.: HHS-OCR-2019-0007; RIN 0945-AA11)

To Whom it May Concern:

The New York State Department of Health (NYSDOH) submits the following comments in response to the notice in the Federal Register soliciting comments on the Proposed Rule regarding "Nondiscrimination in Health and Health Education Programs or Activities" (84 Fed. Reg. 27846). NYSDOH supervises the administration of a wide range of programs that provide services and support to low-income families and individuals. The mission of NYSDOH is to protect, improve and promote the health, productivity and well-being of all New Yorkers.

Thank you for the opportunity to comment.

Sincerely,



Howard A. Zucker, M.D., J.D.
Commissioner

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

New York State Department of Health

Comments in Response to the Center for Medicare & Medicaid Services' Notice of Proposed Rulemaking

The New York State Department of Health (NYSDOH) strongly opposes the rule proposed by the Centers for Medicare & Medicaid Services, titled "Nondiscrimination in Health and Health Education Programs or Activities" (hereinafter, "Proposed Rule"). Among other things, this rule would roll back crucial protections for vulnerable populations nationwide, such that individual healthcare providers or healthcare plans will no longer be prohibited under federal law from denying treatment or healthcare coverage to individuals who are transgender or gender non-conforming, or persons who have received or are seeking an abortion.

I. Opposition to the Proposed Rule's Discrimination Provisions

A. New York State Nondiscrimination Laws and Policies

In New York State, it is unlawful to deny equal access to healthcare because of gender identity or expression; indicate that transgender persons are unwelcome or objectionable; refuse to use a transgender person's legal name; refuse to refer to a transgender person by that person's requested pronouns; deny the use of restrooms or other facilities consistent with a person's gender identity; or refuse to treat a transgender person because that person has complained about discrimination.

In 2016, New York State Division of Human Rights (NYSDHR) adopted regulations on gender identity which clarified that discrimination on the basis of gender identity is a form of sex discrimination. These regulations provide that the term "sex," when used in the Human Rights Law, includes gender identity and the status of being transgender, and that harassment on the basis of a person's gender identity or the status of being transgender constitutes sexual harassment (9 NYCRR 466.13[c]).

In 2019, with the passage of the Gender Expression Non-Discrimination Act (GENDA), "gender identity or expression" was added as an explicit protected class under the Human Rights Law (Laws 2019, ch 8, §§ 2,3). The term "gender identity or expression" means "a person's actual or perceived gender-related identity, appearance, behavior, expression, or other gender-related characteristic regardless of the sex assigned to that person at birth, including, but not limited to, the status of being transgender" (N.Y. Exec. Law § 292[35]). Discrimination based on gender identity or expression is prohibited in all places of public accommodation, including hospitals and other healthcare providers (*id.* § 296).[1] These legal amendments only serve to

[1] *See also* NYSDHR, "New Yorkers are Protected from Gender Identity Discrimination by Hospitals," https://dhr.ny.gov/sites/default/files/pdf/postings/DHR_Gender_Identity_Handout.pdf.

amplify what has been the longstanding understanding in New York State: that sex stereotyping and discrimination based on gender identity are forms of sex discrimination.

At that time, NYSDOH also amended the Hospital Patients' Bill of Rights to expressly require all hospitals in New York State to update their statements of patient rights to prohibit discrimination against transgender patients (10 NYCRR 405.7). These regulations required hospitals to affirmatively inform patients of their rights related to gender identity.

Further, New York State's Reproductive Health Act, which codified into state law the reproductive health protections articulated in *Roe v. Wade*, has made New York State a national leader in this area by allowing New Yorkers to make confidential, personal healthcare decisions with their healthcare provider. The Reproductive Health Act is one piece of New York State's commitment to ensuring that individuals are not treated differently based on their reproductive health choices.

Consistent with New York State law, all programs within the Department of Health provide eligible services to individuals regardless of sexual orientation and gender identity or reproductive health choices. NY State of Health (NYSOH)—New York State's Official Health Plan Marketplace—helps New Yorkers enroll in healthcare programs like Medicaid, Child Health Plus, the Essential Plan, and Qualified Health Plans (QHP) and explains what financial assistance is available to help applicants purchase health insurance. These services have always been, and will continue to be, provided regardless of an applicant's sex or gender identity, including identification as an LGBTQ individual. Additionally, the Comprehensive Family Planning and Reproductive Health Care Services Program within the Department's Division of Family Health provides comprehensive, confidential reproductive health services for approximately 300,000 low-income, uninsured and underinsured New Yorkers of reproductive age, including adolescents, through a statewide network of 48 grant-funded healthcare facilities that operate 172 service sites.

B. The Proposed Rule's Effect on Healthcare Discrimination in New York State and Nationwide

NYSDOH understands that the Proposed Rule does not prohibit states from providing greater protections for individuals, and New York State will continue to mandate stronger protections given the importance of equal access to healthcare. Nevertheless, NYSDOH remains concerned about New Yorkers' welfare if this Proposed Rule goes into effect given the regularity and ease of interstate travel. New Yorkers traveling out of state who find themselves in need of medical care should not fear discriminatory conduct merely because they visit a hospital outside of New York State, nor should they be forced to forego necessary medical care rather than risk harassment at an out-of-state healthcare facility. If the federal government is to set the floor for nondiscriminatory conduct, by which all covered healthcare entities must abide, that floor must be higher than the standard set forth in the Proposed Rule. Otherwise, federal law will aggravate existing disparities to healthcare access and harm individual health. As a matter of principle, NYSDOH firmly believes that disparities in access to healthcare must be reduced, not enhanced.

Further, notwithstanding New York State's expansive legal protections, NYSDOH anticipates that the Proposed Rule will negatively impact the healthcare industry nationwide by creating confusion among healthcare employees and recipients alike as to their rights and obligations. In New York State, covered healthcare entities may believe the federal rules prevail rather than New York State's stronger nondiscrimination provisions. NYSDOH will therefore be forced to expend additional resources to monitor reports of LGBTQ individuals being turned away from care based on their identity. Nationwide, the Proposed Rule permits even single healthcare entities to implement varying policies on nondiscrimination across its services depending on whether its healthcare activities are funded by HHS. As a result, vulnerable individuals may receive varying care (or no care at all) merely depending on where they live or which healthcare facility they choose to visit. These healthcare disparities cannot stand.

Finally, by removing "termination of pregnancy" from the definition of sex discrimination, the Proposed Rule could have far-reaching impacts on reproductive health. The Proposed Rule seeks to undo the goals of the New York State Reproductive Health Act by impeding an individual's ability to make personal healthcare decisions without fear of discrimination or retaliation. Such fears could prevent individuals from seeking safe, quality healthcare and promote poor outcomes for infants and their families. Individuals seeking emergency care after a termination could be denied services or referred to a facility at great distance due to healthcare providers' moral or religious objections to the individual's reproductive health choice.

II. Opposition to the Proposed Rule's Limited English Proficiency and Tagline Provisions

As part of its commitment to protecting vulnerable populations, New York State strives to ensure language access. Nearly 1 in 4 New Yorkers (over 4.7 million) have comprehensive health coverage though the NYSOH Marketplace across all 62 counties of the State. Twenty-two percent of these Marketplace enrollees indicated a preferred written language other than English. Providing information and assistance to consumers in their preferred language has been critical to reaching populations with historically higher uninsurance rates. Accordingly, the NYSOH Customer Service Center answered nearly 300,000 calls in one of 101 languages over the course of the most recent open enrollment period, and NYSOH navigators assist consumers in 41 different languages.

The Proposed Rule eliminates the requirement that covered entities include the notice of nondiscrimination and taglines in at least the top 15 languages in significant publications and communications. The currently-required notices are so integrated into NYSOH's processes, including system-generated notices and consumer education materials, that eliminating the notice of nondiscrimination and taglines from notices would result in significant cost increases to New York State. Indeed, NYSOH estimates that removing taglines and testing new notices to ensure they are displaying the correct messages will cost New York State $2 million upon implementation of the Proposed Rule. The human toll is just as costly; removing language access would indirectly increase costs by diminishing public knowledge of the means and methods for accessing health insurance, and regressing gains made in reducing uninsured rates among persons with limited English proficiency.

By limiting protections for persons with limited English proficiency, the Proposed Rule stands to interfere with NYSOH's ability to serve the State's most vulnerable populations, and risks reversing the important progress that has been made in reducing uninsurance rates across the State.

III. Conclusion

NYSDOH adamantly opposes adoption of the Proposed Rule. As the agency whose mission it is to protect, improve and promote the health, productivity and well-being of all New Yorkers, NYSDOH has serious concerns with the Proposed Rule. The prospect of denying vital health services to individuals based on gender identity, sexual orientation, or reproductive choices is dangerous and has the potential to harm the physical health and well-being of these individuals.

EXHIBIT D-30

August 13, 2019

VIA ELECTRONIC SUBMISSION

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Section 1557 NPRM, RIN 0945-AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201.

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

AccessMatters is pleased to submit comments to the Department of Health and Human Services' (HHS) notice of proposed rulemaking (NPRM), "Nondiscrimination in Health and Health Education Programs or Activities," published in the *Federal Register* on June 14, 2019.

AccessMatters is a 501(c)3 non-profit public health organization that innovates, empowers, and works to equalize the access to sexual and reproductive health care for youth and adults in need. Through our unique abilities to engage underserved communities, we are closing the gap between those with access to sexual and reproductive health care and those without.

AccessMatters has worked for over 45 years to ensure individuals, families, and communities have continued access to comprehensive family planning, and related preventative health services through our network of partner organizations. As the Title X Family Planning grantee for Southeastern Pennsylvania, and the largest Ryan White Part D grantee in Philadelphia, we are a critical part of the region's healthcare safety net. We also administer the Pennsylvania Breast and Cervical Cancer Early Detection Program (PA-BCCEDP) – formerly called the HealthyWoman Program – that aims to reduce breast and cervical cancer morbidity and mortality by increasing access to preventive health screenings and follow-up diagnostic services at no cost to patients.

In 2018, AccessMatters' network of Title X Family Planning providers served 103,022 family planning patients, 75% of whom were at 200% of the Federal Poverty Level or below, through a network of 20 healthcare provider organizations with over 73 health centers. Through the

PABCCEDP, AccessMatters' network of providers served over 5,700 patients in 2018, 97.5% of whom are below 200% of the Federal Poverty Level. Our high-impact HIV Prevention Program called Brothers United served 2,031 patients in 2018. Also in 2018, AccessMatters' network of Ryan White Part D providers in Philadelphia served 7,550 patients.

AccessMatters is deeply concerned that the NPRM will have devastating negative effects on access to health care, particularly in communities that already face many barriers to accessing care, including the lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ) and immigrant communities.

The Health Care Rights Law, also known as Section 1557 of the Affordable Care Act (ACA), passed in 2010 with the intent to narrow health disparities by addressing discrimination in healthcare settings on the basis of race, color, national origin, sex, age and disability. While the proposed rule cannot change Section 1557's protections in the law enacted by Congress, if finalized, it would drastically change the intent of the law by significantly narrowing the scope of the current HHS implementing regulations. Considering that the programs we administer are funded by HHS, and would be directly affected, we oppose the proposed rule. Furthermore, we oppose any changes to the Health Care Rights Law that roll back nondiscrimination protections for any protected group under current law.

More specifically, we are concerned with the following proposed changes outlined in the NPRM:

<u>Sex discrimination</u>

- Eliminates prohibitions on discrimination based on gender identity and sexual orientation;
- Adds blanket religious exemptions to covered entities from the general prohibition of discrimination of sex, similar to Title IX's regulations; and
- Allows covered entities to deny, limit or impose additional cost-sharing services that are exclusively available to one sex or gender when they are sought by a person whose sex or gender is different.

Eliminating gender identity and sexual orientation from protected categories under existing anti-discrimination law could interfere with a person's ability to access health care, particularly if they identify as LGBTQ. In Pennsylvania, 4.1% of the population identifies as LGBTQ, 10% is

reported to be uninsured, and 27% have an income of less than $24,200.[1] Prior to the ACA becoming law, being transgender was treated as a pre-existing condition. If the protections included in Section 1557 are rolled back by the proposed rule, transgender patients would face limited access to health insurance coverage and access to healthcare services.

According to a study by the Center for American Progress, transgender people will experience discrimination from healthcare service providers on the basis of their gender identity, not just because of the transition-related treatments, as it is often thought.[2] Eliminating gender identity as a protection from discrimination will jeopardize the quality of care that transgender people and others who identify as LGBTQ receive.

The proposed change to add a religious exemption to the Health Care Rights Law similar to the religious exemption in Title IX is antithetical to the purpose of the law. It would allow certain healthcare entities to discriminate against and deny services to people based on sex. AccessMatters believes that health care is human right and no one should be discriminated against or denied critical health care, including sexual and reproductive health, on the basis of gender identity or sexual orientation or due to their health status, previous health history, or the health service they are trying to access.

Language Access

- Reduces the standards that covered entities must abide by regarding language assistance services like oral interpretation for people with limited English proficiency (LEP) that could interfere with the quality of health care a person receives
- Removes the current option for video interpreting services to only include services for audio interpreting services

[1] *LGBT Proportion of Population: Pennsylvania*. The Williams Institute, 2018, https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT&area=42#density

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

- Eliminates current regulations requiring that non-discrimination notices include language assistance services and taglines in the top 15 languages spoken by people with limited English proficiency in each state

In our Title X network, 4% of the total clients served in 2018 were people with limited English proficiency. In 2018, 55% of the clients receiving breast and cervical cancer prevention services through the PABCCDEP program in Southeastern Pennsylvania identified that English was not their primary language.

Language barriers often interfere with a person's access to the health care they are seeking, including sexual and reproductive health care. To ensure people receive culturally and linguistically appropriate care, it is critical that all federally funded healthcare entities are held to the same standard when providing language resources to each person based on their individual level of English proficiency. In sexual and reproductive health care specifically, a patient's discussion with their healthcare provider may be sensitive and confidential. Language access resources can help to ensure a patient's privacy is respected when interacting with their provider.

Notice and Grievances

- Eliminates current non-discrimination notice and grievance procedure requirements that allow people to file complaints to the Office of Civil Rights
- Strips private people and entities of the right to file lawsuits in federal court for violations of Section 1557, and to receive compensation for any damages

It is important to acknowledge that many people who seek care in our network of providers, particularly in Title X, have intersecting identities protected by the Health Care Rights Law and would be most affected by any changes that roll back the legal protections that guarantee them health care without discrimination.

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If the NPRM is adopted, it would significantly impact access to health care in marginalized communities that already face many barriers to quality health care. The Health Care Rights Law

ACCESSMATTERS
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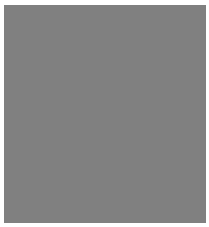
prevents discrimination in healthcare settings; any changes attempting to roll back any provision of the law will increase health disparities in the most vulnerable groups of people in Pennsylvania and across the country. AccessMatters urges that the NPRM be withdrawn immediately.

AccessMatters appreciates the opportunity to provide comments for the NPRM, "Nondiscrimination in Health and Health Education Programs or Activities." If you have questions or would like additional information, please contact me at 215-985-2655 or via email at melissa.weilergerber@accessmatters.org. Thank you.

Sincerely,

Melissa Weiler Gerber
President and CEO

EXHIBIT D-31



August 13, 2019

Secretary Alex Azar
Department of Health & Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Ave S.W.
Washington, DC 20201

Submitted via regulations.gov

RE: Comments on Notice of Proposed Rulemaking re Section 1557 of the Affordable Care Act, "Nondiscrimination in Health and Health Education Programs or Activities"
RIN 0945-AA11

Dear Secretary Azar,

Equality North Carolina writes today to comment in response to the notice of proposed rulemaking regarding Section 1557 of the Affordable Care Act, "Nondiscrimination in Health and Health Education Programs or Activities," published in the Federal Register on June 14, 2019. Equality North Carolina works to secure equality and justice for lesbian, gay, bisexual, transgender and queer (LGBTQ) North Carolinians. An important part of Equality NC's mission is to work to achieve health, safety, and equity for LGBTQ people in North Carolina, including ensuring that transgender and non-binary people have access to the healthcare that we need.

Equality North Carolina strongly opposes the proposed rule, and urges that it be withdrawn. If finalized and implemented as currently written, the proposed rule would create confusion among patients about their rights and among providers about their obligations under federal law, and promote discrimination against LGBTQ patients. The resulting confusion and discrimination will significantly impact LGBTQ patients' access to all forms of healthcare, but especially transgender and non-binary patients' access to medically necessary healthcare. The proposed rule encourages hospitals to deny care to LGBTQ people, and it enables insurance companies' denial of healthcare services for transgender people that they otherwise cover for cisgender (non-transgender) people. The proposed rule's removal of important protections means that it would be harder for other people experiencing discrimination in healthcare to know and exercise their rights, including people with limited English proficiency (LEP), people who live with chronic health conditions like HIV, and many members of the LGBTQ community are also members of those communities. In short, there is nothing about the proposed rule that would increase equity and result in better health, so Equality North Carolina urges the Department of Health & Human Services (HHS) to withdraw the rule.

The proposed rule threatens LGBTQ people's access to healthcare and coverage

Discrimination against LGBTQ people in health coverage and care remains a pervasive problem. Despite recent advances in legal protections for LGBTQ individuals, the estimated nine million LGBTQ people living across the United States—and nearly 300,000 LGBTQ people living in North Carolina—continue to regularly encounter discrimination on the basis of sexual orientation and gender identity when seeking health insurance coverage and health care.

Numerous surveys, studies, and reports have documented the widespread extent of the discrimination experienced by LGBTQ individuals and their families in the health system. A 2017 study from the Center for American Progress "Discrimination Prevents LGBTQ People From Accessing Healthcare," a nationally representative survey assessing the health care experiences of LGBTQ people, found that respondents reported experiencing at least one of the following types of discrimination:[1]

- Healthcare providers using harsh or abusive language
- Healthcare providers refusing to see them or refusing to provide them healthcare because of their sexual orientation
- Healthcare providers inflicting unwanted physical conduct up to sexual assault

The same study reported that patients who were turned away from a healthcare practice often had difficulty finding an alternative provider. Further, these experiences of discrimination deterred LGBTQ people from seeking healthcare when they needed it.

Similarly, the 2015 U.S. Transgender Survey, the largest survey ever devoted to the lives and experiences of transgender people, found pervasive discrimination in health care among its nearly 28,000 transgender respondents within the previous year, including large numbers who had been denied coverage for transition-related care and other necessary treatments because of being transgender; being harassed, attacked, or turned away by health care providers; and postponing needed medical care because of fear of mistreatment by providers.[2] In a report specifically examining the experiences of respondents living in North Carolina, the U.S. Transgender Survey found that:[3]

- 29 percent of respondents living in North Carolina were living in poverty;
- In the past year, 21 percent experienced a problem with their insurance related to being transgender, such as being denied needed coverage for transition-related care or being denied coverage for other care because of being transgender;
- In the past year, 29 percent of those who saw a health provider had at least one negative experience related to being transgender, such as being harassed, physically assaulted, or turned away; and
- In the past year, 42 percent did not see a doctor when they needed to because they could not

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[1] Center for American Progress, *Discrimination Prevents LGBTQ People From Accessing Healthcare* (2017), available at: https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[2] S.E. James et al., *2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality, available at: http://www.ustranssurvey.org/report.

[3] *2015 U.S. Transgender Survey: North Carolina State Report.* (2017). Washington, DC: National Center for Transgender Equality, available at: http://www.transequality.org/sites/default/files/docs/usts/USTS_NC_state_report.pdf.

afford it.

These encounters with discrimination and lack of access have serious negative consequences for the health and well-being of LGBTQ individuals. They also exacerbate the significant health disparities that affect the LGBTQ population at large. Sources such as the Institute of Medicine,[4] the Centers for Disease Control and Prevention, and Healthy People 2020[5] have found that discrimination threatens the health of the LGBTQ population in ways that include:

- Increasing risk factors for poor physical and mental health such as smoking and other substance use;[6]
- Driving high rates of HIV among transgender women and gay and bisexual men;[7]
- Barring access to appropriate health insurance coverage, especially for transgender people;[8]
- Obstructing access to preventive screenings;[9] and
- Putting LGBTQ people at risk of poor treatment from health care providers who are unprepared to meet the needs of LGBTQ patients.[10]

Many of these disparities are even greater for LGBTQ youth, LGBTQ elders, and LGBTQ people who are also members of other groups disadvantaged because of their race, ethnicity, primary language, disability, or other aspects of their identity.[11]

Equality NC has fielded numerous stories of difficulties that LGBTQ people have had in accessing healthcare and experiences of discrimination they have had to endure. For example, a 65-year-old transgender woman was refused healthcare services at the only hospital in her area of western North Carolina; was told that if she returned, she would be arrested by the police; and was stopped and interrogated by police upon leaving the hospital. She had to drive an hour to a hospital in a different town in order to be seen for the healthcare services she needed. A lesbian woman had difficulty being seen when her wife accompanied her to a hospital in southeastern North Carolina for care. We

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[4] *See, e.g.,* Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), available at: http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx.

[5] U.S. Department of Health and Human Services, *Healthy People 2020: LGBT Health Topic Area* (2015), available at: http://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health.

[6] Centers for Disease Control and Prevention, *Lesbian, Gay, Bisexual, and Transgender Health* (July 2014), available at: http://www.cdc.gov/lgbthealth/about.htm.

[7] Office of National AIDS Policy, *National HIV/AIDS Strategy* (2015), available at: https://www.whitehouse.gov/administration/eop/onap/nhas.

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

[9] Fenway Institute, *Promoting Cervical Cancer Screening Among Lesbians and Bisexual Women* (2013), available at: http://www.lgbthealtheducation.org/wp-content/uploads/Cahill_PolicyFocus_cervicalcancer_web.pdf.

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

[11] Institute of Medicine, *supra* note 5; Center for American Progress, "Health Disparities in LGBT Communities of Color: By the Numbers" (2010), *available at* https://www.americanprogress.org/issues/lgbt/news/2010/01/15/7132/health-disparities-in-lgbt-communities-of-color.

commonly hear of transgender people in outlying areas like Kitty Hawk, Pembroke, and Wilmington who drive up to four hours to obtain healthcare in Durham and Raleigh.

However, even more densely populated areas like Durham and Raleigh present their own issues with healthcare access: we have assisted four transgender North Carolinians over the past few months with overcoming insurance denials of medically necessary transition-related healthcare, not only in rural areas like Nash County but also in urban centers like Durham and Raleigh. The author's own personal experience with accessing transition-related healthcare includes being told by an OB/GYN "I hope you weren't thinking we were going to help you with that here," and a subsequent physician in Apex who had been providing hormone replacement therapy who moved his practice to cash-only. Although hormones themselves are usually relatively inexpensive, the labwork required can cost $700-800 twice a year, making cash-only healthcare essentially no healthcare at all to transgender people who are often unemployed or living below the poverty level.

The 2016 final rule promotes equal access to medically necessary health services

The final rule implementing Section 1557 that was released in May 2016 is a sound rule that reflects a prolonged period of deliberation and public comment. It took six years after the Affordable Care Act was passed for HHS to study the healthcare landscape and solicit two periods of public comment. 25,000 stakeholder comments showed the overwhelming public support for protections against discrimination based on sex stereotyping and gender identity. The author personally participated in listening sessions and conferences through which HHS engaged stakeholders prior to releasing the final rule in 2016.

Not only do the nondiscrimination protections of the 2016 final rule reflect stakeholder consensus, they also reflect two decades of federal case law[12] and unequivocal Supreme Court precedent.[13] The overwhelming majority of courts that have been presented with the question of whether sex discrimination laws such as Section 1557 specifically cover anti-transgender discrimination have firmly ruled that they do.[14]

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[12] *See, e.g., Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015); *Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. 2016); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090 (S.D. Cal. Sept. 27, 2017); *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018); *Boyden v. Conlin,* No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018); *Whitaker v. Kenosha Unified School District*, No. 16-3522 (7th Cir. 2017) (Title IX and Equal Protection Clause); *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal Protection Clause); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011) (Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004) (Title VII); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); Grimm v. Gloucester County School Board, No. 4:15-cv-54 (E.D. Va. August 9, 2019); M.A.B. v. Board of Education of Talbot County, 286 F. Supp. 3d 704 (D. Md. March 12, 2018).

[13] *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989).

[14] *See, e.g., Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (holding that discrimination against hospital patient based on his transgender status constitutes sex discrimination under Section 1557 of the Affordable Care Act); *Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018) (holding that a Medicaid program's refusal to cover treatments related to gender transition is "text-book discrimination based on sex" in violation of the Affordable Care Act and the Equal Protection Clause of the Constitution); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. 2016) (holding exclusion invalid under the Medicaid Act and the Affordable Care Act); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090 (S.D. Cal. Sept.

Equality North Carolina is also opposed to the proposed changes to pull back other long-standing rules that prohibit discrimination on the basis of sexual orientation and gender identity.[15] HHS Office for Civil Rights does not have jurisdiction over these rules and regulations to begin with. Additionally, the subject matter of those rules pre-dates Section 1557 and is unrelated to Section 1557, and thus beyond the scope of this rulemaking. HHS has not given any legal, policy, or cost analysis of the operations of those rules or their impact on the various CMS programs over the years, sometimes decades, that they have been in place. HHS has not given any explanation about the particular need to alter those rules now, and it is arbitrary and capricious for HHS to refer to their changes as "conforming amendments" without any meaningful justification for combining the Section 1557 rulemaking with this separate regulatory subject matter.

The 2016 final rule has been crucial for LGBTQ patients to be able to access the care that they need

The protections under Section 1557 of the Affordable Care Act and the 2016 implementing rule have played a critical role in extending healthcare coverage and healthcare services to LGBTQ North Carolinians. The nondiscrimination provisions of Section 1557 and the 2016 rule have given many LGBTQ people meaningful healthcare options that they did not have before, and made it possible for many transgender and cisgender people to access essential care.

Like anyone else, the estimated 45,000 transgender people in North Carolina[16] need acute care when they are sick and preventive care to keep from becoming sick. In addition, transgender North Carolinians need access to medically necessary care related to gender transition. Despite the medical necessity of transition-related care for transgender people, many insurance plans have historically limited access to care associated with gender transition. These limits—typically exclusions or coverage denials for transition-related care—target transgender people for discrimination by forcing them to forego necessary treatments or to pay out-of-pocket for the same medically necessary services provided to non-transgender people.

Even where insurance plans have not *explicitly* excluded transition-related care, transgender people are often denied medically necessary care. Such denials may occur if the plan records a "gender mismatch," such as when a transgender man needs a hysterectomy or other type of "sex-specific" service (such as a Pap smear or a mammogram), or because plans continue to justify denials of care by categorizing certain procedures as cosmetic or experimental when needed for transition-related purposes. As a result, the same procedures—such as a hysterectomy—are typically covered for non-transgender people but denied as cosmetic or experimental for transgender people. For instance, 21 percent of transgender

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27, 2017) (holding that discrimination against transgender patients violates the Affordable Care Act); *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018) (holding that Section 1557 of the Affordable Care Act prohibits discrimination on the basis of gender identity); *Boyden v. Conlin,* No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018) (holding that a state employee health plan refusal to cover transition-related care constitutes sex discrimination in violation of Title VII, Section 1557 of the ACA, and the Equal Protection Clause).

[15] Specifically, 45 CFR 155.120(c)(1)(ii) and 155.220(j)(2), 45 CFR 147.104(e), 45 CFR 156.200(e) and 156.1230(b)(3), 42 CFR 460.98(b)(3) and 460.112(a), 42 CFR 438.3(d)(4), 438.206(c)(2), and 440.262.

[16] Andrew R. Flores et al., *How Many Adults Identify as Transgender in the United States?* (2016), available at: http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf.

North Carolinians reported experiencing a problem with their insurance in the past year because they were transgender, such as being denied needed treatment.[17] These types of coverage denials were particularly common in the absence of explicit prohibitions on sex-specific denials and on blanket exclusion policies like those provided in the 2016 final rule.

For example, the North Carolina State Health Plan, which covers almost three-quarters of a million teachers and state employees in North Carolina, had a blanket exclusion on transition-related care until the end of 2016.[18] At that time, the Board of Trustees removed the exclusion in response to the 2016 implementing rule. State employees and their dependents had access to coverage for transition-related healthcare beginning January 1, 2017, and many employees and their family members began a course of treatment that year. However, the Board of Trustees silently allowed the coverage to "sunset" at the end of 2017 in response to the *Franciscan Alliance* decision[19], despite an outcry from affected state employees and their family members. Thus, healthcare that state employees had coverage for the previous year was suddenly no longer reimbursed beginning January 1, 2018. One heartbroken state employee told us that her child had been in therapy during the 2017 plan year in anticipation of gender transition, and that they had an appointment on January 2, 2018, to begin hormone replacement therapy, only to find that there was no longer coverage that had been there the week before.

The confusion for both patients and providers that the *Franciscan Alliance* decision introduced will only be exacerbated if the provisions of the proposed rule become final. It will be even more unclear what healthcare providers' obligations are to provide this care, and health plans' obligations to cover this care. The resulting confusion for patients about what their rights are will mean that people will be dissuaded from seeking healthcare when they need it, and more healthcare providers will feel that discrimination against those patients is acceptable and legal. Just as the plaintiffs in *Kadel v. Folwell* had to seek legal remedy, transgender people across North Carolina will now have to go to court in order to get the healthcare that they need.

The proposed rule will impede health care access for people with HIV/AIDS and other serious or chronic conditions

People living with HIV and/or other serious or chronic health conditions benefit from Section 1557 and the 2016 implementing regulations' prohibition on discrimination in marketing practices and benefit design. Without these non-discrimination requirements, insurance plans could put drugs that treat HIV or other chronic conditions in the highest-cost tier in order to save money, a practice called adverse tiering. The proposed rule's deletion of nondiscrimination in benefit design and marketing could result in health insurers designing prescription drug formularies in a way that makes needed prescriptions prohibitively expensive, thus limiting access to medically necessary care for people living with HIV and other chronic conditions. Deletion of this provision could also result in outright exclusions for that care.

North Carolina's HIV control measures currently do not provide for criminal penalties for condomless sex if the patient's viral load has been undetectable for six months and they are currently in care.[20] If benefit design were suddenly able to exclude coverage for HIV-related healthcare, not only would more North

[17] See supra note 3.
[18] See generally *Kadel v. Folwell*, No. 1:19-cv-00272, M.D.N.C., filed March 11, 2019.
[19] *Franciscan Alliance, Inc., et al., v. Burwell*, 7:16-cv-00108-O, N.D. Tex., filed December 31, 2016.
[20] 10A NCAC 41A .0202 (1)(a)(i).

Carolinians go untreated and thus fail to achieve viral suppression, they could then be subject to criminal penalties for violation of the HIV control measures.[21]

The proposed rule will disproportionately harm LGBTQ people who are limited English proficient (LEP) and/or who need access to reproductive care

Just as LGBTQ health disparities are greater for LGBTQ people who are also members of other groups disadvantaged because of race, ethnicity, primary language, disability, or other aspects of their identity, LGBTQ people's intersectional experiences of discrimination will be exacerbated. The effects of anti-LGBTQ discrimination are magnified for LGBTQ people who are LEP, who need access to reproductive healthcare, and/or who are living with chronic conditions.

The general confusion about obligations and rights that the proposed rule will cause for LGBTQ people will be even more challenging for LGBTQ patients who are limited-English-proficient or who have LEP family members. Many LGBTQ LEP people may not understand what their rights are to access healthcare free of discrimination, and they may not know that language services are available to help them understand those rights, or how to file a complaint if those rights are violated and they face discrimination. The proposed rule's elimination of tagline requirements and notice standards will heighten the risk of people with LEP not understanding their rights, and thus will undermine LGBTQ LEP people's access to healthcare, health insurance, and legal remedies.

Similarly, the proposed rule will have a heightened impact on LGBTQ people who need to access reproductive healthcare. If the proposed rule is implemented and protections against discrimination on the basis of termination of pregnancy are eliminated, healthcare providers would be able to discriminate against anyone who has had an abortion. Additionally, providers following the proposed rule could deny critical care to pregnant patients who need to medically manage miscarriage. The proposed rule would also unfairly impact LGBTQ people in need of reproductive healthcare by allowing more health plans to refuse to cover reproductive health services like pregnancy care, fertility treatments, contraception and abortion. In addition to lesbian, bisexual, and queer cisgender women, transgender men and non-binary people assigned female at birth may be able to get pregnant and face discrimination when attempting to access contraception, fertility, abortion, and pregnancy services. For example, when a transgender man in Charlotte became pregnant and was admitted to the hospital for the delivery, he learned that his medical chart identified him as female, so hospital staff were referring to him as "Miss."[22]

Finally, the proposed rule would unlawfully incorporate a broad religious exemption to Section 1557's protections against discrimination on the basis of sex, contrary to the express purpose of Section 1557 and the plain language of the statute. It is already difficult for transgender patients to find healthcare providers in North Carolina who will treat them. In rural parts of our state where it may be difficult to find any affirming healthcare providers, adding a religious exemption would embolden healthcare providers to discriminate against LGBTQ patients and deny life-saving healthcare. Refusing to render life-saving care violates the most basic medical oath to do no harm. The weight of the federal government should be used to ensure that patients can get that care, not to encourage healthcare providers to discriminate against people in the most vulnerable moments of their lives.

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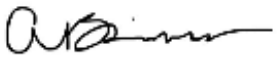
[21] N.C.G.S. 130A-25(a)-(b).

[22] Anna Douglas, "#TeamPregnantDad: How Did This Happen?!"," Charlotte Observer, May 9, 2019, available at https://www.charlotteobserver.com/news/special-reports/article228875629.html.

Thank you for the opportunity to comment on the proposed rule. We once again urge HHS to withdraw this rule.

If you have any questions about our comments and recommendations, please contact Ames Simmons at ames@equalitync.org.

Sincerely,



Ames Simmons, Esq.
Policy Director
Equality North Carolina

EXHIBIT D-32

NoHLA
Northwest Health Law Advocates

August 13, 2019

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

Director Roger Severino
Office for Civil Rights
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Submitted electronically at www.regulations.gov

RE: Section 1557 NPRM, DOCKET ID HHS-OCR-2019-0007, RIN 0945-AA11, "Nondiscrimination in Health and Health Education Programs or Activities"

Dear Secretary Azar and Director Severino:

On behalf of Northwest Health Law Advocates (NoHLA), we write in response to the Department of Health and Human Services' (HHS) Notice of Proposed Rulemaking (NPRM) entitled "Nondiscrimination in Health and Health Education Programs or Activities" to express our strong opposition to the proposed changes regarding Section 1557 of the Patient Protection and Affordable Care Act (ACA). NoHLA is a nonprofit health care advocacy organization whose mission is to ensure that all Washington state residents have access to quality, affordable health care. If finalized, this proposed rule would severely threaten access to all forms of health care, create confusion among patients and providers about their rights and obligations, and promote discrimination. The rule would make it harder for people experiencing discrimination in health care to know and exercise their rights, including individuals who are limited English proficient (LEP), LGBTQ persons, women, and people with disabilities and chronic conditions. The proposed changes could create additional barriers and potentially lead to worse health outcomes.

Section 1557 is the key nondiscrimination provision of the Affordable Care Act (ACA).[1] It prohibits discrimination in health programs and activities receiving federal financial assistance, health programs and activities administered by the executive branch, as well as entities created under the ACA, including the Marketplaces and health plans sold through the Marketplaces. The 2016 Section 1557 implementing final rule is the product of a lengthy process of deliberation and public input. The rule was developed over the course of six years of study with nearly 25,000

[1] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010); 42 U.S.C. § 18116.

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THE ALLIANCE for Equal Justice MEMBER

comments from stakeholders, who overwhelmingly supported including protections against discrimination based on sex stereotyping, limited English proficiency, and gender identity.

Section 1557 of the ACA and the 2016 implementing rule provide many Washington state residents with meaningful access to health care where there was previously none. Section 1557 has helped address the pervasive discrimination that specific populations – including LGBT individuals, LEP individuals, women, and people of color – face in health care and coverage, and has made it possible for many people to access essential care. Because the proposed rule would deeply impact residents of Washington State, NoHLA urges the Department of Health and Human Services to withdraw the proposal and instead leave the 2016 final Section 1557 regulations in place in their entirety.

The Proposed Rule Impermissibly Narrows the Scope of Section 1557 Protections

NoHLA opposes the proposed changes to §§ 92.1 – 92.3 that would narrow the scope of application of Section 1557. The 2016 final rule made clear that Section 1557 applies to all health programs and activities that receive federal financial assistance from HHS, all health programs and activities administered by HHS, and state-based marketplaces. The 2016 final rule defines health programs and activities to include all operations of an entity receiving federal financial assistance that is principally engaged in the provision or administration of health-related services or health-related insurance coverage.

The proposed rule would narrow the scope of coverage in two cumulative ways, both contrary to the statute. First, it would narrow the health insurance plans that are covered at all by providing that if the issuer of a health plan is not principally engaged in the business of providing health care (as opposed to health insurance), only its Marketplace plans would be covered and any plans it offers outside the marketplace would not be subject to Section 1557.[2] Second, for the health insurance plans that remain covered, protections would be narrowed only to the portion of a health care program or activity that receives federal financial assistance. Both narrowing interpretations are impermissible under Section 1557 because the statute clearly applies more broadly to "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)."[3]

This change would harm consumers, particularly those who purchase short-term limited duration insurance ("STDLI"). Implementing the proposed rule would deprive these consumers of protection because their insurers would no longer be considered health care entities, and these specific plans do not receive federal financial assistance. Thus, an enrollee in an STLDI policy would be unprotected from discriminatory practices. For example, the proposed rule would permit short-term plans to discriminate against women by refusing to cover reproductive health services, such as maternity, contraceptive care or fertility care and coverage, or deny coverage

[2] 84 *Fed. Reg.* at 27862.
[3] 42 U.S.C. § 18116(a) (emphasis added).

altogether for other conditions, such as breast or cervical cancer. A 2018 study found that no short-term plan covered maternity care.[4]

The proposed changes run counter to the text and intent of Section 1557 and would severely limit its application, leaving consumers vulnerable to discrimination.

The Proposed Rule Impermissibly Eliminates Prohibitions on Discrimination in Insurance Plan Benefit Design and Marketing

Preventing health care discrimination based on disability is a critical national priority made fundamental by the ACA. Over 133 million people in the U.S. live with at least one chronic condition,[5] and over 61 million people live with a disability.[6] Over 900,000 individuals with disabilities reside in Washington State, comprising nearly 13% of the state's population.[7]

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

Under the 2016 final rule, covered entities are prohibited from designing benefits that discourage enrollment by persons with significant health needs. For example, insurers are prohibited from placing all or most prescription drugs used to treat a specific condition, such as HIV prescriptions, on a plan's most expensive tier.[8] Additionally, covered entities are prohibited from using discriminatory marketing practices, such as those designed to encourage or discourage particular individuals from enrolling in certain health plans.[9] The proposed rule improperly attempts to eliminate these prohibitions.

The Proposed Rule Will Negatively Impact Individuals with Limited English Proficiency

There are over 500,000 LEP individuals in Washington State who would lose meaningful access to health care if the proposed rule were to be implemented.[10] NoHLA disagrees with HHS's claim that the nondiscrimination notice, taglines and language access plan provisions in the 2016

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

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

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

[7] Wash. State Division of Vocational Rehab, *Disabilities and DVR Statistics Report* 1 (July 2017), https://www.dshs.wa.gov/sites/default/files/JJRA/dvr/pdf/2017%20Disability%20%26%20DVR%20Statistics%20Report.pdf.

[8] 45 CFR Part 92. *See also* 81 *Fed. Reg.* at 31434.

[9] 45 CFR § 92.207.

[10] LEP.gov, Limited English Proficiency Data Maps, https://www.lep.gov/maps/2015/national/US_state_LEP_count.ACS_5yr.2015.pdf

Final Rule were not justified by need and were overly burdensome. For LEP individuals, language differences often compound existing barriers to access and receiving appropriate care. LEP individuals often have more difficulty navigating an already complicated healthcare system, particularly related to complex and technical medical or insurance terminology. Moreover, these barriers are often compounded by discrimination based on national origin, immigration status, race, ethnicity, sexual orientation, and gender/gender identity.

The Language Access Requirements in the 2016 Final Rule Are Justified by Need
HHS provides no tangible analysis of the costs and burdens of repealing the notice and tagline requirement. Instead, HHS provides only acknowledgment that repeal may impose costs, such as decreasing access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services. HHS perfunctorily labels the impact as "negligible" while providing no evidentiary basis.

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

Discrimination on the basis of national origin, which encompasses discrimination on the basis of language, creates unequal access to health care. Language access in health care is just as critical now as when the Civil Rights Act was originally passed in 1964. Language assistance is necessary for LEP persons to access federally funded programs and activities in the health care system. Without meaningful access, the over 500,000 individuals who are LEP in Washington State would be excluded from programs and services they are legally entitled to,

The Regulatory Impact Analysis is Insufficient and Fails to Justify the Proposal
The proposal provides a Regulatory Impact Analysis (RIA) that is insufficient to justify the extensive scope of the proposed changes to language access and entirely fails to identify and to quantify costs to protected individuals. HHS's estimate of the burden to covered entities for compliance with the nondiscrimination notice and tagline requirements is based on voluntary actions and interpretations by covered entities. HHS based the elimination of the notice and taglines on these estimates, but did not consider whether alternatives, such as further clarification about the requirements, was warranted in the form of FAQs or other guidance. Meaning, HHS failed to consider alternatives to a complete repeal of notices and taglines that could have appropriately balanced the need to inform individuals of their rights while recognizing there may be a difference in the intentions behind the 2016 Final Rule and how covered entities have interpreted it.

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

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

The rollback of these provisions will actually increase public health costs by decreasing access to health services, further exacerbating health inequities. The Joint Center for Political and Economic Studies estimates that health inequities and premature deaths cost the U.S. economy $309.3 billion a year.[11]

Proposed Repeal of In-Language Taglines
The requirement for covered entities to provide in-language taglines informing recipients of the availability of language assistance on significant documents should not be repealed. Eliminating this important informational resource threatens the civil rights of LEP persons. The inclusion of taglines is well-supported by long-standing federal and state regulations, guidance and practice.[12] The use of taglines is a cost-effective approach to ensuring that covered entities are not overly burdened while providing communication essential to maintaining access for LEP individuals.

In the absence of fully translated documents, taglines are necessary "to ensure that individuals are aware of their protections under the law, and are grounded in OCR's experience that failures of communication based on the absence of auxiliary aids and services and language assistance services raise particularly significant compliance concerns under Section 1557, as well as Section 504 and Title VI."[13] As such, we oppose the proposal to eliminate them.

Proposed Repeal of Video Interpretation Standards
We oppose the removal of technical and training requirements for the use of video remote interpreting services for spoken language interpretation. The type of interpreting during a medical visit should depend on the encounter as telephonic communication may be appropriate for scheduling, but not for interpreting information for trauma, mental health, or death. Nonverbal cues in the health care setting or prescription writing cannot be observed via

[11] Thomas A. LaVeist, Darrel J. Gaskin., & Patrick Richard, *The Economic Burden of Health Inequalities in the United States*, Joint Ctr. for Pol. and Econ. Stud., https://jointcenter.org/sites/default/files/Economic%20Burden%20of%20Health%20Inequalities%20Fact%20Sheet.pdf (last visited Jul. 23, 2019).
[12] See Title VI Coordination Regulations, 29 C.F.R. § 42.405(d)(1); Marketplace and QHP issuer requirements, 45 C.F.R. § 155.205(c)(2)(iii); Medicaid Managed care plans, 42 C.F.R. § 438.10(d)(3); DOL WIOA Nondiscrimination requirements, 29 C.F.R. § 38.9(g)(3); USDA SNAP Bilingual Requirements, 7 C.F.R. § 272.4(b); and the 2003 HHS LEP Guidance.
[13] Nondiscrimination in Health Programs and Activities, Notice of Proposed Rulemaking, 45 CFR Part 92, September 8, 2015.

telephone. Further, even with the higher cost in equipment and training, Video Remote Interpreting has saved costs from in person interpreting as there are no minimums, travel time, or cancellation risks; though we believe in-person interpreting is still best for the patient. Keeping the current standard allows providers to determine which technology is appropriate and when an entity uses video, that it is high quality and without any lag time.

Language Access Plans
We oppose removing all references to language access plans. Under the 2016 Final Rule, they are voluntary, not required, and only a factor to be considered. Language access plans are not required by Title VI or its regulations but have long been recognized as a way for a covered entity to demonstrate it is compliant with Title VI. OCR has required language access plans from covered entities as a key component of Title VI enforcement actions involving LEP individuals since before Executive Order 13166 was issued in 2000. Executive Order 13166 also required HHS to create and implement a language access plan for its federally conducted programs and activities. That Executive Order also required HHS to issue Title VI LEP Guidance which provided multiple factors an entity could take when developing a language access plan. As such, repealing the voluntary language removes a tool that HHS has used for enforcement and that covered entities can use to support their compliance efforts. Covered entities may, as a result, fail to fully plan on how to best meet the needs of LEP patients and consumers.

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

Protections Related to Pregnancy
The 2016 Final Rule made clear that sex discrimination under Section 1557 includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related conditions. The proposed rule attempts to roll back these protections and would delete the 2016 final rule's clarification that the ban on sex discrimination includes all pregnancy related care. In doing so, HHS attempts to eliminate the express protections that apply to someone who has had an abortion or has experienced a miscarriage or ectopic pregnancy and needs care for those conditions. While the scope of protection under Section 1557 is clear, discrimination is still more than likely to occur, without unambiguous implementing regulations, and enforcement, harming Washington residents who can become pregnant.

The proposed rule would disproportionately impact women and people of color who are pregnant, especially those living in rural areas. Women of color already face unique barriers to accessing pregnancy-related and/or abortion care, such as a discrimination, harassment, refusals

of care, and high rates of pregnancy-related complications. For example, Asian American and Pacific Islander ("AAPI") women are 2 times more likely to die from pregnancy-related causes than white women, Black women are 3-4 times more likely to die from pregnancy related complications than white women, and Native American women were 4.5 times more likely to die during or immediately after pregnancy than white women.[14] In Washington State, white women have the lowest rates of maternal mortality, while rates for American Indian/Alaska Native women are more than eight times higher and three times higher for Black women.[15]

Protections Against Discrimination Based on Sex Stereotyping and Gender Identity
Sex discrimination in health care disproportionately harms LGBT people. This was especially true for transgender individuals prior to the passage of the ACA, when being transgender was treated as a pre-existing condition. As a result, transgender people could not get insurance coverage or affordable insurance. Transgender, nonbinary, and gender nonconforming people faced unique barriers to accessing care, such as high uninsurance rates, discrimination, and harassment. For example, transgender, nonbinary, and gender nonconforming people assigned female at birth whose gender marker is male or nonbinary could be denied coverage for necessary care such as a pap smear or mammogram. Similarly, transgender, nonbinary, and gender nonconforming people assigned male at birth whose gender marker is female or nonbinary could be denied coverage for necessary care, such as a prostate exam.

In a July, 2012 letter to the National Center for Lesbian Rights, the Office of Civil Rights clarified that sex-based discrimination includes discrimination on the basis of gender identity and sex stereotypes under Section 1557 of the ACA.[16] The 2016 final rule clarified that Section 1557's prohibition on sex discrimination includes a prohibition of discrimination on the basis of gender identity, including transgender and/or nonbinary status. The 2016 Rule provided a safety net for LGBT individuals in Washington State – whereby even if a provider or insurer discriminated against them – they would still have access to remedies.

Prior to the passage of the ACA, being transgender was treated as a pre-existing condition. As a result, transgender people could not get insurance coverage or affordable insurance. By removing all references to the ACA's protection on the basis of sex stereotyping and gender identity, the proposed rule would allow states and Marketplaces to discriminate against LGBT people in eligibility determinations, enrollment periods, and more. Similarly, agents and brokers who assist with enrollment in marketplace plans could discriminate against LGBT individuals. This could result in less health care and poorer health outcomes for communities in Washington State.

In addition, the proposed incorporation of Title IX's religious exemption into Section 1557 regulations would disproportionately harm women of color and LGBT people and women of color. For example, the proposed rule impermissibly tries to carve out Title IX's religious exemption to Section 1557's protection against sex discrimination, which could embolden

[14] Adrian Dominguez, et al., Urban Indian Health Inst., Seattle Indian Health Bd., Community Health Profile: National Aggregate of Urban Indian Health Program Service Areas 37 (2016), http://www.uihi.org/wp-content/uploads/2017/08/UIHI_CHP_2016_Electronic_20170825.pdf.
[15] Maternal Mortality Review: A Report on Maternal Deaths in Wash. 2014 -2015, Wash. State Dept. of Health 4 (July 2017), https://www.doh.wa.gov/Portals/1/Documents/Pubs/140-154-MMRReport.pdf.
[16] HHS, Office of Civil Rights letter dated July 12, 2012 http://www.nachc.com/client//OCRLetterJuly2012.pdf

providers to invoke personal beliefs to deny access to a broad range of health care services, including birth control, sterilization, certain fertility treatments, abortion, and gender-affirming care. Similarly, the Administration once again attacks abortion access by impermissibly incorporating the "Danforth Amendment", which carves out abortion care and coverage from the ban on discrimination of sex in the education context. Both attempts to incorporate exemptions from other laws violate the plain language of Section 1557.

Undermining Protections Independent of Section 1557

NoHLA is opposed to the proposed changes to roll back other, long-standing rules that prohibit discrimination on the basis of gender identity and sexual orientation.[17] These changes are outside of the Office for Civil Rights' jurisdiction and are unrelated to Section 1557 of the ACA. It is not appropriate for these rulemakings to be combined, and it is arbitrary and capricious for HHS to characterize them as "conforming amendments" without offering any legal, policy, or cost-benefit analysis about them and their impacts on various CMS programs. In particular, HHS offers no analysis of the impact these regulations have had during the years – in some cases over a decade – that they have been in effect or the impact of changing them now.

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

The proposed rule impermissibly limits the enforcement mechanisms available under Section 1557 for those who have experienced discrimination, including eliminating notice and grievance procedure requirements, private rights of action, opportunities for money damages, and separating remedies and enforcement for each protected class – blatantly ignoring intersectional discrimination.[18]

The proposed changes to §92.301 as newly designated §92.5 limits the remedies available under Section 1557, in part by referencing the regulations implementing the cited statutes. One goal of Section 1557 was to build and expand on prior civil rights laws so that individuals seeking to enforce their rights would have access to the full range of available civil rights remedies and not be limited to only the remedies provided to a particular protected group under prior civil rights laws. Section 1557 expressly provides individuals access to any and all of the "enforcement mechanisms provided for and available under" the cited civil rights statutes, regardless of the type of discrimination. Requiring notice to people protected by civil rights statutes of their rights is an essential element in enabling them to understand and assert them, and to remove them fundamentally undermines Congress's intent to give them practical effect.[19]

[17] These are: 45 CFR 155.120(c)(1)(ii) and 155.220(j)(2), 45 CFR 147.104(e), 45 CFR 156.200(e) and 156.1230(b)(3),
42 CFR 460.98(b)(3) and 460.112(a), 42 CFR 438.3(d)(4), 438.206(c)(2), and 440.262.

[18] Discrimination based on an individual's multiple intersecting identities, including but not limited to English language proficiency, national origin, immigration status, race, ethnicity, sex, sexual orientation, and gender/gender identity.

[19] *See e.g.,* EEOC Notice of Employees' Rights, https://www.eeoc.gov/employers/upload/eeoc_self_print_poster.pdf and HUD Notice of Fair Housing Rights, https://www.hud.gov/sites/documents/FHEO_BOOKLET_ENG.PDF.

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

Conclusion

The proposed rule could impose wide-ranging harm, that would disproportionately burden Washington State residents who identify as LGBTQ, individuals with LEP, women, and people with disabilities/chronic conditions. The proposed rule contravenes the plain language of Section 1557, specifically, and the ACA broadly. For these reasons, HHS should immediately withdraw the proposed rule in its entirety.

Thank you for the opportunity to comment. Please contact us with any questions regarding our comments.

Sincerely,

Huma Zarif
Staff Attorney
Northwest Health Law Advocates
huma@nohla.org

EXHIBIT D-33

AMERICAN PSYCHIATRIC ASSOCIATION

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August 9, 2019

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

RE: Nondiscrimination in Health and Health Education Programs or Activities – Docket No.: HHS-OCR-2019-0007

Dear Secretary Azar,

On behalf of the American Psychiatric Association (APA), a national medical specialty society representing more than 38,500 physicians specializing in psychiatry, we are writing in response to the Department of Health and Human Services' (HHS or the Agency) proposed rule, *Nondiscrimination in Health and Health Education Programs or Activities*[1], as published in the Federal Register on June 14, 2019. We appreciate the opportunity to comment on this important proposal and focus our comments on the potential negative impacts it may have on health outcomes and patients' mental health.

Background

Franciscan Alliance v. Azar enjoined the implementation of a regulation that would define "on the basis of sex" to include gender identity and termination of pregnancy. The court then granted HHS a remand and stay in order to allow the Agency to correct the problem the court identified. [2] In the proposed rule, HHS deleted the definition of "on the basis of sex," which had included gender identity and termination of pregnancy and altered the definition of covered entities. As a result, the proposed rule will now encourage discrimination in all facets of health care against gender diverse people and women.

The Agency and this Administration do not intend that health care providers should have carte blanche to engage in rank discrimination against entire classes of people

[1] Notice of Proposed Rulemaking, "Nondiscrimination in Health and Health Education Programs or Activities," Federal Register, Vol. 84, No. 115, Friday, June 14, 2019, pgs. 27846-27895.

[2] The issues of whether discrimination "on the basis of sex" includes gender identity and sexual orientation is currently under consideration by the United States Supreme Court in the combined cases *Altitude Express Inc. v. Zarda, Bostock v. Clayton County, GA*, and *R.G. & G.R. Harris Funeral Homes Inc V EEOC*. These cases will consider the issue in the context of Title VII.

with whom they disagree under the cloak of religious freedom. The plaintiffs in *Franciscan Alliance* made it clear that the religious objection was to providing the *service* or *procedure* that is in contrast to their religious beliefs, and **not** to the patient as a person. Thus, plaintiffs challenging provision of gender transition and abortion services recognized the obligation to treat transgender individuals and women who had terminated a pregnancy for "health issues ranging from the common cold to cancer," but stopped short of providing transition related services and abortions. This limit on the claim to religious or conscious objection is a basic and well-understood tenant of our law:

- HHS explicitly recognized a concern "that the proposed regulation could serve as a pretext for health care workers to claim religious beliefs or moral objections….in order to discriminate against certain classes of patients, including illegal immigrants, drug and alcohol users, patients with disabilities or patients with HIV, or on the basis of race or sexual preference." 73 Fed. Reg. at 78,079 -80 (2008). It clarified that the regulation was not intended to permit unlawful discrimination on any basis, for "the health care provider conscience protection provisions have existed in law for many years, and this regulation only implements these existing requirements. As a result, there is nothing in this regulation that newly permits" discrimination against categories of individuals based on their individual characteristics for any reason (including, e.g., on the basis of race, color, national origin, disability, age, sex, religion, or sexual preference). 73 Fed. Reg. at 78,080 (2008).
- In 2011, an HHS action rescinded much of the 2008 Federal Health Care Conscience Rule, at least in part, as a response to litigation that was filed contesting it. The 2011 issuance made clear that the "conscience statutes were intended to protect health care providers from being forced to participate in *medical procedures* that violated their moral and religious beliefs. They were never intended to allow providers to refuse to provide medical care to an individual because the individual engaged in behavior the health care provider found objectionable." 76 Fed. Reg. at 9,973-74 (emphasis added).

Because the proposed rule does not clarify the limitation of the religious and conscience objection to providing the *procedure or service* related to abortion, gender identity or sexual orientation, it may empower providers to refuse **any** health care service or information to entire classes of people even if the health care sought is unrelated to the religiously objectionable procedure. **By eliminating the definitions of terms such as "on the basis of sex" and changing the definition of "covered entity," without making it clear that discrimination against entire classes of individuals for all health services is unlawful, this rule opens to the door to discrimination against vulnerable Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) and female patients, placing them at-risk of serious or life-threatening results in emergency situations.** The Agency cannot mean that people who have had abortions or who are LGBTQ should be lawfully denied access to treatment for cancer, heart disease or mental illness because someone with a religious belief does not think they are worthy of basic health care. Health care providers need clear instruction on what is and is not a permissible refusal to treat a patient under the guise of religious freedom.

Impact on Gender Diverse Patients

As written, the proposed rule would roll back the current definition of sex discrimination, that includes gender identity and sex stereotyping. This policy change would allow providers to refuse to treat LBGTQ patients, further endangering access to care for an already-vulnerable patient population. Additionally, if

implemented, the proposed rule would allow covered entities, such as insurers, to deny, limit, and impose additional cost-sharing for gender-specific services (such as cervical cancer screenings for women) or services related to gender transition (such as hormone therapy, mental health counseling, and surgeries) that a transgender patient may seek. As physician experts, we know that appropriately evaluated transgender and gender diverse individuals can benefit greatly from medical and surgical gender-affirming treatments.[3] It is our official policy to oppose categorical exclusions of coverage for such medically necessary treatment when prescribed by a physician.

We are especially concerned about the rule's potential to exacerbate health disparities among LGBTQ patients. There is ample evidence that patients in protected classes (e.g. LGBTQ patients) are already hesitant to seek medical and mental health care and that discriminatory policies have detrimental mental health and medical impacts on the population subject to discrimination.[4] Despite the need for health services, half of gender minorities educate their own providers about necessary care and 20 percent report being denied care.[5,6] The literature on the "minority stress model" highlights the impact of social prejudice, isolation and invisibility as the primary factors leading to an increased health burden and greater risk of mental health issues, homelessness and unemployment.[7] Research shows that LGBTQ patients have many of the same health concerns as the general population, but they experience some health challenges at higher rates, and face several unique health challenges shaped by a host of social, economic, and structural factors. LGBTQ individuals are two and a half times more likely to experience depression, anxiety, and substance misuse. These patients also experience higher rates of sexual and physical violence against them as compared to their heterosexual counterparts.[8] Like other minority groups, transgender individuals are more likely to experience prejudice and discrimination in multiple areas of their lives (e.g., employment, housing, school, healthcare), which exacerbate these negative health outcomes and makes access to appropriate medical care all the more important. Due to their limited access to care, transgender patients have significantly increased rates of mental disorders, substance use, and suicide,[9] while the risk of physical conditions is also intensified with increased rates of

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[3] American Psychiatric Association. Position Statement on Access to Care for Transgender and Gender Diverse Individuals (2018). https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Access-to-Care-for-Transgender-and-Gender-Diverse-Individuals.pdf

[4] Hatzenbuehler ML, McLaughlin KA, Keyes KM, Hasin DS. 2010. The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: a prospective study. Am J Public Health. 100(3): 452-459.

[5] Grant JM, Lisa A, Mottet Justin, Tanis Jack, Harrison Jody, Herman L, Keisling Mara. Injustice at every turn: A report of the National Transgender Discrimination Survey. Washington, DC; National Center for Transgender Equality and National Gay and Lesbian Task Force; 2011.

[6] Sandy James et al., 2015 U.S. Transgender Survey 11, 12, 14 (2016), http://www.transequality.org/sites/default/files/docs/USTS-Full-Report- FINAL.PDF

[7] Ilan Meyer. "Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence" Psychological Bulletin. 2003 Sep; 129(5): 674–697.

[8] Jen Kates et al., "Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S." August 2017.

[9] Agnes Gereben Schaefer et al., Assessing the Implications of Allowing Transgender Personnel to Serve Openly, RAND Corporation (2016).

tobacco use, HIV and AIDS, and weight problems.[10] **We urge the Administration to remove barriers to care and support evidence-based coverage for medical care, which would help the mental well-being of gender diverse individuals.**

Impact on Women's Access to Care

The proposed rule would expand abortion exemptions by incorporating blanket exemptions from Title IX and including intentionally broad language to incorporate future abortion exemptions. While the existing regulation already includes exemptions derived from federal statutory protections for religious freedom and conscience, broadening the language to include exemptions beyond abortion services could have a dangerous effect on women's access to care. In essence, this language would allow a provider to turn away a patient from any health service if they previously sought an abortion, simply because having an abortion violates the provider's religious beliefs. As the U.S. continues to see rising maternal mortality rates,[11] enabling providers to turn patients away could worsen health outcomes for women and lead to higher health costs. In rural communities, where women experience poorer health outcomes and have even more limited access to health care,[12] these expanded exemptions could be particularly devastating. **APA opposes governmental restrictions on family planning and abortion services[13] and as such, recommends that the Administration not expand abortion exemptions.**

Broader Implications for Health Costs and Mental Health

As the frontline physicians providing treatment for mental illness and substance use disorders, our goal is to ensure that all patients have access to effective treatment and receive care that is compassionate to their individual needs. According to the most recent National Survey on Drug Use and Health, 80.7 percent of people aged 12 or older who needed substance use treatment at a specialty facility did not receive it. In addition, 57.4 percent of adults with any mental illness did not receive mental health care.[14] The indirect cost of untreated mental illness to employers is estimated to be as high as $100 billion a year in the U.S. alone.[15] Ethnic/racial minorities often bear a disproportionately high burden of disability resulting from mental disorders. Lack of cultural understanding by health care providers may contribute to underdiagnosis and/or misdiagnosis of mental illness with language differences between patient and

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[10] Sari Reisner et al., Global Health Burden and Needs of Transgender Populations: A Review. The Lancet, 388, 412-436.

[11] MacDorman, M., Declercq, E., Cabral, H., Morton, C., "Is the United States Maternal Mortality Rate Increasing? Disentangling trends from measurement issues: Short title: U.S. Maternal Mortality Trends." Obstet Gynecol. 2016 Sep; 128(3):447-55.

[12] American College of Obstetricians and Gynecologists. "Health Disparities in Rural Women" (2014). https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc=1&ts=20190730T0304131196

[13] American Psychiatric Association. Position Statement on Abortion (2018). https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Abortion.pdf

[14] Center for Behavioral Health Statistics and Quality. (2018). 2017 National Survey on Drug Use and Health: Detailed Tables. Substance Abuse and Mental Health Services Administration, Rockville, MD.

[15] Finch, R. A. & Phillips, K. (2005). An employer's guide to behavioral health services. Washington, DC: National Business Group on Health/Center for Prevention and Health Services. Available from: www.businessgrouphealth.org/publications/index.cfm

provider being a contributing factor. Lack of coverage, limited access to culturally competent providers, distrust in the health care system, and stigma are additional main barriers to accessing effective care for diverse populations.

For this reason, **we oppose the Agency's proposal to eliminate requirements for covered entities to provide non-discrimination notices and grievances procedures. In addition, we oppose the proposal to eliminate the standards ensuring access to language assistance services, including oral interpretation and written translation, for individuals with limited English proficiency.** As an organization, we train physicians to deliver culturally competent care to serve the needs of evolving, diverse, underrepresented patient populations. Clear communication is essential to delivering quality care and these provisions would undermine necessary efforts to reduce disparities in mental health care.

A rule that would allow health care workers to deny any health care services to transgender individuals or women who have terminated a pregnancy and scales back patient protections for underserved patients will only exacerbate existing problems of access. While the proposal boasts cost savings, the proposed rule will result in higher health care costs and mortality rates, a less productive workforce, and an increased need for already scarce mental health and substance use services. It is important for us to work together to address these challenges to reduce the burden of mental health and substance use issues on patients, their families, communities, and the government. Religious freedoms can be respected without jeopardizing the basic health needs of a substantial portion of the population. We must also ensure that we do not exacerbate the need for services by adding barriers, such as discrimination or fear of discrimination against people in need of treatment. **Thus, we strongly urge the Administration to rescind this proposed rule to ensure that all patients have access to care without fear of discrimination.**

Thank you for the opportunity to offer our expertise. If you have any questions, please contact Kathy Orellana, Associate Director of Practice Management Policy, at korellana@psych.org or at 202-559-3911.

Best,

Saul Levin, MD, MPA, FRCP-E
CEO and Medical Director

EXHIBIT D-34

AAMC

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August 12, 2019

Via Electronic submission at www.regulations.gov

Roger Severino
Director, Office for Civil Rights
US Department of Health and Human Services
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Washington, DC 20201

Re: Nondiscrimination in Health and Health Education Programs or Activities, Docket No.: HHS-OCR-2019-0007, RIN 0945-AA11

Dear Mr. Severino:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid, Office for Civil Rights, and Office of the Secretary proposed rule, *Nondiscrimination in Health and Health Education Programs or Activities,* 84 *FedReg* 27846 (June 14, 2019). The AAMC is a not-for-profit association representing all 154 accredited U.S. medical schools and 17 accredited Canadian medical schools, nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers, and more than 80 academic and scientific societies. Through these institutions and organizations, the AAMC represents more than 173,000 faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

Our members are key health care providers to their communities and are strongly committed to treating all patients and families with respect and providing the highest quality, most equitable care. The comments below reflect our concerns that the proposed changes to regulations that implement section 1557 of the Affordable Care Act (ACA; 42 USC §18816) will harm patients and their families; exacerbate existing inequities in health and health care in the communities served by our members; and may leave the providers who care for these patients without payment for that care.

In our October 2015 letter in response to the initial Notice of Proposed Rulemaking (RIN 0945-AA02), the AAMC voiced strong support for the HHS proposal to extend nondiscrimination protections to transgender populations and to strengthen protections for persons living with disability and those with limited English proficiency (LEP). Further, we encouraged HHS to explicitly include lesbian, gay and bisexual individuals in the definition of "sex" proffered in the rule. We voiced this support and encouragement based, in part, on the endemic inequities in health and health care experienced by those populations in the face of decreased health care access, implicit and explicit bias within the health care system, and pervasive stigma and discrimination.

Ultimately, implementation of the final rule was blocked in July 2017, and in the intervening two years not only have those inequities persisted, but for some groups – transgender women of color in

particular – the situation has worsened.[1] To ensure that regulations reflect the broad scope of section 1557 that "an individual shall not . . . be excluded from participation in, be denied the benefits of, or be subject to discrimination under, any health care program or activity that is administered by an Executive Agency or any entity established under this title . . ." **the AAMC urges HHS to withdraw the proposed changes to the Section 1557 regulations.**

More specific comments follow.

To clearly and consistently implement Section 1557 and ensure that the regulations reflect the clear meaning of the statute, the definitions of "on the basis of sex" and "covered entity" should not be changed.

Definitions are essential for the appropriate implementation of section 1557 requirements. Given the extensive comments that were received in response to the proposed definitions, including those of "on the basis of sex" and "covered entity" (see 81 FedReg 31376, May 19, 2019) it is clear that definitions are needed to ensure a consistent understanding of the application and enforcement of the regulation.

As HHS noted in the preamble to the final 2016 rule, "we sought comment on the best way of ensuring that this rule includes the most robust set of protections supported by the courts on an ongoing basis." (81 *FedReg* 31388). The AAMC was disappointed that the final rule did not add gender identity and gender expression to the definition of "on the basis of sex." While the proposed rule cites the Franciscan Alliance case to bolster this proposal, "every district court that has considered this issue [regarding that "on the basis of sex" includes discrimination based on "gender identity and "termination of pregnancy"] over the past two years has concluded that discrimination against transgender individuals is prohibited by Section 1557 itself (rather than the regulation)."[2]

The proposed revisions to Section 1557 regulations would limit the scope of the application of the rule to "entities with a health program or activity, any part of which receives Federal financial assistance from the Department" (p. 27877). It would also exclude short term limited duration insurance. The impact of these limitations on Section 1557 will mean that individuals will not have the protections afforded to them that were intended by Congress when it enacted the legislation.

The AAMC notes Section VIII of the proposed role provides a list of issues for which it is requesting comments, many of which focus on the <u>costs</u> of the current rule. However, there is no attempt by HHS to consider the <u>benefits</u> that will accrue to individuals who are protected by the rule. As was noted in the 2016 final rule:

> In enacting Section 1557 of the ACA, Congress recognized the benefits of equal access to health services and health insurance that all individuals should have, regardless of their race, color, national origin, age, or disability. Section 1557 brought together the rights to equal access that had been guaranteed under Title VI, the Age Act and Section 504. At the

[1] A National Epidemic: Fatal Anti-Transgender Violence in America in 2018 https://www.hrc.org/resources/a-national-epidemic-fatal-anti-transgender-violence-in-america-in-2018 Accessed 8/6/19.

[2] *HHS Proposes to Strip Gender identity, Language Access protections from ACA Anti-Discrimination Rule,* Katie Keith, Health Affairs Blog, 10.1377/hblog20190525.831858, May 25, 2019.

> same time, Congress extended these protections and rights to individuals seeking access to health services and health insurance without discrimination on the basis of sex. (p. 31459)

In the final rule Table 7-Accounting Statement, noted as qualitative benefits, "potential health improvements and longevity extensions as a result of reduced barriers to medical care for transgender individuals." (p. 31465)

AAMC strongly opposes the removal of <u>any and all</u> discrimination prohibitions from the rule

While AAMC is glad to see that OCR proposes to maintain protections for persons living with disability, we oppose the roll back of protections for the LBGTQ population.

According to the Centers for Disease Control and Prevention (CDC), the LGBTQ community experiences significant inequities across a wide array of health and health care outcomes, including (but not limited to) tobacco use, depression, and HIV infection for gay and bisexual men; obesity, gynecological cancer, and heart disease for lesbian and bisexual women; and lack of insurance coverage, suicidality, and exposure to violence for transgender persons.

While multiple factors influence the development of these unjust and avoidable differences in health between the LGBTQ population and their heterosexual/cisgender counterparts, stigma, discrimination, and trans/homophobia in health care is a significant contributor.[3] AAMC's own research shows that members of the LGB community are more likely than heterosexuals to report they do not feel respected by their health care provider.[4]

There is no cost benefit to hospitals associated with permitting discrimination. There is no burden reduction related to sanctioning bias. The only outcomes of greenlighting systematic bigotry in health care will be to increase fear of discrimination, decrease health care access and use for the LGBTQ community, and widen already unconscionable health inequities.

HHS' stated mission is to "enhance and protect the health and well-being of all Americans". The AAMC encourages HHS to follow through on that promise and reject discrimination in health care.

There is no need to expand religious exemptions

HHS proposes that Section 1557 should incorporate abortion and religious exemptions contained in Title IX.

As we stated when we commented on the original 2008 Federal Health Care Conscience Rule, no individual or entity in this country has the option to pick and choose the laws to which he/she will adhere. Every health care provider and entity already has the obligation to comply with all applicable

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[3] Health and Care Utilization of Transgender and Gender Nonconforming Youth: A Population-Based Study. G. Nicole Rider, Barbara J. McMorris, Amy L. Gower, Eli Coleman, Marla E. Eisenberg Pediatrics Mar 2018, 141 (3) e20171683; DOI: 10.1542/peds.2017-1683.

[4] Dill, Michael J. 2014. "Sexual Orientation, Access to Care and Patient-Provider Communications." AAMC Health Workforce Research Conference. Washington, D.C.

federal laws. The Department has offered little evidence that this has not been the case. The Office of Civil Rights has received just forty-four complaints since it was designated with authority to enforce the Church, Coats-Snow, and Weldon Amendments. The paucity of complaints does not provide compelling evidence of a need for the expansion of OCR's authority, or the need for changes in the current regulations.

As the preamble to the proposed rule demonstrates, statutes and regulations already exist that broadly provide for religious exemptions. There is no need for additional exemptions.

Further, AAMC wishes to restate its concern that religious exemptions, particularly for family planning, will do harm to lower income Americans, racial and ethnic minorities, the LGBTQ community, and patients in rural areas.[5]

For rural- and frontier-dwelling Americans who reside in a health professional shortage area, access to certain services might functionally cease to exist as a result of religious exemptions: seeking care in distant locales might be too burdensome or expensive. This holds, too, for lower income Americans who lack the financial means to seek out care for procedures when their primary physicians decline to provide services.

Racial and ethnic minority women have reported experiencing race-based discrimination when receiving family planning care.[6] Religious exemptions may exacerbate this problem and the consequences that follow for women of color and their children.

For the LGBTQ communities, religious exemptions may further exacerbate health care access disparities. As noted above, LGBTQ Americans experience discrimination in health care settings, erecting a barrier to accessing health care services.[7] Religious exemptions codify what many within and beyond the LGBTQ communities view as state-sanctioned discrimination, and allow providers to refuse care or appropriate referrals solely based on their patients' sexual orientation or gender identity. This stands in stark opposition to OCR's stated goal to "protect fundamental rights of nondiscrimination."

The protections provided LEP populations by notice / tagline requirements outweigh any cost savings that might be achieved.

The 2016 final rule set forth specific requirements on how to communicate with individuals with limited English proficiency (LEP), including notice and tagline requirements to alert LEP individuals of the availability of free language assistance services. The AAMC strongly believes that the proposed recommendation to repeal the non-discrimination notice and tagline requirements would impede

[5] https://www.aamc.org/download/488276/data/aamccommentsonhhsproposedconsciencerightsrule.pdf
[6] Thorburn S, Bogart LM. "African American women and family planning services: perceptions of discrimination," *Women Health*. 2005;42(1):23–39.
[7] Cahill, S. "LGBT Experiences with Health Care," *Health Affairs* Vol. 36, No.4. 2017. Available from: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0277

access to critical language assistance services for millions of LEP individuals, contributing to and exacerbating existing racial and social inequities related to healthcare access and utilization.[8]

The Regulatory Impact Analysis in the final rule estimated that implementation of the notice requirements would impose $3.6 million in costs in the first year of compliance and zero costs in the four years following implementation. The final rule also estimated that the tagline requirements would incur the same cost as the notice requirement (a total of $7.2 million dollars). HHS contends that after independent analysis, the Department's original projection of the one-time notice and tagline costs "underestimated the actual costs associated with including nondiscrimination notices and taglines in significant communications and publications,"[9] and provides an alternative estimated burden of $147 million to $1.34 billion in annual costs and a cost savings projection of $3.16 billion over five years.[10] It is notable that HHS recognizes that "repealing the notice and taglines requirement may impose costs, such as decreasing access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services. Even so, such an impact is expected to be negligible."[11]

The AAMC believes the Agency's cost estimations are inflated and at most add incremental burden given hospitals and healthcare facilities already print notice and tagline statements and therefore, these costs should not count toward the "recurring costs" (e.g., paper, postage) that HHS indicates the final rule failed to account for in its regulatory burden assessment. HHS' conclusions also lack sufficient evidence to justify the removal of the notice and tagline requirements, especially without proposing an alternative process that ensures meaningful access to LEP assistance.

We also strongly disagree with HHS' contention that the result of removing the notice and tagline requirements would have negligible impact on LEP populations. To illustrate the impact of these requirements, HHS relies primarily on data and anecdotal feedback from private health insurance companies.[12,13] We urge HHS to engage minority health professional organizations and advocacy groups to better understand the real human and societal costs of repealing the nondiscrimination and tagline requirements. Relying primarily on cost assessments and feedback from select covered entities/stakeholders to measure the impact of the notice and tagline requirements does not provide a complete and accurate perspective on the value of the current regulations.

The AAMC appreciates the opportunity to comment on ensuring nondiscrimination in health care, and we look forward to working with the HHS on this issue. Please contact me or my colleagues Philip M.

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[8] *Proposed Changes to the Health Care rights Law and Language Access*, Asian & Pacific Islander American Health Forum, "25 million individuals in the U.S. are LEP, meaning they speak little to no English" (June 2019). Available from: https://www.apiahf.org/resource/proposed-changes-to-the-health-care-rights-law-and-language-access/

[9] 84 Fed. Reg. 27858 (June 14, 2019).

[10] *Id*.

[11] 84 Fed. Reg. 27882 (June 14, 2019).

[12] 84 Fed. Reg. 27846 (June 14, 2019), Aetna Health Plan Representatives, *Member Reaction to 1557 Taglines* (April 13, 2017).

[13] 84 Fed. Reg. 27882 (June 14, 2019), "Reports from covered entities suggest, anecdotally, that utilization of translation services did not appreciably rise after the Final Rule's imposition of notice and taglines requirements." *Id*.

Alberti, PhD (palberti@aamc.org) or Ivy Baer, JD (ibaer@aamc.org) with questions about these comments.

Sincerely,

David J. Skorton, MD
President and CEO
Association of American Medical Colleges

EXHIBIT D-35

POWER TO DECIDE
the campaign to prevent unplanned pregnancy

August 13, 2019

VIA ELECTRONIC SUBMISSION

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

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

Dear Secretary Azar:

Power to Decide submits these comments in response to the Department of Health and Human Services' ("HHS", "the Department") and the Center for Medicare and Medicaid Services ("CMS") Notice of Proposed Rulemaking ("proposed rule," "NPRM") to express our concerns with the proposed rule entitled "Nondiscrimination in Health and Health Education Programs or Activities", published in the Federal Register on July 14, 2019.

Power to Decide, the campaign to prevent unplanned pregnancy, believes that all young people should have the opportunity to pursue the future they want and realize their full possibility. These beliefs guide our work to ensure that all young people have the power to decide if, when, and under what circumstances to get pregnant and have a child. We provide objective, evidence-based information about sexual and reproductive health, and we work to guarantee equitable access to the full spectrum of reproductive health services. We are a national, non-partisan organization that is committed to common ground, common sense solutions and catalyzing innovation in the public and private sectors.

We are extremely concerned with the proposed rule that seeks to remove nondiscrimination protections in health care that would disproportionately affect access to the full range of reproductive health care for those already facing access barriers. While Section 1557 of the Affordable Care Act (ACA) is still the law, this proposed rule attempts to change the administrative implementation in a way that is contrary to the plain language of the law. The NPRM's proposed changes pose significant risks to those the law is intended to protect, including: lesbian, gay, bisexual, transgender, and queer ("LGBTQ") people; people who need reproductive health care, including abortion; women of color; people living with disabilities and/or chronic conditions; and people whose primary language is not English–all people who already experience significant barriers to accessing health care. The proposed changes could create additional barriers and

potentially lead to worse health outcomes, disproportionately impacting those living at the intersections of these identities.

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

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

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

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

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

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

The 2016 final rule made clear that sex discrimination under Section 1557 includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or

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

recovery from those conditions, childbirth or related conditions. The proposed rule attempts to roll back these protections. Although HHS acknowledges in the preamble to this proposed rule that Title IX prohibits discrimination based on pregnancy, including termination of pregnancy, it refuses to state whether the Department would enforce those protections. While the scope of protection under Section 1557 is clear, without unambiguous implementing regulations, and enforcement, illegal discrimination is likely to flourish.

The proposed rule would disproportionately impact LGBTQ people, and especially transgender, nonbinary, and gender nonconforming people, who already face unique barriers to accessing care, such as high uninsurance rates, discrimination and harassment. Under the proposed rule, those barriers would only increase.

The proposed rule would disproportionately impact women and people of color who are pregnant, especially those living in rural areas. Women of color already face unique barriers to accessing pregnancy-related and/or abortion care, such as a discrimination, harassment, refusals of care, and high rates of pregnancy-related complications. For example, Black women are three to four times more likely to die from pregnancy related complications than white women, and Native American women were 4.5 times more likely to die during or immediately after pregnancy than white women.

The proposed rule also impermissibly tries to add Title IX's religious exemption to Section 1557's protection against sex discrimination, which could embolden providers to invoke personal beliefs to deny access to a broad range of health care services, including birth control, sterilization, abortion, and gender-affirming care.

Across the country, more than 19.5 million women in need of publicly funded family planning services live in contraceptive deserts[2], where they lack reasonable access to a clinic offering the full range of contraceptive methods. Within those deserts, 1.6 million women in need live in counties without a single clinic offering the full range of contraceptive methods. The Administration is also seeking to redirect Title X family Planning funding to entities that offer next to no methods of contraception. Without Title X going to grantees committed to offering the full range of methods, the number of women in need living in counties without a single clinic offering the full range of contraceptive methods nearly triples.[3] The 1557 proposed rule threatens to exacerbate these access gaps even more by allowing providers to discriminate and deny access to birth control. These barriers are felt most acutely by people of color, LGBTQ people, people in rural areas, and people with low incomes. These people already struggle to access the care they need, as our contraceptive desert research makes clear.

The Proposed Rule Impermissibly Attempts to Eliminate Language Access Protections

The proposed rule would illegally pull back on language access protections for people with Limited English proficiency ("LEP") and those who have LEP family members by proposing

[2] https://powertodecide.org/what-we-do/access/access-birth-control
[3] https://powertodecide.org/news/too-many-women-lack-birth-control-access

to roll back requirements for the inclusion of taglines on significant documents and remote interpreting standards and by proposing to eliminate recommendations that entities develop language access plans.

For LEP individuals, language differences often compound existing barriers to access and receiving appropriate care. LEP often makes it difficult for many to navigate an already complicated healthcare system, especially when it comes to medical or insurance terminology. Moreover, these barriers are often compounded by discrimination based on national origin, immigration status, race, ethnicity, sexual orientation, and gender/gender identity.

The proposed rule will disproportionately impact people with LEP who are living with low income and/or are people of color. For example, Asian Americans and Native Hawaiian and Pacific Islanders make up 22 percent of those considered LEP in the U.S., and Latino people make up 63 percent of those considered LEP in the U.S. LEP individuals are more likely to live in poverty than their English proficient counterparts.

Language access is incredibly important to breaking down health care information and access barriers. At Power to Decide, that's why we created the Spanish language version of our evidence-based birth control support network, Bedsider.[4] Conversely, when people cannot access the information they need, they cannot take care of their reproductive health care, access the birth control they need, and find providers who speak their language. The proposed rule will exacerbate these language barriers by rolling back the current protections for people with LEP.

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

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

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

Conclusion

This proposed rule could impose wide ranging harm, particularly falling hardest upon the most underserved populations who already struggle to access health care. The proposed

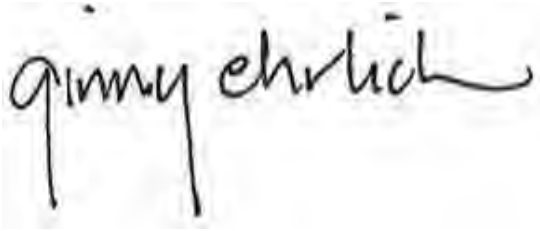
[4] https://www.bedsider.org/es

rule comes on top of other actions the Administration has taken that make it harder for people in already marginalized communities—people seeking reproductive health care, including abortion, LGBTQ individuals, individuals with LEP, including immigrants, those living with disabilities, and people of color—to access the health care they need. Moreover, this rule would embolden compounding levels of discrimination against those who live at the intersection of these identities. The proposed rule is dangerous and contravenes the plain language of Section 1557, specifically, and the ACA broadly.

For the reasons detailed above, HHS and CMS should not finalize the proposed rule.

Thank you for the opportunity to submit comments on the proposed rule. Please do not hesitate to contact Rachel Fey, Director of Public Policy at rfey@powertodecide.org or (202) 478-8529 to provide further information.

Sincerely,



Ginny Ehrlich
Chief Executive Officer

EXHIBIT D-36

August 13, 2019

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Section 1557 NPRM, RIN 0945-AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically

Re: Comment on Proposed Rule Regarding Section 1557, Health Care Rights Law

The ACLU of Northern California, the ACLU of Southern California, and the ACLU of San Diego and Imperial Counties (collectively "ACLU of California") submit these comments on the proposed rule published at 84 Fed. Reg. 27,846 (June 14, 2019), RIN 0945-AA11, with the title "Nondiscrimination in Health and Health Education Programs or Activities" (the "Proposed Rule").

The ACLU of California is a collaboration of the three California-based ACLU affiliates with more than 270,000 members and supporters, working to protect and advance the civil rights and civil liberties of all Californians. The ACLU of California has a long history of working to advance access to quality healthcare for all individuals and has specific experience and expertise in preserving and enhancing access to care for lesbian, gay, bisexual, transgender, and queer ("LGBTQ") individuals and for people in need of reproductive health care services. The ACLU of California is thus particularly well-positioned to comment on the Proposed Rule and the serious concerns it raises about access to health care.

The rule currently in place implementing Section 1557, titled "Nondiscrimination in Health Programs and Activities" (the "Current Rule"), was developed after years of review and consideration of comments from a variety of stakeholders. The Current Rule meets a critical need and fulfills Congress's intent to provide "equal access to health services and health insurance that all individuals should have, regardless of their race, color, national origin, age, or disability." 81 Fed. Reg. 31,459. Discrimination in the health care context leads to lasting harms to people's health and wellbeing, and the Department of Health and Human Services (the "Department" or "HHS") made detailed factual findings to that effect in support of the Current Rule: People subject to discrimination postpone or fail to obtain health services and are denied necessary care; such discrimination exacerbates health disparities in underserved communities.

The Proposed Rule, however, is yet another attempt by the Trump Administration and HHS to undermine access to health care for the most vulnerable individuals and communities, while emboldening discriminatory and dangerous denials of care. The Proposed Rule's explicit reductions in the scope of antidiscrimination protections, as well as the implicit invitation for health care providers to undermine access to care, completely disregard the potential harms to individuals trying to access health care and coverage. This approach is contrary to the statutory language of Section 1557, and is a reversal of the reasoned policy decisions underlying the Current Rule. Further, it will fail to accomplish its stated goal to *decrease* confusion, instead *increasing* the burdens and costs of compliance.

For these reasons, as well as the ones that follow, the ACLU of California recommends that the Department decline to finalize the Proposed Rule in its entirety.

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

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

In promulgating the Current Rule, the Department recognized the importance of affirmative regulatory protections—specifically against all enumerated forms of sex discrimination. The Current Rule defines discrimination based on sex to include discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity. 45 CFR 92.4. The Proposed Rule eliminates this key provision that clarifies what discrimination on the basis of sex encompasses, and removes explanatory examples of prohibited activity. The Proposed Rule also amends regulations—and incorporates an abortion exemption—that are unrelated to Section 1557. These changes are without justification and will directly harm patients seeking care.

1. The proposed amendments abandon LGBTQ individuals and people seeking reproductive health care, who depend on HHS to protect their statutory rights.

Section 1557 and the Current Rule are intended to protect people from the pervasive problem of sex-based discrimination in the health care context. LGBTQ patients, as well as people who seek or have obtained reproductive health services, face discrimination based on sex in accessing health care. This discrimination can range from providers using harassing or abusive language to completely refusing necessary medical care. Sex-based exclusions from health care coverage can also make essential medical care unaffordable. For example, some transgender and non-binary individuals are subject to discriminatory categorical exclusions for health care related to gender transition that put necessary health care out of financial reach. By eliminating the definition of discrimination on the basis of sex, as well as stripping protections against discrimination based on gender identity and sexual orientation from other unrelated HHS regulations, the Proposed Rule will invite such discrimination against LGBTQ individuals and people seeking reproductive health care.

Though the federal government's own Office of Disease Prevention and Health Promotion recognizes that lesbian, gay, bisexual, and transgender ("LGBT") people face disproportionate health disparities linked to societal stigma, discrimination, and denial of their civil and human rights[1], HHS fails to even consider the impact that the Proposed Rule would have on individuals who are protected under the Current Rule.

According to a study published by the Williams Institute in March 2019, approximately 1,615,000 adults in California openly identify as LGBT, accounting for 5.3 percent of California's adult population; and of those, 218,400 adults in California openly identify as transgender, accounting for 0.76 percent of California's population.[2] LGBT people in California are more likely to be unemployed, food insecure, and living below the federal poverty line than their non-LGBT counterparts[3], suggesting an increased need for affordable and quality health care.

The Department must prioritize the impact that inviting discrimination against patients will have on public health, particularly the harms to transgender and non-binary individuals, as well as people who need or have obtained pregnancy-related health services, all of whom would no longer have explicit regulatory protections against sex discrimination if the Proposed Rule is finalized.

2. The proposed amendments do not provide clarity, but only create more confusion.

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

Because discrimination based on sex would still be prohibited, discrimination based gender identity would remain unlawful under Section 1557 as well. In Section 1557, Congress directed HHS to apply existing civil rights law and regulations to healthcare and the ACA

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[1] Lesbian, Gay, Bisexual, and Transgender Health, (last accessed Aug. 8, 2019), available at: https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health.

[2] Adult LGBT Population in the United States, UCLA School of Law Williams Institute, March 2019, https://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf.

[3] See *id*.

exchanges, including Title IX of the Education Amendments Act of 1972 prohibiting discrimination on the basis of sex in federally funded educational programs and activities. Courts have consistently held that Title IX's prohibition on sex discrimination protects individuals from discrimination based on gender nonconformity. *See EEOC v. R.G. &. G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 572 (6th Cir. 2018), *cert. granted in part*, 139 S. Ct. 1599 (2019); *Whitaker ex rel. Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1046–54 (7th Cir. 2017); *Glenn v. Brumby*, 663 F.3d 1312, 1316 (11th Cir. 2011); *Schwenk v. Hartford*, 204 F.3d 1187, 1201 (9th Cir. 2000); *Rosa v. Park W. Bank & Tr. Co.*, 214 F.3d 213, 215–16 (1st Cir. 2000). District courts across the country have also recognized that discrimination against transgender individuals because their gender identity diverges from their sex assigned at birth violates the plain text of Section 1557. *See Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 953 (D. Minn. 2018); *Flack v. Wis. Dep't of Health Servs*., 328 F. Supp. 3d 931, 951 (W.D. Wis. 2018); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1098–1100 (S.D. Cal. 2017). Given the extensive legal precedent, the Department cannot simply assert by regulation that covered entities will not be liable for gender identity discrimination claims where such discrimination is prohibited by the statutory text.

Further, while the preamble to the Proposed Rule attempts at inordinate length to justify the elimination of gender identity as an identified form of sex discrimination, it does not explain why the other definitional provisions are eliminated as well. Removing the definition of sex discrimination cannot change the underlying legal precedent that the current definition was based on and that still prohibits discrimination on the enumerated bases, including discrimination based on gender identity and pregnancy.

For example, the following California laws prohibit discrimination based on gender identity, gender expression, pregnancy, childbirth, and related medical conditions, and have long supported the argument that discrimination on the basis of sex encompasses such categories:

- The California Fair Employment and Housing Act (FEHA) expressly prohibits discrimination by employers, labor organizations, and apprenticeship training programs on the basis on sex, which is defined to include pregnancy, childbirth, and related medical conditions, and on the basis of gender identity and gender expression as independent protected categories. Cal. Gov't Code § 12940. FEHA provides specifically that, while employers may impose gender-based dress codes, an employee must be permitted to appear or dress in a manner consistent with their gender identity. Cal Gov't Code § 12949. FEHA also prohibits gender identity discrimination related to renting, buying, and selling a house, which extends to public and private land use and real estate listings. Cal. Gov't Code §§ 12955(l), (j).

  Even prior to the addition of gender identity as an express category in 2011, California recognized that statutorily prohibited discrimination on the basis of "sex" encompassed gender identity. *See, e.g., In the Matter of the Accusation of the Dep't of Fair Employment & Hous.* (Feb. 1, 2006) FEHC Dec. No. 06-01 (finding that the challenged policy impermissibly promoted the sex stereotype that men should not wear "feminine attire" and that anti-transgender discrimination was prohibited as sex discrimination under the Unruh Act).

- The California Unruh Civil Rights Act (Unruh Act) prohibits sex discrimination in public accommodations and defines "sex" to include gender identity, gender expression, pregnancy, childbirth, and related medical conditions. Cal Civ. Code § 51. The Unruh Act has been found to apply to physicians' offices and hospitals that serve the public. *See, e.g., North Coast Women's Care Med. Group v. San Diego County Sup. Ct.*, 44 Cal.4th 1145 (2008) (medical group providing services to the public is a "business establishment" under the Unruh Act).

- The California Education Code prohibits discrimination on the basis of gender and prohibits instruction or school-sponsored activities that "promote[] a discriminatory bias". Cal. Educ. Code §§ 220; 51500. "Gender" under the California Education Code is defined to include gender identity and gender expression. Cal. Educ. Code § 210.7.

- The California Insurance Gender Nondiscrimination Act prohibits health plans from discriminating against individuals based on sex and defines "sex" to include gender identity and gender expression. Cal. Health & Saf. Code, § 1365.5.

To the extent there is variance among California and federal courts as to what constitutes discrimination based on sex, the Current Rule provides crucial uniformity.

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

The Proposed Rule would unnecessarily incorporate the abortion exemption from Title IX into regulations implementing Section 1557. Incorporating the abortion exemption violates the text and purpose of Section 1557, which prohibits discrimination "on the *ground[s]* prohibited under" the referenced civil rights statutes, not the attendant exemptions contained in those statutes. 42 U.S.C. § 18116 (emphasis added). Congress has already spoken clearly as to the restrictions it intended to place on abortion care and coverage, through both the ACA itself, *see* 42 U.S.C. § 18023(b)(1)(A), (b)(4), as well as the Weldon, Church, and Coats Amendments. Abortion care is health care related to pregnancy, and targeting it for exclusion undermines and stigmatizes access to care that is a constitutionally protected right and a necessity for millions of Americans.

* * *

Taken as a whole, the Proposed Rule strips explicit regulatory protections for LGBTQ individuals and for people who require reproductive health care, indicating that the underlying purpose for the amendments is to target transgender and non-binary individuals, as well as other people who face sex-based discrimination in accessing health care and insurance coverage. That is neither consistent with the text of the statute, nor the appropriate mission of the Department. The Proposed Rule is also untimely, as the U.S. Supreme Court plans to hear argument in October in three cases addressing whether sex discrimination encompasses discrimination based on sexual orientation, gender identity, and discrimination against transgender individuals due to

sex stereotyping under Title VII. *Altitude Exp., Inc. v. Zarda*, 139 S. Ct. 1599 (2019); *Bostock v. Clayton Cty., Ga.*, 139 S. Ct. 1599 (2019); *R.G. & G.R. Harris Funeral Homes, Inc. v. EEOC*, 139 S. Ct. 1599 (2019). Because Title IX generally adopts the standards for discrimination under Title VII, the Department will need to address the practical implications of any decision by the Court through a renewed comment process. Accordingly, the Department should abandon the Proposed Rule and instead leave in place the existing rule that discrimination based on gender identity is a form of sex discrimination, as is discrimination based on pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, and sex stereotyping.

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

Historically, people with disabilities in the United States have been unable to access the health care they need because of discrimination by the health insurance industry. Prior to the ACA, people with disabilities were commonly denied or terminated from health coverage, faced annual and lifetime benefit limits, and could not find affordable coverage. Access to adequate health care at affordable rates is central to the ability of disabled people to participate fully in society.

The Department proposes to eliminate Section 92.207 of the Current Rule in its entirety, which would undermine the right of people with disabilities to challenge discriminatory benefit design. Under the Current Rule, for example, plans that cover bariatric surgery in adults but exclude such coverage for adults with particular developmental disabilities, place most or all drugs that treat a specific condition on the highest cost tiers, or exclude bone marrow transplants regardless of medical necessity, constitute disability discrimination in violation of Section 1577. The Department claims that the provision is redundant or may be confusing in relation to the Department's preexisting regulations. But the Current Rule is needed precisely because existing laws were insufficient to dismantle barriers to adequate health insurance for people with disabilities. The deletion thus contravenes Section 1557's plain language.

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

C. HHS should not weaken protections for individuals with Limited English Proficiency.

The Department should not eliminate the language access protections as described by the Proposed Rule. In California, there are 6,766,073 people with limited English proficiency[4] ("LEP"), 39.5 percent of Californians speak a language other than English at home, and one in

[4] Limited English Proficient (LEP), An Inter-Agency Website, *Total Persons 5 Years and Over Who Speak a Language Other Than English at Home and Speak English Less Than "Very Well"*, (last visited: August 12, 2019), available at: https://www.lep.gov/maps/2015/national/US_state_LEP_count.ACS_5yr.2015.pdf.

five Californians has a level of English proficiency that suggests that they would benefit from language assistance when accessing the health care system.[5] These Californians should all have meaningful access to health care and coverage. Language assistance is necessary to ensure that LEP persons are guaranteed such access, and is a critical protection to combat discrimination on the basis of national origin, which encompasses discrimination on the basis of language.

The Proposed Rule would eliminate significant protections for LEP persons by removing the requirement that covered entities provide notices of legal rights and in-language taglines on significant publications. The taglines are cost-effective ways to maintain access for LEP individuals without translating entire documents. The Department ignores the impact on LEP individuals should this requirement be eliminated, relying solely on reports from health plans, with no public outreach to determine the impact of the taglines or to explore alternatives. Likewise, the Department should not eliminate references to language access plans, which are a useful tool for covered entities to fully plan how to meet the needs of LEP patients and consumers. Such plans also support covered entities' own compliance efforts, benefiting both LEP individuals and covered entities alike.

LEP individuals face unique risks and barriers to knowing and asserting their rights in the health care context. In California, studies have found that LEP individuals are less likely to have a usual source of health care, less likely to have had a mammogram in the last two years, and have lower rates of crucial diagnostic blood tests.[6] Overall, language barriers reduce patient access to health care, even among patients with health insurance coverage through Medicare.[7] Language barriers in health care result in life and death consequences for LEP patients; they face difficulties in communicating directly with providers about their symptoms and needs, and prescription instructions are often not translated properly and can result in misuse of prescribed medicine.[8] LEP patients need more and better access to translation and interpretation services, not less. The proposed rule puts the health and well-being of LEP patients in jeopardy by scaling back crucial language access protections. The proposed elimination of protections to aid communication with LEP individuals—both while they are accessing services and so that they know their rights—should be abandoned.

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[5] Chen, Alice Hm, *Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature*, 1, The California Endowment (August 2003) available at: https://ncihc.memberclicks.net/assets/documents/cal.endow.bibliography.pdf.

[6] Once, Ninez A., Ku, Leighton, Cunningham, William E., Brown, Richard E., *Language Barriers to Health Care Access Among Medicare Beneficiaries*, Inquiry 43: 66–76 (Spring 2006), available at: https://publichealth.gwu.edu/departments/healthpolicy/DHP_Publications/pub_uploads/dhpPublication_3B0D8691-5056-9D20-3D5363F46853C7A6.pdf.

[7] Id.

[8] Guzik, Hannah, *Language Barriers in California Health Care*, The California Health Report (May 27, 2014), available at: https://www.calhealthreport.org/2014/05/27/language-barriers-in-california-health-care/.

II. THE DEPARTMENT SHOULD NOT LIMIT THE BROAD INTENDED IMPACT OF SECTION 1557.

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

A. HHS Should Not Import a Religious Exemption into Section 1557.

The Proposed Rule wrongly would allow religiously affiliated healthcare providers to discriminate based on sex and to refuse access to necessary medical care, by importing Title IX's expansive religious exemptions into Section 1557. Religiously affiliated healthcare providers make up a significant percentage of the healthcare facilities in the United States. One in six patients is now treated in a Catholic facility each year, and religious hospitals are also gradually becoming the *only* health care option in many regions.

In California, as in many parts of the country, the size and scope of Catholic hospitals has been increasing in recent years. At present, there are 37 general acute care hospitals throughout the state that follow Catholic doctrine. In the Northern California communities of Red Bluff and Redding, Catholic hospitals are the only option for patients in the region.

The largest hospital provider in California is Dignity Health, a Catholic-affiliated health system. Dignity Health requires its hospitals and other facilities to follow the Ethical and Religious Directives for Catholic Healthcare Services or its Statement of Common Values. Both documents are non-medical and restrict physicians from practicing medicine in alignment with their training and with patients' autonomy.

Dignity Health is in the process of merging with Catholic Health Initiatives to create CommonSpirit Health. This new entity is projected to be responsible for caring for one in six patients in this country. Aside from the sheer numbers of patients who rely on these institutions for care, mergers of this type increasingly give Catholic entities outsize influence and corporate power in the health care market. A worst-case scenario would be that these entities, which push non-medical restrictions on their patients and improperly interfere in the patient-provider relationship, set the industry standard in health care.

The proposed religious exemption violates the text and purpose of Section 1557, as well as the constitutional commitment to the separation of church and state. The statute prohibits discrimination "on the *ground[s]* prohibited under" the referenced civil rights statutes, 42 U.S.C. § 18116 (emphasis added), but does not incorporate the attendant exemptions contained in those statutes—many of which are wholly inapposite to the health care context. The Department should not reverse course by incorporating the exemption, having initially rejected invitations to do so. Further, the First Amendment forbids government action favoring religion to the point of

forcing third parties to bear the costs of those beliefs. *See Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 708–10 (1985). The Proposed Rule's exemption flies in the face of the careful balance courts have struck between civil rights and religious liberty, running afoul of the Establishment Clause.

Permitting a blanket religious exemption to Section 1557's nondiscrimination mandate threatens access to critical care for countless patients, especially transgender patients and patients seeking reproductive health services. The Proposed Rule altogether fails to consider the harmful consequences of importing a broad religious exemption into the health care context.

The ACLU of California has collected stories of denials of healthcare based on religious directives as part of our All Care Everywhere campaign. The stories of Oliver, Evan, Tyler, Rebecca, and Sarah below demonstrate that people are turned away or denied services for medically necessarily, life-saving care, running counter to medical ethics and training.

Oliver Knight lives in Humboldt County, California where Catholic hospitals dominate. Oliver was prepped and ready for gender-affirming surgery at St. Joseph Hospital in Eureka when his doctor informed him that this common procedure was being refused by the hospital pursuant to the hospital's religious policies. Minutes later, Oliver was asked to leave the hospital. He still had booties on his feet as the nurse escorted him outside. Oliver felt humiliated as he sat on the curb waiting for his roommate to pick him up. In March 2019, The ACLU Foundation of Northern California, ACLU Foundation of Southern California, and the law firm Rukin Hyland & Riggin filed a lawsuit on behalf of Oliver Knight.

Evan Minton was scheduled to receive a hysterectomy at Mercy San Juan Medical Center, a hospital in the Dignity Health system, near Sacramento. Two days prior to the appointment, a nurse called to discuss the surgery and Evan mentioned that he is transgender. The next day, the hospital canceled the procedure. The delay put Evan's other scheduled treatments in flux until he was eventually able to schedule the surgery at another hospital. Evan's doctor said that she routinely performs hysterectomies at Mercy San Juan and had never before been prevented from performing the surgery. In April 2017, the ACLU Foundation of Northern California, ACLU Foundation of Southern California, and the law firm Covington & Burling LLP filed a lawsuit on behalf of Evan Minton.

Rebecca Chamorro, a patient at Mercy Medical Center Redding, decided with her obstetrician that she would receive a postpartum tubal ligation immediately following her scheduled C-section. Her obstetrician sought authorization from Mercy Medical Center, a Dignity Health hospital, to perform the tubal ligation, which would only take a few minutes and required no additional resources from the hospital. Mercy Medical Center refused her obstetrician's request to perform the procedure, citing religious directives that deem sterilization procedures as "intrinsically evil." In December 2015, the ACLU Foundation of Northern California, ACLU Foundation of Southern California, and law firm Covington & Burling LLP filed a lawsuit on behalf of Rebecca Chamorro.

Sarah, a patient at Mercy Medical Center Redding, sought authorization with her obstetrician for the same procedure as Rebecca Chamorro, a postpartum tubal ligation immediately following a scheduled C-section. Mercy Medical Center was the only hospital within 150 miles of Sarah's home and her only available, affordable option for the C-section and tubal ligation. Sarah was devastated when the hospital refused her obstetrician's request to perform the procedure.

When Tyler decided to pursue gender-affirming surgery, St. Joseph's Santa Rosa Memorial Hospital near Tyler's home and community was the natural hospital choice. After her doctor had trouble scheduling the surgery, Tyler drove to the hospital to schedule the surgery in person. The hospital staff misgendered Tyler and denied her gender-affirming surgery, citing their religious directives. She felt humiliated and dehumanized.

Allowing a religious exemption to section 1557's nondiscrimination mandate would further threaten patients' access to the critical health care they need.

B. HHS Should Not Narrow the Scope of Covered Entities.

The Proposed Rule would further undercut Section 1557 by limiting the entities covered by the provision. Limiting the application of Section 1557's protections would sanction discriminatory denials of coverage by entities that are presently covered by Section 1557, causing confusion and serious harm to those unable to access care. Additionally, the Proposed Rule displays no awareness of the potential harm to individuals denied coverage of and access to health care due to the proposed limitations on Section 1557's application.

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

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

The Current Rule adopts a uniform standard, applicable to all grounds covered by Section 1557, and incorporates enforcement mechanisms that exist under any of the civil rights laws referenced by Section 1557. This includes a private right of action for disparate-impact claims and the availability of compensatory damages for all claims under Section 1557. In removing these provisions, the proposed rule creates a scheme in which people are denied certain legal remedies because of the type of discrimination they experience. Such a change also privileges

purported business interests in relieving regulatory burdens over the interests of the public and of individuals seeking health care. However, by removing the certainty of the Current Rule, covered entities and protected individuals alike would be uncertain as to the law's requirements and protections, instead leaving them to look to four other separate civil rights laws and various agencies' implementing regulations for clues.

The Proposed Rule's silence regarding the availability of a private right of action is at worst contrary to the rights-expanding aims of the statute and, at best, purposeless. Parties asserting private rights of action pursuant to Section 1557 have significantly expanded access to health care and combatted discriminatory health care policies, and will continue to do so, regardless of regulatory language explicitly affirming that such a right exists.

The Department should also not eliminate the Current Rule's provision for disparate-impact claims, which promotes better compliance with Section 1557's nondiscrimination provisions. The disparate-impact mechanism encourages health care providers to identify disparities and to adopt solutions that make a crucial difference in eliminating those disparities for individuals and improving public health.

These enforcement mechanisms are particularly important for people of color. Addressing racial disparities in health care is a matter of life and death. Such disparities are found across a range of illnesses and health care services, even when accounting for socioeconomic factors. Disparities in health care also have historic roots. As in other sectors of society, segregated health care was once sanctioned by law, and government-sanctioned discrimination continues to have a systemic impact on access to quality health care. At the same time, research suggests that many racial and ethnic health disparities could be reduced or even eliminated if identified and addressed. A disparate-impact private right of action is a crucial enforcement mechanism to confront and redress discrimination.

The Department's proposal would instead make enforcement more difficult, and would increase confusion as to the scope of Section 1557's protections. The Department should accordingly continue to affirm existing enforcement mechanisms, including the private right of action for disparate-impact claims.

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

The Proposed Rule would unnecessarily eliminate the specific grievance procedures established under Section 1557, which would leave covered entities and impacted individuals without cohesive, uniform procedures for investigating grievances. Further, the Department should not eliminate the explicit requirement that such procedures "incorporate appropriate due process standards," which provides that the procedures in place are sufficient to address claims of discrimination promptly and equitably. 45 CFR 92.7. Likewise, the Department should not eliminate the requirement that covered entities provide notice to the public that they do not discriminate, as the current procedure is crucial to ensure that individuals are aware of the safeguards in place and of the steps they can take to effectuate the protections under Section

1557. 45 CFR 92.8. The costs associated with the notice requirement are well worth the benefit of ensuring that protected individuals receive adequate notice of their rights.

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

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

* * *

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

* * *

Sincerely,

Aditi Fruitwala
ACLU Foundation of Southern California

Amanda Goad
ACLU Foundation of Southern California

Elizabeth Gill
ACLU Foundation of Northern California

Melissa Deleon
ACLU Foundation of San Diego
and Imperial Counties

EXHIBIT D-37

NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

August 13, 2019

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

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

Dear Secretary Azar:

On behalf of the National Association of County and City Health Officials (NACCHO) and the nearly 3,000 local health departments across the United States that we represent, I write to provide comments in response to the Department of Health and Human Services' (HHS) and the Center for Medicare and Medicaid Services' (CMS) Notice of Proposed Rulemaking. We are concerned that the proposed rule entitled "Nondiscrimination in Health and Health Education Programs or Activities," published in the Federal Register on July 14, 2019, would exacerbate health disparities. While the scope of protection under the Health Care Rights Law is clear, without unambiguous implementation of regulations and strong enforcement, illegal discrimination is likely to increase, limiting health care access and harming the public's health.[1]

Local health departments work every day in their communities to prevent disease, promote wellness, and protect health. They convene community partnerships and facilitate important conversations with diverse stakeholders on how to create the conditions in which all people can be healthy. NACCHO and local health departments are partners with HHS and agencies like the Centers for Disease Control and Prevention (CDC) to enhance the health of all individuals in the United States.

NACCHO and our members recognize the value of and are committed to expanding health care access to all who need it. Unfortunately, the proposed rule would do the opposite. The proposed rule would change the Health Care Rights Law (Section 1557 of the Affordable Care Act) that prohibits discrimination based on race, color, national origin, sex, age, and disability in health programs and activities receiving federal financial assistance. By narrowing civil rights protections under the Health Care Rights Law, the proposed rule would limit health care access for limited English proficient populations, transgender people, women, and individuals with disabilities and chronic conditions. These are some of society's most vulnerable people who already face healthcare challenges and need protection from discrimination. The proposed rule would change those protections against discrimination for a host of reasons, including gender, sexual orientation, pregnancy, and national origin and language needs.

[1]MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), Retrieved August 8, 2019 from https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

As the first broad prohibition against sex-based discrimination in healthcare, Section 1557 is crucial to ending both sex-based and gender-based discrimination in the healthcare industry.[2] Sex and gender discrimination in health care has a disproportionate impact on women of color, LGBTQ people, and individuals living at the intersections of multiple identities–resulting in them paying more for healthcare, receiving improper diagnoses at higher rates, being provided less effective treatments, and sometimes being denied care altogether. The proposed rule would disproportionately impact LGBTQ people, and especially transgender, nonbinary, and gender nonconforming people, who already face unique barriers to accessing care, such as high uninsured rates, discrimination and harassment. Under the proposed rule, those barriers would only increase.

Protections are also needed against discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth, or related conditions. Although HHS acknowledges in the preamble to this proposed rule that Title IX prohibits discrimination based on pregnancy, including termination of pregnancy, it does not state whether HHS would enforce those protections.

Discrimination based on national origin, which encompasses discrimination based on language, creates unequal access to health care. Over twenty-five million Americans are limited English proficient (LEP).[3] An estimated 19 million LEP adults are insured.[4] Language assistance, including "taglines" notifying LEP persons of available services in the top 15 languages spoken by LEP individuals, is necessary for them to access federally funded programs and activities in the healthcare system. The proposed changes, including narrowing the scope of who is subject to the Health Care Rights Law, eliminating a private right of action and repealing the notice, taglines and language access plans threaten the civil rights of LEP persons. Without the notice, members of the public will have limited means of knowing that language services and auxiliary aids and services are available, how to request them, what to do if they face discrimination, and their right to file a complaint. Taglines are well-supported by existing federal and state regulations, guidance and practice.[5] In the absence of translated documents, taglines are necessary "to ensure that individuals are aware of their protections under the law, and are grounded in OCR's experience that failures of communication based on the absence of auxiliary aids and services and language assistance services raise particularly significant compliance concerns under Section 1557, as well as Section 504 and Title VI."[6]

The proposed rule also impermissibly seeks to limit the enforcement mechanisms available under the Health Care Rights Law for patients who have experienced discrimination, including by attempting to eliminate notice and grievance procedure requirements, private rights of action, opportunities for money damages, and by claiming that the remedies and enforcement mechanisms for each protected characteristic (race, color, national origin, age, disability or sex) are different and limited to those available under their referenced statute. The proposed rule would create a confusing mix of legal standards and available remedies under a single law, and could limit claims of intersectional discrimination, going against the text and intent of the Health Care Rights Law. Ultimately, the proposed rule will make it harder for those who are discriminated against to access meaningful health care and to enforce their rights. While the Health Care Rights Law would

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[2] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), Retrieved August 8, 2019 from https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

[3] Asian & Pacific Islander American Health Forum Analysis of 2017 American Community Survey Data.

[4] Asian & Pacific Islander American Health Forum Analysis of 2017 American Community Survey Public Use Microdata Sample Files.

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

[6] Nondiscrimination in Health Programs and Activities Proposed Rule, RIN 0945–AA02, September 8, 2015. Retrieved August 8, 2019 from https://www.govinfo.gov/content/pkg/FR-2015-09-08/pdf/2015-22043.pdf.

still be intact, this proposed rule attempts to change the administrative implementation in ways that are contrary to the law's plain language.

The Section 1557 2016 final rule made clear that the Health Care Rights Law protects from these discriminations, however the proposed new rule attempts to roll back those same protections, which would have devastating effects on vulnerable populations and lead to access barriers. Therefore NACCHO calls on HHS reject the proposed rule and maintain strong health protections for all. NACCHO and local health departments are prepared to work with your Department to improve and protect health across our nation. Please contact Adriane Casalotti, MPH, MSW, NACCHO Chief of Government and Public Affairs, with any questions at acasalotti@naccho.org.

Sincerely,

Lori Tremmel Freeman, MBA
Chief Executive Officer

EXHIBIT D-38

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Office of the President
Ted L. Anderson, MD, PhD, FACOG

August 13, 2019

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

RE: RIN 0945–AA11: Nondiscrimination in Health and Health Education Programs or Activities

Dear Director Severino:

On behalf of the American College of Obstetricians and Gynecologists (ACOG), I appreciate the opportunity to provide comments on the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) proposed rule RIN 0945–AA11: "Nondiscrimination in Health and Health Education Programs and Activities" (Proposed Rule). ACOG has more than 58,000 members representing more than 90 percent of all board-certified obstetrician-gynecologists (ob-gyns) in the United States. As the premiere national medical specialty of women's health care physicians, we support the goals of the Patient Protection and Affordable Care Act (ACA) to expand access to continuous and meaningful health insurance coverage and reject discriminatory practices that jeopardize patient care.

Women as well as lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ+) individuals face frequent barriers to health care. For example, women are more likely than men to delay care due to cost concerns.[1] Women who identify as lesbian or bisexual encounter concerns around confidentiality, disclosure, and a limited understanding as to what their health risks may be.[2,3] Moreover, transgender individuals face lack of adequate insurance coverage, mistreatment by health care providers, and health providers' discomfort or inexperience with the transgender population.[4,5,6,7] According to the 2015 U.S. Transgender Survey Report, nearly 25 percent of transgender individuals did not see a doctor when they needed to in the past year because of fear of being mistreated as a transgender person.[8] Thirty-three percent did not see a doctor due to cost.[9]

Prior to the passage of the ACA, women and LGBTQ+ people faced even greater barriers to health care, including higher patient cost-sharing and discriminatory benefit design.[10,11] Notably, Section 1557 of the ACA provides substantial civil rights protections to our patients and prohibits discrimination in health care on the basis of sex. Existing regulations recognize that Section 1557's broad prohibition of discrimination on the basis

of sex includes, but is not limited to, "discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity."[12] ACOG recognizes that ensuring women and LGBTQ+ people are able to access health care that is free from discrimination is critical for the health and safety of the patients we serve.[13]

The Proposed Rule seeks to weaken these civil rights protections by eliminating the definition of sex discrimination from the Section 1557 regulation. It also seeks to eliminate prohibitions on discrimination in health insurance products and limit the number of entities and types of insurance products subject to the nondiscrimination requirements. In addition, the Proposed Rule seeks to limit protections for individuals with limited English proficiency and virtually removes an individual's private right of action to sue for discrimination under Section 1557. Each of these proposals will negatively impact access to care for our most vulnerable patients. For these reasons, and those explained in detail below, we urge OCR to withdraw this Proposed Rule in its entirety.

I. The Proposed Rule would eliminate the definition of sex discrimination, weakening protections for LGBTQ+ patients and access to comprehensive women's health care.

Section 1557 broadly prohibits discrimination in health care on the basis of sex. ACOG supports existing regulations that correctly recognize that, among other things, discrimination on the basis of sex for the purposes of Section 1557 includes sex stereotyping, discrimination based on gender identity, and discrimination based on pregnancy status, including termination of pregnancy. The Proposed Rule would eliminate this definition, seeking to undermine the protections of Section 1557 and expose patients to unnecessary harm.

A. The Proposed Rule eliminates recognition that gender identity is a form of prohibited sex discrimination in health care.

ACOG endorses equitable treatment for all patients regardless of gender identity or sexual orientation.[14] OCR's proposal seeks to eliminate recognition of gender identity, which includes gender expression and transgender status, as a form of prohibited sex discrimination. ACOG opposes discrimination on the basis of gender identity and opposes the Proposed Rule's failure to recognize gender identity and sexual orientation as forms of prohibited sex discrimination under Section 1557.[15,16]

Each of OCR's proposed changes related to gender identity are antithetical to Congressional intent and do not align with existing case law which recognizes that sex discrimination includes discrimination based on gender identity.[17,18,19,20] Moreover, failing to recognize gender identity and sex stereotyping as prohibited forms of sex discrimination in health care could put millions of people at significant risk of mistreatment.

Recognition by HHS that gender identity is a prohibited form of sex discrimination under Section 1557 has been a vital tool in our efforts to overcome barriers to health care for transgender patients.[21] Since the implementation of Section 1557, 18 states have implemented affirmative coverage protocols in their respective Medicaid programs to ensure coverage of medically necessary transition-related care.[22] Additionally, a 2019 Marketplace analysis of 622 silver plan options from 129 issuers in 38 states found that 41 percent of plans surveyed had affirmative coverage policies while only six percent had transgender-specific exclusions.[23] This progress – in both Medicaid and the Marketplace – is in jeopardy if OCR's rule is finalized as proposed.

B. The Proposed Rule eliminates recognition of forms of sex discrimination against women.

Existing regulations made clear that sex discrimination under Section 1557 includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related conditions.[24] Under the Proposed Rule, OCR seeks to roll back these protections. Although the preamble of the Proposed Rule acknowledges that the prohibition against sex discrimination includes termination of pregnancy, it refuses to state whether OCR would enforce those protections. Moreover, the Proposed Rule seeks to eliminate the 2016 regulation's clarification that the ban on sex discrimination includes all pregnancy related care. While the scope of protection under Section 1557 is clear, ambiguous implementing regulations and enforcement mean discriminatory practices are likely to flourish.

ACOG believes that health care must be delivered in a way that is respectful of patient autonomy, timely and effective, evidence based, and nondiscriminatory.[25] This includes all care related to pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related conditions. ACOG opposes OCR's attempt to weaken nondiscrimination protections for women seeking basic medical care.

C. The Proposed Rule codifies overly broad exemptions to anti-discrimination requirements that threaten access to care for women.

ACOG's Code of Professional Ethics states that the "welfare of the patient (beneficence) is central to all considerations in the patient-physician relationship."[26] Moreover, the American Medical Association's Code of Medical Ethics requires medical professionals to act in good faith to protect patient health, even when a patient's health interests conflict with a physician's personal views.[27] As physicians dedicated to providing quality care to women, ACOG supports physician autonomy and the right to practice medicine according to one's conscience, however, ACOG does not support discrimination based on those beliefs.[28]

The Proposed Rule would establish blanket religious exemptions to the prohibition on sex discrimination based on termination of pregnancy. Under the Proposed Rule, a patient in need of abortion services could be denied or discouraged from seeking necessary health care, placing her health or life at risk. Additionally, women who have experienced a prior

termination could be discriminated against if they disclose their prior abortion on a medical history. ACOG believes that safe, legal abortion is a necessary component of women's health care that is essential to women's health and well-being.[29,30] Section 1557 already contains sweeping religious exemptions. ACOG does not support regulatory creation of additional exemptions that go beyond recognized law – especially if they could inhibit patients' ability to achieve full health care equity.

II. The Proposed Rule would eliminate prohibitions on discrimination in health insurance products, allowing issuers to discriminate against certain populations and medical conditions.

ACOG believes that all Americans should be provided with adequate and affordable health coverage.[31] As women's health care physicians, ACOG is determined to stop all efforts to turn back the clock on women's health, including efforts to return to a time before the ACA where health insurance issuers openly discriminated against women and individuals with preexisting conditions.

Section 1557 includes a ban on discriminatory behavior by health insurance issuers. Under the current regulations, covered entities are prohibited from denying, canceling, limiting, or refusing to issue or renew a health insurance policy; denying or limiting coverage of a health insurance claim; imposing additional cost-sharing or other limitations or restrictions on coverage; or using discriminatory marketing practices or insurance benefit designs because of race, color, national origin, sex, age, or disability. These important protections would be eliminated under the Proposed Rule, opening the door for health insurance issuers to discriminate against certain populations and medical conditions.

For example, under the Proposed Rule, insurers could limit access to transition services for transgender individuals. ACOG recognizes that medical and mental health treatments related to gender transition are beneficial and medically necessary for many transgender patients.[32] Further, when access to transgender health care is limited or denied, the results can be dire. According to a recent study published by the American Academy of Pediatrics (AAP), more than 50 percent of transgender male adolescents have attempted suicide.[33] Similarly, 41.8 percent of adolescents who do not identify as exclusively male or female have attempted suicide, followed by nearly 30 percent of transgender female adolescents.[34] ACOG encourages all health plans to cover the various treatments associated with gender identity disorder.[35] This lifesaving care should not be restricted.

The Proposed Rule would also give health insurance issuers the authority to place all drugs for certain diseases or infections – such as HIV – into the highest cost-sharing tier, making them cost prohibitive for many patients. Moreover, the Proposed Rule would allow insurance companies to implement prior authorization or step therapy requirements as well as age restrictions for certain medications, even those that have been found to be clinically effective for all ages.

It is foreseeable that some health plans may target contraceptive methods for prior authorization, step therapy requirements, or age restrictions. ACOG has routinely

discouraged the Centers for Medicare and Medicaid Services (CMS) from allowing entities to require prior authorization and step therapy for family planning services and supplies and for family planning-related services. We believe that medically-appropriate clinical services must be available to patients without costly delays or the imposition of additional barriers.[36]

This is particularly concerning for adolescent access to long-acting reversible contraception (LARC). Notably, ACOG, AAP, the Centers for Disease Control and Prevention, and the Society of Family Planning support the use of LARC by adolescents as these methods have higher efficacy, higher continuation rates, and higher satisfaction rates compared with shorter-acting contraceptives among adolescents who choose to use them.[37] Granting health plans the power to limit access to these critical medications may create barriers for patients to access the method of their choice, potentially leading to inconsistent use of inferior methods and higher rates of unintended pregnancy. Each of these actions by health plans would constitutes sex discrimination under the current Section 1557 regulations, however, these practices would be condoned under the Proposed Rule. ACOG discourages OCR from finalizing these provisions.

III. The Proposed Rule would limit the number of entities and types of insurance products subject to the nondiscrimination requirements.

The Proposed Rule would significantly narrow the applicability of Section 1557 in two ways. First, it would carve out all HHS programs and activities that were not expressly created under Title I of the ACA. This includes programs like the National Health Service Corps and the Indian Health Service, neither of which would need to comply with nondiscrimination protections under the Proposed Rule. Second, while the regulations would still apply to non-health care entities (i.e., health insurance issuers), they would only apply to lines of business that receive federal financial support. Under the current regulations, Section 1557 applies to the insurer itself, meaning any product sold by that insurer cannot discriminate based on race, color, national origin, age, disability, or sex. Under the Proposed Rule, only the lines of business sold by the insurer that receive federal funding would need to comply.

These proposed changes would dramatically limit the scope of nondiscrimination protections across federal programs and health insurance products. Moreover, the Proposed Rule expressly exempts short-term, limited-duration insurance (STLDI) products from complying with Section 1557. STLDI plans often exclude coverage for critically important health care services; vary premium rates by gender, health status, and age; and put individuals and families at significant financial risk. Further exempting these plans from ACA protections via Section 1557 will only harm patients more.

ACOG disagrees with OCR's interpretation of the statute regarding the scope of Section 1557 and the entities covered. To protect patients from discrimination across health programs and insurance types, we urge OCR to keep the 2016 regulations in place.

IV. The Proposed Rule disregards the needs of vulnerable populations.

In addition to provisions that will harm women and LGBTQ+ patients, the Proposed Rule would also undermine protections for individuals with limited English proficiency (LEP) and other vulnerable populations. Under the Proposed Rule, people with LEP could face additional challenges in access to culturally and linguistically appropriate care, including information about accessing services and health insurance. ACOG is concerned that OCR's proposal will result in fewer LEP individuals and families being aware of their health benefits and rights. Additionally, we are concerned that by proposing to eliminate language access plans and other critical protections for LEP individuals seeking care without articulating other, workable solutions, OCR is discouraging entities from taking steps to accommodate the needs of people with LEP.

This change could make health care inaccessible for many marginalized or linguistically isolated communities. According to the U.S. Census Bureau, over 21 percent of the U.S. population, or 66 million people, speak a language other than English at home, with 25 million of them speaking English less than "very well."[38,39] ACOG believes language proficiency should not determine whether people have access to care or the quality of a person's care. Further, ACOG ardently supports the health and well-being of all women and girls, irrespective of immigration status.[40]

In addition to the proposed changes for individuals with LEP, the Proposed Rule seeks to limit an individual's private right of action to sue covered entities for discrimination under Section 1557. Moreover, the Proposed Rule seeks to limit an individual's ability to pursue a disparate impact claim. ACOG supports the civil rights protections enshrined in Section 1557 and discourages OCR from scaling back these critical patient protections.

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Thank you for the opportunity to comment on RIN 0945–AA11: "Nondiscrimination in Health and Health Education Programs and Activities." As articulated above, ACOG believes Section 1557's nondiscrimination protections enshrined in the current regulations are critical to the health and safety of our patients. We urge OCR not to adopt a narrow interpretation of the broad protections afforded by Section 1557 and to instead withdraw this proposal in its entirety. Should you have any questions regarding our comments, please contact Emily Eckert, Health Policy Analyst, at eeckert@acog.org or 202-863-2485.

Sincerely,

Ted L. Anderson, MD, PhD, FACOG
President

[1] Kaiser Family Foundation. Women's coverage, access, and affordability: Key findings from the 2017 Kaiser Women's Health Survey. March 2018. Available at: http://files.kff.org/attachment/Issue-Brief-Womens-Coverage-Access-and-Affordability-Key-Findings-from-the-2017-Kaiser-Womens-Health-Survey

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[7] Lambda Legal. When health care isn't caring: Lambda Legal's survey of discrimination against LGBT people and people with HIV. New York, NY: Lambda Legal. 2010.

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[11] Kaiser Family Foundation. The Affordable Care Act and insurance coverage changes by sexual orientation. January 18, 2018. Available at: https://www.kff.org/disparities-policy/issue-brief/the-affordable-care-act-and-insurance-coverage-changes-by-sexual-orientation/

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[13] The limits of conscientious refusal in reproductive medicine. ACOG Committee Opinion No. 385. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2007;110:1203–8.

[14] Health care for lesbians and bisexual women. Committee Opinion No. 525. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2012;119:1077–80.

[15] Health care for transgender individuals. Committee Opinion No. 512. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2011;118:1454–8.

[16] ACOG press release: America's frontline physicians urge Trump Administration to protect transgender patients and women's reproductive health. May 28, 2019. Available at: https://www.acog.org/About-ACOG/News-Room/Statements/2019/Physicians-Urge-Trump-Administration-to-Protect-Transgender-Patients-and-Womens-Health?IsMobileSet=false

[17] *Prescott v Rady Children's Hospital*, 265 F.Supp.3d 1090 (S.D. Cal. Sept. 27, 2017) (holding that discrimination against transgender patients violates the Affordable Care Act)

[18] *Flack v Wisconsin Department of Health Services*, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018) (holding that a Medicaid program's refusal to cover treatments related to gender transition is "text-book discrimination based on sex" in violation of the Affordable Care Act)

[19] *Boyden v Conlin*, No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018) (holding that a state employee health plan refusal to cover transition-related care constitutes sex discrimination in violation of Title VII, Section 1557 of the ACA, and the Equal Protection Clause)

[20] *Tovar v Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018) (holding that Section 1557 of the Affordable Care Act prohibits discrimination on the basis of gender identity)

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EXHIBIT D-39

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health
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Boston, Massachusetts 02114-2575

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August 13, 2019

Department of Health and Human Services
Office for Civil Rights
Attention: Section 1557 NPRM, RIN 0945–AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Re: Comments on HHS Proposed Rule on Nondiscrimination in Health and Health Education Programs or Activities (RIN 0945–AA11)

Dear OCR Director Roger Severino:

On behalf of the Massachusetts Department of Mental Health (DMH), I am writing to provide comments on the HHS Proposed Rule[1] on Nondiscrimination in Health and Health Education Programs or Activities, and its associated proposed conforming changes, as published in the Federal Register on June 14, 2019. 84 FR 27860 (the Proposed Rule). The Proposed Rule substantially revises HHS' regulations under Section 1557 of the Patient Protection and Affordable Care Act (ACA § 1557), codified at 45 CFR part 92 (the 1557 Regulations). DMH opposes the Proposed Rule and respectfully requests that it be withdrawn.

DMH, an agency within the Massachusetts Executive Office of Health and Human Services, is the State Mental Health Authority. DMH operates the state inpatient psychiatric hospitals, licenses and regulates the 68 private psychiatric hospitals and units within general hospitals in Massachusetts, and annually provides services to 29,000 adults with serious and persistent mental illness and children and youth with serious emotional disturbance and their families. As the State Mental Health Authority, DMH's mission is to assure and provide access to

[1] https://www.govinfo.gov/content/pkg/FR-2019-06-14/pdf/2019-11512.pdf

services and supports to meet the mental health needs of individuals of all ages; enabling them to live, work and participate in their communities.

DMH strongly opposes the Proposed Rule because it exposes the vulnerable population served by DMH to potential discrimination, erodes access to language assistance for individuals with limited English proficiency (LEP), and limits the ability of individuals to seek assistance when they have experienced discrimination. Our comments are focused on the changes in definitions pertaining to sexual and gender identity and on assurances for language assistance for individuals who are not proficient in English.

The proposed revisions are likely to result in both increased barriers to care for the individuals we serve, and ultimately higher health care costs if such individuals are discouraged from seeking primary and preventive care services. Further, these changes are likely to create considerable confusion among state agencies, providers and other entities who have already taken substantial steps to ensure their programs comply with the current regulations.

Proposed Changes could Lead to Discrimination in Vulnerable Communities, including against the LGBTQ Community

HHS proposes to eliminate the definitions set forth at section 45 CFR 92.4, which include, among other important clarifying definitions, additional detail on what constitutes discrimination on the basis of sex. DMH is strongly opposed to the removal of these definitions. If finalized, HHS' proposed changes would eliminate the current regulation's prohibition of discrimination on the basis of gender identity and sex stereotyping, which will likely lead to increased barriers to care for members of LGBTQ communities, especially those who also face the stigma and potential for discrimination related to their mental illness.

LGBTQ individuals and others with diverse sexual orientations and gender identities experience significant health challenges and higher rates of illness when compared to other groups,[2] making access to equitable treatment and care for these populations especially important. For instance, LGBTQ individuals are at increased risk for adverse health outcomes, including[3] increased risk for suicide, HIV and other sexually transmitted diseases (STDs), and are less likely to seek care for behavioral health services, cancer, depression, and smoking. Higher rates of chronic diseases such as lifetime asthma, arthritis, and obesity are of major concern especially among lesbians and bisexual women.[4] Beyond adverse health outcomes for individuals, increased barriers to care for LGBTQ communities can also lead to negative public health outcomes including higher rates of HIV and STDs, and other serious consequences.[5]

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[2] https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health?topicid=25
[3] www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx
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[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3490559/pdf/AJPH.2011.300379.pdf

At the same time, LGBTQ individuals can also face discrimination when trying to access needed care. For example, among transgender individuals who had visited a doctor or health care provider's office in the past year, 29% reported that a doctor or other health care provider refused to see them because of their gender identity.[6] Further, LGBTQ individuals also experience discrimination in accessing housing and are at increased risk for homelessness, which has also been shown to lead to poor health outcomes. These health disparities are often compounded for LGBTQ individuals of color, and/or LGBTQ individuals living with disabilities.[7] The results from a study reported in the American Journal of Public Health suggest that disparities in chronic health conditions, health risk behaviors, and poor physical and mental health among LGBTQ adults may contribute to the heightened prevalence of disability. Higher mental distress prevalence among all of the groups and higher poor physical health among gay men and bisexual women and men are also significant indicators of disability.[8]

The proposed changes to this rule will likely exacerbate these existing disparities by potentially allowing providers and plans to discriminate against individuals on the basis of sex, including gender identity and sexual orientation, by denying or limiting health care coverage for LGBTQ individuals, and/or requiring higher cost sharing amounts for their care. Such actions could range from excluding coverage or denying care for medically necessary, gender-affirming care to transgender individuals, to refusing to serve LGBTQ individuals altogether, even for routine preventive care such as primary care visits or flu shots.

Adverse health outcomes for this population are also likely to lead to higher costs for DMH, as well as other state Medicaid programs and Medicare, particularly if groups of members facing discrimination are unable to access, or are discouraged from accessing, primary or preventive health services, and must ultimately resort to more expensive urgent or emergency care.

Access to Language Assistance Improves Health and Lowers Costs

The 1557 Regulations required covered entities to provide language assistance services, multi-language "taglines," and nondiscrimination notices to ensure meaningful access for *each* LEP individual. The Proposed Rule requires "reasonable steps to provide meaningful access" to LEP individuals, in general and not to each specific individual, as required by the current rule. The Proposed Rule would relax the current requirement to provide meaningful access to each individual by adopting a four-part balancing test which would allow covered entities to potentially deny language assistance services to every LEP member who needs

[6] https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/
[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3490559/pdf/AJPH.2011.300379.pdf;
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3490559/

them when a covered entity decides the costs of doing so outweigh the benefits. DMH recommends that HHS should continue to require providers and plans to provide meaningful access to such interpretation and translation services for each LEP individual.

Additionally, HHS' Proposed Rule would also repeal the current rule's requirement that covered entities develop, post, and/or provide prescribed notices and taglines. Because such notices and taglines facilitate communication for LEP individuals within the health care system, DMH recommends that HHS should also continue to require their use.

Both quality and patient safety can be influenced by the provision of LEP services. Relaxing the current standards could limit access to necessary care, jeopardize patient safety and incur higher costs. LEP patients who do not receive professional interpretation at admission and discharge have longer lengths of stay and higher readmission rates compared to patients who receive professional interpretation services[9]. An AHRQ Evidence Summary[10] lays out the evidence for LEP services in the hospital, the costliest care setting.

Studies show that LEP patients experience high rates of medical errors with worse clinical outcomes than English-proficient patients and receive lower quality of care by other metrics[11]. Patient safety can be impacted by poor patient comprehension of their medical condition, treatment plan, discharge instructions, complications, and follow-up; inaccurate and incomplete medical history; ineffective or improper use of medications or serious medication errors; improper preparation for tests and procedures; and poor or inadequate informed consent.

Providing language assistance and translation service to members is critical. Indeed, while there may be potential cost savings to Medicaid agencies associated with changes to translated member communications as a result of the relaxed requirements in the Proposed Rule, HHS should balance these potential savings against the potentially increased costs incurred when members are unable to communicate with, or understand information provided by, their providers, health plans, or insurers. This is especially true if individuals are unable to access primary/preventive care services and ultimately require urgent or emergency care.

HHS Request for Comments: Access and Accommodation Standards for Persons with Disabilities

HHS seeks comment on whether to maintain current access standards for persons with disabilities, although the agency has not proposed changes to those standards at this time. DMH strongly urges HHS to maintain existing standards to ensure access to care and reasonable accommodations for persons with disabilities. A significant portion of DMH clients have disabilities (in addition to their serious mental illness, which is and of itself, a

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3445680/
[10] Why focus on safety for patients with limited English proficiency? https://www.ahrq.gov/teamstepps/lep/handouts/lepevidencesum.html
[11] AMA J Ethics. 2017;19(3):263-271. doi: 10.1001/journalofethics.2017.19.3.medu1-1703.

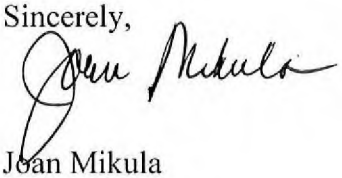
disability), and the existing access and accommodations requirements are critical to ensuring that these clients are able to properly access the benefits and services they need to maintain health and independence. This includes the provision of auxiliary aids and services to ensure effective communication, requiring compliance with ADA construction and architectural standards, and providing reasonable modification in policies, practices and procedures to prevent discrimination. Further, Massachusetts has worked closely with CMS, its clients, and other stakeholders on the State Demonstration to Integrate Care for Dual Eligible Individuals (known as One Care), which is explicitly designed to improve care and reduce costs for dual eligible individuals ages 21 to 64 who are living with disabilities. As with the other proposed changes to this rule, removing these protections for individuals with disabilities could lead to increased barriers to care and reduced access to benefits and services, resulting in poorer health outcomes and increased costs for dual eligible populations, and jeopardizing the potential of innovative initiatives, like One Care, which are expressly designed to improve the lives and health care experiences of these communities but which depend on the ability of members to access critical benefits and services to be successful.

Conclusion

DMH is deeply troubled that adoption of the proposed revisions to the 1557 Regulations would send a potentially dangerous message that devalues the lives of many of the diverse communities that make up the Commonwealth and would perpetuate inequality among the vulnerable population served by DMH.

For these reasons, and the reasons detailed above, DMH respectfully requests that HHS withdraw the Proposed Rule and revert to the 1557 Regulations. Thank you for consideration of these comments.

Sincerely,



Joan Mikula
Commissioner

cc: Marylou Sudders, Secretary, Executive Office of Health and Human Services

EXHIBIT D-40

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

August 13, 2019

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

Re: RIN 0945-AA11

Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority

Dear Secretary Azar:

WASHINGTON, DC OFFICE
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Washington, DC 20037-1886

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On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on a proposed rule relating to changes to Section 1557 of the Affordable Care Act (ACA), as it affects our practice of emergency medicine and the patients we serve.

We strongly believe that discrimination in any form should be prohibited in health care, and therefore we object to this proposed rule and do not believe it should be finalized. As written, it does not reflect nor allow for our moral and legal duty as emergency physicians to treat everyone who comes through our doors. Both by law[1] and by oath, emergency physicians must care for all patients seeking emergency medical treatment. Denial of emergency care or delay in providing emergency services on the basis of race, religion, sexual orientation, **gender identity**, ethnic background, social status, type of illness, or ability to pay, is unethical under our Code of Ethics as emergency physicians [2].

Background

Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, or disability under any health program or activity that receives Federal financial assistance. In 2016, the Department of Health and Human Services (HHS) finalized a regulation that defines "on the basis of sex" to include sex stereotyping, gender identity, and termination of pregnancy. Based on recent federal court action regarding the enforcement of this specific definition of discrimination, HHS has now

[1] 42 U.S. Code § 1395dd - Examination and treatment for emergency medical conditions and women in labor.
[2] ACEP Code of Ethics for Emergency Physicians; Approved Jan 2017; https://www.acep.org/clinical--practice-management/code-of-ethics-for-emergency-physicians.

decided to remove gender identity and termination of pregnancy from the Section 1557 regulation. HHS also proposes to amend ten other regulations that had been issued by the Centers for Medicare & Medicaid Services (CMS) to implement the prohibition on discrimination on the basis of sex, to make them consistent with the approach taken in the newly proposed ACA Section 1557 rule.

Application of Proposals in Emergency Situations

As emergency physicians, we are surprised and concerned that the proposed rule does not in any way address how changing the ACA Section 1557 regulations could interact with the federally-mandated provision of emergency services. The Emergency Medical Treatment and Labor Act (EMTALA) requires clinicians to screen and stabilize every patient who comes to the emergency department (ED). Such patients have every right to expect the best possible care and to receive the most appropriate treatment and information about their condition.

Patients with life-threatening injuries or illnesses may not have time to wait to be referred to another physician or other healthcare professional to treat them if the present provider has a moral or religious objection. Likewise, EDs operate on tight budgets and do not have the staffing capacity to be able to have additional personnel on hand 24 hours a day, seven days a week to respond to different types of emergencies that might arise involving patients with different backgrounds including sexual orientations and gender identities. The proposed rule seems to demand that, to meet EMTALA requirements, an ED must anticipate treating transgender patients, survey its employees to ascertain who might object treating such a patient, and staff accordingly. This is an impossible task that jeopardizes the ability to provide care, both for standard emergency department readiness and for emergency preparedness. EDs serve as the safety net in many communities, providing a place where those who are most vulnerable and those in need of the most immediate attention can receive care. By not addressing the rights and needs of all patients undergoing an emergency, the legal obligations of emergency physicians, and the budget and staffing constraints that EDs face, this rule will undermine the critical role that EDs play across the country.

In light of the above concerns, ACEP urges the Department to withdraw the proposed rule. We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory Affairs at jdavis@acep.org.

Sincerely,

Vidor E. Friedman, MD, FACEP
ACEP President

EXHIBIT D-41

MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

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August 13, 2019

VIA ELECTRONIC SUBMISSION

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

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

Dear Secretary Azar:

The Massachusetts Medical Society submits these comments in response to the Department of Health and Human Services' ("HHS", "the Department") and the Center for Medicare and Medicaid Services ("CMS") Notice of Proposed Rulemaking ("proposed rule," "NPRM") to express our concerns with the proposed rule entitled "Nondiscrimination in Health and Health Education Programs or Activities" published in the Federal Register on July 14, 2019.

The Massachusetts Medical Society is the largest physician-led organization in Massachusetts, with more than 25,000 members representing physicians, residents and medical students across all clinical disciplines, organizations and practice settings. We are a proactive organization that advocates for the shared interests of patients and our profession and takes a leadership role in the development of health care policy. We advocate to enhance and protect the physician-patient relationship and preserve physicians' ability to make clinical decisions for the benefit of patients. The Medical Society's code of ethics recognizes that the physician's responsibility to the patient is paramount. Our code of ethics also tells us that a physician shall respect the law but recognizes the responsibility to seek changes to requirements which are contrary to the best interest of the patient. That responsibility compels us today to write today in opposition the NPRM. The Medical Society is deeply concerned by the substance and likely effects of this proposed rule, which would undermine health care nondiscrimination protections and disproportionately affect the most vulnerable patients in Massachusetts, especially transgender and gender nonconforming people, the entire LGBTQ community, people needing abortion services, and people whose first language is not English.

While Section 1557 is still the law, this proposed rule attempts to change the administrative implementation in a way that is antithetical to the plain language of the law. The NPRM's proposed changes pose significant risks to those the law is intended to protect, including lesbian, gay, bisexual, transgender, and queer ("LGBTQ") people; people who need

reproductive health care, including abortion; women of color; people living with disabilities and/or chronic conditions; and people whose primary language is not English–all people who already experience significant barriers to accessing health care. The proposed changes could create additional barriers and potentially lead to worse health outcomes, with a disproportionate impact those living at the intersections of these identities.

The Medical Society believes that health care is a human right and maintains a long-standing policy to strive for universal access to health care and nondiscrimination in health care settings for all people. To that end, the Medical Society is committed to working for the best possible health care for every patient in the Commonwealth regardless of racial identification, national or ethnic origin, sexual orientation, gender identity, religious affiliation, disability, immigration status, or economic status. As such, the Medical Society vehemently opposes the proposed elimination or rollback of critical protections guaranteed by Section 1557 of the Affordable Care Act ("ACA") and the 2016 Nondiscrimination in Health Programs or Activities final rule ("2016 final rule"). Discrimination has no place in health care and this rule will only serve to worsen health outcomes for patients who have historically faced barriers to accessing care. We urge that this NPRM be rescinded in its entirety.

I. **The Proposed Rule Impermissibly Attempts to Narrow the Scope of Section 1557**

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

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

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

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

A 2018 study, for example, found that not a single short-term plan covered maternity care.[1] Short-term plans also discriminate based on gender identity, such as by excluding coverage for transition-related services and erecting barriers for people needing primary care services that insurers view as not corresponding to an individual's gender marker (such as trans man needing a pap smear because he still has female reproductive organs). Short-term plans are notorious for discriminating against consumers based on gender, age and disability. If implemented, the proposed rule would embolden short-term plans to discriminate against women by refusing to cover reproductive health services, such as maternity, contraceptive care or fertility care and coverage, or deny coverage altogether for other conditions, such as breast or cervical cancer.

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

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

The proposed rule would have a disproportionate impact on LGBTQ people -- especially transgender, non-binary and gender nonconforming people, who already face unique barriers to accessing care, such as high un-insurance rates, discrimination and harassment. The 2016 final rule implementing Section 1557 had clarified that health care providers cannot refuse to treat someone because of their gender identity. The proposed rule illegally purports to allow a health care provider to refuse to treat someone because of their gender identity. For example, a doctor could refuse to treat a transgender person for a cold or a broken bone, simply because of their gender identity. The Massachusetts Medical Society strongly supports legal protections against discrimination for transgender individuals and recognizes the significant negative health outcomes and health care disparities caused by discrimination against transgender individuals based on their gender identity and expression.

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

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

Transgender, non-binary and gender nonconforming people already experience high rates of discrimination and harassment in health care. According to the 2015 U.S. Transgender Survey, 33 percent had at least one negative experience in a health care setting relating to their gender identity in the past year.[2] According to a 2018 study from the Center for American Progress, 23 percent had a provider intentionally mis-gender or use the wrong name for them, 21 percent had a provider use harsh or abusive language when treating them[3] and 29 percent experienced unwanted physical contact from a health provider, such as fondling, sexual assault or rape.[4] The proposed rule could impermissibly open the door to further discrimination.

The 2016 final rule made clear that sex discrimination under Section 1557 includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related conditions. The proposed rule attempts to roll back these protections. Although HHS acknowledges in the preamble to this proposed rule that Title IX prohibits discrimination based on pregnancy, including termination of pregnancy, it refuses to state whether the Department would enforce those protections. While the scope of protection under Section 1557 is clear, without unambiguous implementing regulations, and enforcement, illegal discrimination is likely to flourish.

The proposed rule would have a disproportionate impact on women and other people who are pregnant, especially those living in rural areas. Women of color already face unique barriers to accessing pregnancy-related and/or abortion care, such as a discrimination, harassment and refusals of care, and experience high rates of pregnancy-related

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[2] S.E. James, et al., Nat'l Ctr. for Transgender Equality, Report Of The 2015 U.S. Transgender Survey 96-97 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[3] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[4] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

complications. For example, Black women are 3-4 times more likely to die from pregnancy related complications than white women.

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

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

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

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

Under the proposed rule, Programs of All-Inclusive Care for the Elderly ("PACE") organizations, which serve people ages 55+, could discriminate against LGBTQ people.[5] There are more than 3 million LGBTQ people age 55+ in the U.S. That number is expected to double within the next 20 years.[6] Many older LGBTQ adults already feel reluctant to discuss their sexual orientations and gender identities with health providers due to fear of

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

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

judgment and/or substandard care.[7] The proposed rule would only further discourage older LGBTQ adults from sharing information that may be relevant to the health services they need.

A member of the Massachusetts Medical Society who is an OBGYN provider with over 35 years of clinical experience and over 24 years as a member of the LGBTQ community put it very succinctly: this rule will push people back into the proverbial closet and negatively impact their lives and health, with a direct public health impact. The Medical Society believes that a physician's nonjudgmental recognition of sexual orientation, behavior, and gender identity enhances the ability to render optimal patient care in health as well as in illness. A patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems. Implementation of this rule will harken back to a time when LGBTQ people were so afraid of discrimination that they would avoid medical care or if they had medical contacts, not reveal sexual orientation information that is medically critical to give the correct care, such as HIV and STD screening. It is vital to maintain the protections currently contained in Section 1557, which have had a direct positive impact on the ability of LGBTQ people to live full lives participating in all aspects of society, including the ability to access health care.

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

The proposed rule would illegally pull back on language access protections for people with Limited English proficiency ("LEP") individuals and those who have LEP family members by proposing to roll back requirements for the inclusion of taglines on significant documents and remote interpreting standards and by proposing to eliminate recommendations that entities develop language access plans. The Medical Society recognizes the importance of language barriers and cultural sensitivity and supports the use of interpreter services, whether for reasons of language, culture, or physical disability. In fact, MMS collaborated with health plans in Massachusetts to provide coverage for increased costs of interpreter services, in recognition of the necessity of such services in providing high-quality medical care to patients who have significant language and/or cultural barriers or physical disabilities.

Discrimination on the basis of national origin, which encompasses discrimination on the basis of language, creates unequal access to health care. Over 25 million Americans are limited English proficient. An estimated 19 million LEP adults are insured. Language assistance is necessary for LEP persons to access federally funded programs and activities in the health care system.

For LEP individuals, language differences often compound existing barriers to access and receiving appropriate care. LEP often makes it difficult for many to navigate an already

[7] Robert Espinoza, Servs. & Advocacy for Gay, Lesbian, Bisexual, & Transgender Elders, Out & Visible: The Experiences and Attitudes of Lesbian, Gay, Bisexual, and Transgender Older Adults, Ages 45-75, 8 (2014), https://www.sageusa.org/wp-content/uploads/2018/05/sageusa-out-visible-lgbt-market-research-full-report.pdf.

complicated healthcare system, especially when it comes to medical or insurance terminology. Moreover, these barriers are often compounded by discrimination based on national origin, immigration status, race, ethnicity, sexual orientation, and gender/gender identity.

The proposed rule would have a disproportionate impact on people with LEP who are low income and/or are people of color. For example, Latinx people make up 63% of those considered LEP in the U.S., while Asian Americans and Native Hawaiian and Pacific Islanders ("AANHPIs") make up 22%. LEP individuals are more likely to live in poverty than their English proficient counterparts. The proposed rule could further exacerbate these disparities and will disproportionately burden LEP individuals with health care costs.

We strongly disagree that nondiscrimination notice, taglines and language access plan language in the 2016 Final Rule were not justified by need, were overly burdensome and created inconsistent requirements. The notice requirement is consistent with the long history of civil rights regulations requiring the posting of notice of rights. The notice is not redundant as OCR created the option of using one consolidated civil rights notice to minimize burden on covered entities. Without the notice, members of the public will have limited means of knowing that language services and auxiliary aids and services are available, how to request them, what to do if they face discrimination, and their right to file a complaint.

Taglines are well supported by existing federal and state regulations, guidance and practice. Taglines are a cost-effective approach to ensure that covered entities are not overly burdened. In the absence of translated documents, taglines are necessary "to ensure that individuals are aware of their protections under the law and are grounded in OCR's experience that failures of communication based on the absence of auxiliary aids and services and language assistance services raise particularly significant compliance concerns under Section 1557, as well as Section 504 and Title VI."

We oppose removing all references to language access plans because under the 2016 Final Rule, they are voluntary, not required by law and only a factor to be considered. We oppose changes in the NPRM that would shift the inquiry of meaningful access away from the individual LEP person to that of the entity, as doing so would weaken the standard.

Finally, the regulatory impact analysis is insufficient and fails to identify and quantify costs to protected individuals. OCR has provided no tangible analysis on the costs and burdens to protect individuals from removal of the notice and tagline requirements. The costs are not only reduced awareness of language services by LEP persons, but also reduced awareness by the general public about their rights as protected by 1557.

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

Before the ACA, people with serious and/or chronic health conditions were often denied health insurance coverage or paid high prices for substandard plans with coverage exclusions, leaving many people unable to afford the health care they needed. Under the ACA, insurers can no longer charge higher premiums or deny coverage for people with pre-existing conditions. These protections have been lifesaving for many people. The Medical has pledged to work to ensure that no health carrier or its designee may adopt or implement a benefit that discriminates on the basis of health status, race, ethnicity, color, national origin, age, sex, gender identity, sexual orientation, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

Under the 2016 final rule, covered entities are prohibited from designing benefits that discourage enrollment by persons with significant health needs. For example, insurers are prohibited from placing all or most prescription drugs used to treat a specific condition, such as HIV prescriptions, on a plan's most expensive tier.[8] Additionally, covered entities are prohibited from using discriminatory marketing practices, such as those "designed to encourage or discourage particular individuals from enrolling in certain health plans."[9] The proposed rule improperly attempts to eliminate these prohibitions.

The proposed rule will have a disproportionate impact on LGBTQ people and people of color who live with disabilities and/or chronic conditions. Due to systemic barriers to health care and the stress of stigma and discrimination, people of color and LGBTQ people, and especially gay, bisexual, and queer men of color and transgender women of color, are at a higher risk of developing chronic conditions and have a higher prevalence of disabilities.

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

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

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

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

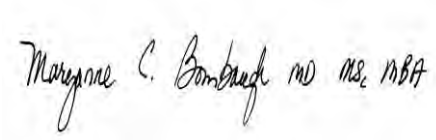
As a result, the proposed rule would create a confusing mix of legal standards and available remedies under a single law, and could limit claims of intersectional discrimination, going against the text and intent of Section 1557. Ultimately, the proposed rule will make it harder for those who are discriminated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

VI. **Conclusion**

This proposed rule could create significant harm, particularly for our most underserved populations who already struggle to access health care. The proposed rule will erect barriers to care for transgender people and the LGBTQ community; people seeking reproductive health care, including abortion services; individuals with LEP, including immigrants; those living with disabilities and people of color. Moreover, this rule would embolden compounding levels of discrimination against those who live at the intersection of these identities. The proposed rule is dangerous and contravenes the plain language of Section 1557, specifically, and the ACA broadly.

For the reasons detailed above, HHS and CMS should not finalize the proposed rule.

Sincerely,



Maryanne C. Bombaugh, MD, MSc, MBA, FACOG

EXHIBIT D-42

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Executive Director

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August 12, 2019

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

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

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

Dear Secretary Azar and Mr. Severino:

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

Section 1557 is the key nondiscrimination provision of the Affordable Care Act (ACA).[1] It prohibits discrimination in health programs and activities receiving federal financial assistance, health programs and activities administered by the executive branch, as well as entities created under the ACA, including the Marketplaces and health plans sold through the Marketplaces. Section 1557's protections extend to discrimination on the basis of race, color, national origin (including language access), sex, age, and disability by building on existing civil rights laws.[2] It is the first federal law to ban sex discrimination in health care. Section 1557 recognizes that individuals may be part of multiple protected classes and may face discrimination because they belong to one or more of these classes.

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

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

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

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

[3] U.S. Dep't of Health & Human Servs., *Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities*, 78 Fed. Reg. 46558 (Aug. 1, 2013); U.S. Dep't of Health & Human Servs., *Nondiscrimination in Health Programs and Activities* (Notice of Proposed Rulemaking), 80 Fed. Reg. 54172 (Sept. 8, 2015); U.S. Dep't of Health & Human Servs.,*Nondiscrimination on the Basis of Race, Color, National Origin, Sex, Age, or Disability in Health Programs or Activities Receiving Federal Financial Assistance and Health Programs or Activities Administered by the Department of Health and Human Services or Entities Established under Title I of the Patient Protection and Affordable Care Act*, 45 C.F.R. Part 92, 81 Fed. Reg. 31376 (May 18, 2016) (hereinafter "2016 Final Rule").

[4] 81 Fed. Reg. 31376.

Section 1557 regulations as well as the other conforming provisions. HHS should instead leave the 2016 final Section 1557 regulations in place in their entirety.

II. Reasons for the Proposed Rulemaking

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

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

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

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

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

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

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

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

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

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

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

[10] 45 C.F.R. § 92.2(c).

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

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

[13] 84 Fed. Reg. 27849.

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

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

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

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

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

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[14] *Id*.

[15] 102 F. Supp. 3d 688, 698–99 (E.D. Pa. 2015).

[16] See, e.*g*., *Doe One v. CVS Pharmacy, Inc*., 348 F. Supp. 3d 967, 981 (N.D. Cal. 2018) (stating that "[n]o consensus has yet emerged as to the standard for assessing ACA anti-discrimination claims" and describing the different standards of *Rumble* and *SEPTA*). Only one appellate decision has addressed this question to date, so there is also no consensus from the appellate courts. *See Doe v. BlueCross BlueShield of Tennessee, Inc*., 926 F.3d 235, 241 (6th Cir. 2019).

[17] *Rumble v. Fairview Health Servs*., 2015 WL 1197415 at *11 (D. Minn. 2015).

[18] *See* 84 Fed. Reg. 27873, citing to a nonexistent 2017 ruling. Presumably, HHS is referring to the 2015 decision cited above.

[19] *Id*.

[20] *Rumble v. Fairview Health Servs.,* 2015 WL 1197415 at *11 (D. Minn. 2015).

[21] *See, e.g., Callum v. CVS Health Corp.*, 137 F.Supp.3d 817, 845 (D.S.C. 2015); *Esparza v. Univ. Med. Ctr. Mgmt. Corp.*, No. CV 17-4803, 2017 WL 4791185, at *4 (E.D. La. Oct. 24,

further explains that allowing disparate impact actions for some plaintiffs but not others, depending on their protected class, would be an "absurd inconsistency" that would also leave courts with no clear standard when a plaintiff alleging discrimination belonged to more than one protected class.[22]

HHS also overstates the impact of pre-ACA cases and misrepresents their holdings when arguing that disparate impact claims are not available under Section 1557.[23] For example, the NPRM cites to *Crocker* for support, yet *Crocker* refused to make a decision on whether there was a private right of action for disparate impact discrimination under Section 504 and discussed the issue only in dicta.[24] HHS then makes a second leap that the *Crocker* dicta applies to Section 1557 claims.[25] In its analysis, HHS also fails to recognize that Congress passed Section 1557 as a key component of the ACA, a set of sweeping reforms that changed what health care and health insurance practices were acceptable and banning discriminatory activities that courts had previously allowed. Cases cited in the NPRM have overly relied on interpretations of the underlying statutes without recognizing the inherent shifts that ACA made in the health care realm. If Section 1557 were limited by the constraints of the referenced statutes, its passage would have been largely unnecessary, as the four civil rights statutes already apply to organizations "in the business of providing . . . health care."[26]

HHS' reliance on select case law to support regulatory changes is misleading and presents a distorted picture of Section 1557's enforcement mechanisms. The changes suggested in the proposed rule will not clarify the law, and may make it harder for people who experience discrimination to enforce their rights through administrative and judicial complaints.

2017); *Griffin v. Gen. Elec. Co.*, No. 1:15-CV-4439-AT, 2017 WL 8785572, at *3 (N.D. Ga. Dec. 6, 2017), aff'd, 752 F. App'x 947 (11th Cir. 2019); *Audia v. Briar Place, Ltd.*, No. 17 CV 6618, 2018 WL 1920082, at *3 (N.D. Ill. Apr. 24, 2018); *Ass'n of New Jersey v. Horizon Healthcare Servs., Inc.*, No. CV 16-08400(FLW), 2017 WL 2560350, at *4 (D.N.J. June 13, 2017); *York v. Wellmark, Inc.*, 2017 WL 11261026, at *16 (S.D.Iowa Sep. 06, 2017); *Briscoe v. Health Care Serv. Corp.*, 281 F.Supp.3d 725, 737 (N.D. Ill. 2017).

[22] *Rumble* at *11-12.

[23] 84 Fed. Reg. 27851.

[24] *Crocker v. Runyon*, 207 F.3d 314 (6th Cir. 2000).

[25] 84 Fed. Reg. 27851.

[26] See, *e.g.*, 29 U.S.C. § 794 (2018) (Rehabilitation Act).

c. The current regulations are already consistent with the regulations of HHS and other agencies

HHS vastly overstates the need for the Section 1557 regulations to be consistent with other HHS regulations and the regulations of other agencies, and the extent to which the current Section 1557 regulations are inconsistent with other regulations.

The current regulations underwent extensive review for consistency with the regulations of HHS and other agencies before they were promulgated. As HHS notes, Executive Order 12250 § 1-201 requires the Attorney General to "coordinate the implementation and enforcement of [Title VI, Title IX, Section 504 and a]ny other provision of other provision of Federal statutory law which provides, in whole or in part, that no person in the United States shall, on the ground of race, color, national origin, handicap, religion, or sex, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance."[27] In the case of the current Section 1557 regulations, DOJ did indeed review the rule before it was published. Another Executive Order, Executive Order 12866, explicitly requires that: "Each agency shall avoid regulations that are inconsistent, incompatible, or duplicative with its other regulations or those of other Federal agencies."[28] As required by that executive order the current Section 1557 rule was vetted by OMB/OIRA and deemed consistent with other regulations by HHS and other agencies.[29]. Despite HHS's suggestion to the contrary, the current Section 1557 rule was extensively reviewed by the executive branch for consistency with other regulations before it was finalized. HHS provides no explanation for why these review processes were not sufficient or failed to identify purported inconsistencies.

In the preamble to this proposed rule, HHS also cites 42 U.S.C. § 6103(a)(4) requiring consistency with other regulations.[30] That part of the Age Discrimination Act requires:

> the head of each Federal department or agency which extends Federal financial assistance to any program or activity by way of grant, entitlement, loan, or contract other than a contract of insurance or guaranty, shall transmit to the Secretary and publish in the Federal Register proposed regulations to carry out

[27] Cited at 84 Fed. Reg. 27851 n. 28.
[28] Executive Order 12866 § 1(b)(10).
[29] *See* Executive Order 12866 §§ 2(b), 3(f)(2), 4(c)(5); *see also* Executive Order 13563 § 1(a).
[30] Cited at 84 Fed. Reg. 27851 n. 28.

> the provisions of section 6102 [prohibiting age discrimination] and to provide appropriate investigative, conciliation, and enforcement procedures. Such regulations shall be consistent with the final general regulations issued by the Secretary [of HHS], and shall not become effective until approved by the Secretary.[31]

Since the 1557 final rule was promulgated by HHS, by the terms of this statutory provision, it did not need to undergo separate HHS review. Thus, this provision is simply not relevant to the question of consistency, since it only applies to other agencies besides HHS, and applies in the specific context of applying the provisions of the Age Discrimination Act. In any event, HHS drafted the final rule with knowledge of its prior regulations on age discrimination and crafted the rule to be consistent with its other regulations.

Moreover, the specific examples of purported inconsistencies given by HHS in the preamble are not actually inconsistent with the current Section 1557 regulations. For example, the fact that NIH has a policy that its grants should explain certain differences between males and females based on biological factors is not inconsistent with the current Section 1557 regulations' determination that discrimination on the basis of sex encompasses discrimination on the basis of gender identity.[32] Making a clinical distinction between two sexes based on factors such as sex chromosomes, gonads, sex hormones, and non-ambiguous internal and external genitals in no way negates the experience of discrimination by transgender people, whose gender identity does not match the sex they were assigned at birth. Nor does the fact that OCR has separately defined "gender" and "sex" separately in certain regulations imply that "gender" is a concept wholly unrelated to sex, such that discrimination on the basis of sex can never include discrimination based on gender identity or transgender status.[33] And the position taken by DOJ in Title VII litigation and an internal memo as to whether discrimination on the basis of sex includes discrimination on the basis of gender identity is completely irrelevant to the question of whether Section 1557 protects against discrimination on the basis of gender identity.[34] Rather, as described in more detail *infra* Section III.B, the current regulations that protect against discrimination on the basis of gender identity

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[31] 42 U.S.C. § 6103(a)(4).

[32] *See* 84 Fed. Reg. 27853-54.

[33] 84 Fed. Reg. 27854.

[34] 84 Fed. Reg. 27856-57. *See Kisor v. Wilkie*, 139 S. Ct. 2400 (2019) ("[A]n agency's reading of a rule must reflect its 'fair and considered judgment,' . . . . [so a] court should decline to defer, for example, to a merely 'convenient litigating position,' . . . or to a new interpretation that creates 'unfair surprise' to regulated parties.") (citations omitted).

appropriately implement Section 1557. In any event, the proposed changes to the regulations create just as many, if not more inconsistencies with current regulations as described throughout our comments below. This supposed basis for completely overhauling the current regulations is unsupported and unsound.

d. The Costs of the Final Rule Were Unnecessary and Unjustified

Please see our discussion under III.B regarding repealing the notice and tagline requirements as well as our comments regarding the Regulatory Impact Analysis.

III. Nondiscrimination in health programs or activities

Proposed Subpart A – General Provisions

§ 92.2 Nondiscrimination Requirements & § 92.3 Scope of Application

a. The ACA's nondiscrimination protections have broad applicability and scope

Prior to the ACA, health insurance companies routinely discriminated by denying coverage to individuals with pre-existing conditions. Insurance companies charged women higher premiums than men, and often imposed annual and lifetime caps on benefits, which disproportionately affected people living with serious, chronic, or life-threatening medical conditions.

Congress passed the ACA to put an end to these discriminatory practices. The ACA requires guaranteed issue of coverage in the individual and small group health insurance markets so that no one can be denied health insurance due to a preexisting condition.[35] Health insurers may no longer exclude coverage of a preexisting condition.[36]

The ACA further prohibits discrimination against individual participants and beneficiaries based on health status or medical condition, and it prevents insurers from imposing annual or lifetime limits on benefits.[37] The ACA also sought to end discrimination in the types of health benefits offered by requiring most individual and small group health

[35] 42 U.S.C. § 300gg-1.
[36] *Id*.
[37] 42 U.S.C. §§ 300gg–4; 300gg-11.

plans to provide comprehensive health benefits in ten broad categories of coverage, known as Essential Health Benefits, or EHBs.[38]

In the 2016 Final Rule, HHS acknowledged the invidious nature of discrimination prior to the ACA:

> Prior to the enactment of the ACA, insurance companies were allowed to impose higher premiums on women or deny women coverage altogether. If issuers did cover women, they frequently did not cover a number of women's health services, including routine preventive services, such as pap smears or mammograms. Insurance premiums previously could differ by sex, and were often higher for females relative to males. The ACA prohibits differential treatment based on sex, includes maternity coverage essential health benefits, and requires non-grandfathered plans to cover women's preventive services without copays, among other benefits.[39]

In the 2016 Final Rule, HHS further highlighted the purposes of the ACA and how Section 1557's protections are inexorably linked to broader ACA coverage requirements and other protections: "a fundamental purpose of the ACA is to ensure that health services are available broadly on a nondiscriminatory basis to individuals throughout the country."[40] This interpretation is consistent with the Supreme Court's recognition of the broader purpose of the ACA to "expand insurance coverage. . . . [and] ensure that anyone can buy insurance." [41]

Congress has repeatedly rejected attempts to repeal the ACA.[42] The ACA's protections, including Section 1557, remain vitally important for persons with preexisting conditions and those who experience discrimination by health insurance companies and providers. HHS' proposal to rewrite or eliminate regulations implementing Section 1557 is nothing less than an end run around the ACA's statutory protections against discrimination.

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[38] 42 U.S.C. § 18022.

[39] 81 Fed. Reg. 31460.

[40] 81 Fed, Reg. 31379.

[41] *King v. Burwell*, 135 S. Ct. 2480, 2493 (2015).

[42] *See* C. Stephen Redhead & Janet Kinzer, *Legislative Actions in the 112th, 113th, and 114th Congresses to Repeal, Defund, or Delay the Affordable Care Act*, Congressional Research Service (Feb. 7, 2017), https://fas.org/sgp/crs/misc/R43289.pdf.

b. The proposed rule contravenes Congress' intent to broadly apply the ACA's nondiscrimination protections

Section 1557, according to the statute and current regulations, applies to health care programs and activities receiving federal financial assistance or funding; programs administered by the federal government, including Medicare and the Indian Health Service (IHS); and entities created under Title I of the ACA. Covered entities include hospitals, clinics, and health care provider's offices and issuers selling health insurance plans within and outside of the ACA Marketplaces.[43] If an entity is principally engaged in providing or administering health services or health insurance coverage, the current regulations state that all of its activities are covered by Section 1557 if any part receives federal financial assistance.[44]

The current regulations are consistent with Congress's intent in enacting Section 1557. Congress's intended Section 1557 to build and expand upon existing civil rights laws, while providing broad protection against discrimination in health care. Moreover, Congress has repeatedly expressed that it intends civil rights laws to be broadly interpreted in order to effectuate their remedial purposes.[45]

The proposed rule seeks to significantly narrow the scope and applicability of Section 1557 contrary to the plain meaning of the statute and well-established implementation of civil rights laws.

c. HHS proposed definition of federal financial assistance is overly narrow and inconsistent with other regulations

HHS proposes to eliminate the current definition of federal financial assistance (FFA) under Section 1557, and to construe narrowly what entities qualify as a recipient of FFA. This proposed interpretation is inconsistent with Section 1557, and with other HHS regulations defining FFA recipients. For example, in the health care refusals rule *Protecting Statutory Conscience Rights in Health Care* finalized in May 2019, HHS defined FFA broadly as:

1) grants and loans of Federal funds;

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[43] 42 U.S.C. § 18116(a); 45 C.F.R. §§ 92.2(a), 92.4.

[44] 45 C.F.R. § 92.4.

[45] *See Kang v. U. Lim Am., Inc*., 296 F.3d 810, 816 (9th Cir. 2002); *see also* H. Rep. No. 102–40(I), at 88, U.S. Code Cong. & Admin. News at 626 (stating that "remedial statutes, such as civil rights law[s], are to be broadly construed").

2) "the grant or loan of Federal property and interests in property;
3) the detail of Federal personnel;
4) "the sale or lease of, and the permission to use (on other than a casual or transient basis), Federal property or any interest in such property without consideration or at a nominal consideration […]; and
5) "any agreement or other contract between the Federal government and a recipient that has as one of its purposes the provision of a subsidy to the recipient.[46]

HHS explained that this definition "mirrors the definition used in the Department's regulations implementing Title VI, and is intended to carry the same meaning as it has traditionally been understood to carry in the application of those regulations."[47] HHS further argues that modelling the health care refusals' FFA definition on Title VI regulations will make compliance easier since entities subject to this regulation "will be sufficiently familiar with that meaning to understand its application in this final rule."[48]

The 2016 Final Rule defines FFA in the same way – adding only clarifications regarding subsidies and contracts as required by statute and reiterating FFA includes "grants, loans, and other types of assistance in accordance with the definition of Federal financial assistance in the regulations implementing Section 504 and the Age Discrimination Act… and Title IX."[49] This interpretation flows from the text and context of Section 1557, and is correct.

HHS now proposes to eliminate all definitions under Section 1557, including FFA and recipients, and to instead interpret both FFA and recipients narrowly. As justification, HHS contends that the 2016 Final Rule exceeded the bounds of the statute by describing FFA which HHS has a primary responsibility for administering, as well as FFA in which HHS "plays a role in administering.'"[50] (See further discussion on FFA in which HHS "plays a role" in subsection (d) below). Not only is this interpretation inconsistent with Section 1557, but it is inconsistent with HHS's own regulations. The 2019 health care refusals rule does not limit applicability to assistance HHS has a

[46] 45 C.F.R. § 88.2.
[47] 84 Fed. Reg. 23193.
[48] *Id*. citing to 45 C.F.R. § 80.13(f).
[49] 81 Fed. Reg. 31467. In the 2016 Final Rule, HHS relies on Title IX regulations to establish that premium tax credits, while paid to the individual (and for the benefit of the individual) amount to financial assistance for the institution (e.g., insurers and the QHPs they provide) – just as student loans or grants are for the student, but ultimately paid to the institution. 81 Fed. Reg. 31383.
[50] 84 Fed. Reg. 27861, citing 45 C.F.R. § 92.4.

primary responsibility for administering, but instead broadly encompasses "grants and loans of Federal funds" as part of its definition of FFA.[51]

In the Section 1557 proposed rule, HHS does not explain why it defines FFA very broadly for the purposes of allowing providers to deny medically necessary care based upon religious or moral grounds in one regulatory context, yet defines FFA very narrowly for purposes of nondiscrimination in this proposed rule. The proposed, narrow interpretation of FFA is unjustified, and inconsistent with its other regulations defining FFA and is certain to cause confusion about Section 1557's applicability.

Further, if this change were nevertheless implemented, it would have significant consequences, particularly for consumers who purchase short-term limited duration insurance ("STDLI"). If implemented, the proposed rule would generally not apply to STDLI plans because insurers are no longer considered health care entities, and these specific plans do not receive federal financial assistance. Exempting STDLI plans from Section 1557's protections is not consistent with Congress's intent to provide broad protection against discrimination in health care.

We oppose eliminating the current regulation defining FFA, because HHS' selective interpretation that FFA applies narrowly under Section 1557 is incorrect.

d. Section 1557 extends to federal financial assistance in which HHS "plays a role"

The 2016 Final Rule recognizes that premium tax credits constitute FFA which subjects Qualified Health Plans (QHPs) and their issuers to Section 1557 protections.[52] However, the proposed rule says that only FFA administered by HHS constitutes FFA for purpose of the applicability of the rule, since premium tax credits are ultimately provided by the Internal Revenue Service (IRS).[53] The proposed rule also eliminates language in the current rule saying it applies to FFA that HHS "plays a role" in administering.[54]

HHS' proposal would create confusion and seemingly attempts to exempt key parts of ACA Marketplace coverage from Section 1557 regulations. HHS states that QHPs "may" still be subject to HHS regulations and enforcement for Section 1557 on "other

[51] 45 C.F.R. § 88.2.
[52] *See* 45 C.F.R. § 92.4.
[53] 84 Fed. Reg. 27861.
[54] 84 Fed. Reg. 27859.

grounds."[55] Later, HHS says QHPs are subject to HHS regulations as Title I entities (see discussion in subsection (e) below).[56]

Under the proposed rule, the Marketplaces would presumably be covered as entities created under Title I of the ACA. However, premium tax credits and other functions, such as income, identity, and other verifications performed through the data hub might not be. The result would be confusion and fragmentation in applicability of Section 1557.

e. The proposed rule creates confusion regarding its applicability to Title I entities

In the proposed rule, HHS says that "exchange plans" *may* be subject to Section 1557; and QHPs *are* subject to Section 1557 because they are sold through exchanges created by Title I.[57] The ACA defines QHPs, stating that they must meet certification standards established by the exchange "through which such plan is offered."[58] However, stand-alone dental plans and catastrophic plans are also sold through exchanges created by Title I. HHS does not explain why or when an "exchange plan" that is not a QHP would be exempt from Section 1557.

QHPs and other plans sold through exchanges are subject to Section 1557 in two ways – they receive FFA and are entities created under Title I. Instead of adding clarity, HHS' proposed rule creates considerable confusion by suggesting that some exchange plans are subject to Section 1557 while others are not.

f. HHS seeks to exempt itself and other federal programs and agencies from Section 1557's nondiscrimination requirements

The plain language of Section 1557, as well as the 2016 Final Rule, establishes that any health "program or activity" administered by an Executive agency is subject to the law's provisions.[59] However, the proposed rule seeks to exempt from Section 1557 most federal health programs and agencies administering those programs. HHS imagines that Congress sought to limit application Section 1557 only to federal health programs or activities created under Title I of the ACA. This theory stands contrary to the statutory text, design, and intent of Section 1557 and the ACA.

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[55] 84 Fed. Reg. 27861.
[56] *Id*.
[57] 84 Fed Reg. 27861 (emphasis added).
[58] 42 U.S.C. § 18021(a)(1)(A).
[59] 42 U.S.C. § 18116 (a); 42 C.F.R. §§ 92.1, 92.2, 92.4.

HHS' new interpretation of Section 1557 in effect changes the word "or" to "and," specifying that the law applies to health programs or activities administered by an Executive agency "and" created under Title I.[60] This reading of statute would create a surplusage. If Congress had intended to limit Section 1557 only to those entities created under Title I, it would not have included the clause pertaining to executive agencies. *See*, *e.g.*, *Colautti v. Franklin*, 439 U.S. 379, 392 (1979) ("Appellants' argument . . . would make either the first or the second condition redundant or largely superfluous, in violation of the elementary canon of construction that a statute should be interpreted so as not to render one part inoperative.").[61]

Moreover, if implemented, it would lead to a situation whereby recipients of FFA would be subject to Section 1557, but the programs themselves, and the agencies administering them, would be exempt. For example, under HHS new interpretation, state Medicaid programs would be subject to Section 1557 as recipients of FFA, but the Centers for Medicare & Medicaid Services, which administers these programs, would be exempt. Such an interpretation is not only inconsistent with the plain meaning of Section 1557, but it is also inconsistent with section 504, and therefore likely to cause significant confusion. HHS and all its components, including CMS, the Health Resources Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA), are subject to section 504's prohibition on discrimination.[62]

We strongly urge HHS to retain the current regulations addressing the applicability of Section 1557 and not finalize the proposed 45 C.F.R. § 92.3.

g. Health insurance is health care

The current definition of "health program or activity" promulgated by HHS in the 2016 Final Rule cites to the Civil Rights Restoration Act's ("CRRA") definition of "program or activity" as including "all of the operations of an entity [that is] principally engaged" in a covered service.[63] HHS explained that its interpretation of "principally engaged" follows the approach of the CRRA, which it says Congress included in Section 1557 via the four

[60] 84 Fed. Reg. 27862.
[61] See also, *Yates v. United States*, 135 S. Ct. 1074, 1085 (2015) (plurality opinion) (declining to read statute so as to "significantly overlap" with a distinct statute, resisting a reading that would "render superfluous an entire provision passed in proximity as part of the same Act").
[62] 29 U.S.C. § 794; 45 C.F.R. Part 85.
[63] 81 Fed. Reg. 31385.

civil rights statutes referenced therein.[64] HHS acknowledges that under the CRRA, "the entire program or activity is required to comply with the prohibitions on discrimination if any part of the program or activity receives Federal financial assistance."[65] HHS reasonably concluded because "Congress adopted a similar approach with respect to the scope of health programs and activities covered by Section 1557. If any part of a health care entity receives Federal financial assistance, then all of its programs and activities are subject to the discrimination prohibition."[66]

However, in the proposed rule, HHS seeks reverse the current rule, positing that providing health care "differs substantially" from providing health insurance coverage.[67] As such, HHS seeks to exempt a broad swath of health insurance companies from the application of Section 1557. This nonsensical result would, if fully implemented, would significantly reduce the application of the law through regulation. Moreover, it is inconsistent with the plain language of Section 1557 and Congress's intent.

HHS provides no support for its tortured interpretation that health insurance is not a health program or activity within the meaning of Section 1557. An insurer does not simply process claims. Insurers design benefits, establish formularies, payment structures, and networks. Insurers conduct prior authorization, and establish and evaluate other clinical coverage criteria. Insurers exercise considerable control over the health care of enrollees — deciding what providers a patient may see, what hospitals they may visit, and what treatments or medications they may receive.[68] In the 2016 Final Rule, HHS directly addressed the responsibility of insurers to comply with Section 1557 when insurers act as third party administrators for self-insured plans.[69]

HHS' new interpretation, that health insurance is not health care, is not only contrary to the design and intent of the ACA but is contrary to the plan language of Section 1557 which applies to "*any* health program or activity."[70] Thus, at a minimum, Section 1557's

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[64] *Id*. at 31386.
[65] *Id*.
[66] *Id*. See also 45 C.F.R. § 92.4.
[67] 84 Fed. Reg. 27850.
[68] See, *e.g.*, Institute of Medicine*, Controlling Costs and Changing Patient Care? The Role of Utilization Management* 13 (1989); Joseph B. Clamon, *Does My Health Insurance Cover It - Using Evidence-Based Medicine and Binding Arbitrator Techniques to Determine What Therapies Fall under Experimental Exclusion Clauses in Health Insurance Contracts*, 54 Drake L. Rev. 473, 508 (2006).
[69] 81 Fed Reg. 31432.
[70] 42 U.S.C. § 18116(a) (emphasis added).

applicability all of the operations of an entity principally engaged in health care, including health insurers, is the only plausible reading of the CRRA and Section 1557.

As HHS emphasized in the 2016 Final Rule, applying Section 1557 to all the operations of a health insurer, or any other health program or activity, if any part receives FFA, is the very purpose of the ACA and its nondiscrimination protections:

> This interpretation serves the central purposes of the ACA and effectuates Congressional intent, by ensuring that entities principally engaged in health services, health insurance coverage, or other health coverage do not discriminate in any of their programs and activities, thereby enhancing access to services and coverage.[71]

The proposed rule makes no mention of the potential consequences to millions of people if health insurance companies were exempt from Section 1557.

However, in the 2016 Final Rule, HHS explained:

> One of the central aims of the ACA is to expand access to health care and health coverage for all individuals. Equal access for all individuals without discrimination is essential to achieving this goal. Discrimination in the health care context can often lead to poor and inadequate health care or health insurance or other coverage for individuals and exacerbate existing health disparities in underserved communities. Individuals who have experienced discrimination in the health care context often postpone or do not seek needed health care; individuals who are subject to discrimination are denied opportunities to obtain health care services provided to others, with resulting adverse effects on their health status. Moreover, discrimination in health care can lead to poor and ineffective distribution of health care resources, as needed resources fail to reach many who need them. The result is a marketplace comprised of higher medical costs due to delayed treatment, lost wages, lost productivity, and the misuse of people's talent and energy.[72]

Without question, Congress intended the ACA and its key nondiscrimination provision, Section 1557, to broadly provide protections against insurance company abuses. The very notion that HHS would seek to exempt insurers from nondiscrimination requirements defies rational explanation. We oppose proposed § 92.3.

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[71] 81 Fed. Reg. 31386.
[72] 81 Fed. Reg. 31444.

§ 92.4 Assurances required

We strongly support having assurances required for compliance with Section 1557 for those receiving federal funds.

§ 92.5 Enforcement Mechanisms

We oppose the proposed changes to § 92.301 as newly designated § 92.5. HHS's proposed rule incorrectly limits the remedies available under Section 1557. Congress intentionally designed Section 1557 to build and expand on prior civil rights laws such that individuals seeking to enforce their rights would have access to the full range of available civil rights remedies and not be limited to only the remedies provided to a particular protected group under prior civil rights laws. Section 1557 expressly provides individuals access to any and all of the "rights, remedies, procedures, or legal standards available" under the cited civil rights statutes, regardless of the type of discrimination. Rather than recognizing that the statute creates a single standard for addressing health care discrimination, HHS's interpretation of the statute in these regulations as amended and re-designated would instead create multiple piecemeal legal standards and burdens of proof derived from different statutory contexts. HHS's interpretation is contrary to the statutory language and Congress's intent.

The proposed language is not a valid interpretation of Section 1557. While the statute expressly sets out the grounds for discrimination by reference to the cited civil rights statutes, it does not set forth separate remedies, legal standards, and burdens of proof applicable to each prohibited basis of discrimination based on the statutes from which each was incorporated.[73] To the contrary, Congress specified that "[t]he enforcement mechanisms provided for and available under such title VI, title IX, section 504, *or* such Age Discrimination Act shall apply for purposes of violations of this subsection."[74] The use of the disjunctive "or" indicates that any of the enforcement mechanisms applicable under any of the incorporated statutes are available to every claim of discrimination under Section 1557, regardless of the particular type of discrimination triggering the claim. Applying standard rules of construction, all the enforcement mechanisms provided for and available under each of the referenced statutes in Section 1557 are available to every claim of discrimination under Section 1557.

[7373] *See* Sarah G. Steege, *Finding A Cure in the Courts: A Private Right of Action for Disparate Impact in Health Care*, 16 MICH. J. RACE & L. 439, 462 (2011) ("[T]here is no indication in § 1557 that each listed statute's enforcement mechanisms apply only to its own protected classes.").
[74] 42 U.S.C. § 18116(a) (emphasis added).

It is also necessary to read Section 1557 as establishing a single standard for addressing health care discrimination to avoid "patently absurd consequences."[75] HHS's reading of Section 1557 in this proposed section "would lead to an illogical result, as different enforcement mechanisms and standards would apply to a Section 1557 plaintiff depending on whether the plaintiff's claim is based on her race, sex, age, or disability."[76] Moreover, courts would be left without guidance on how to address intersectional claims—should a person who alleges discrimination on the basis of both race and age be subject to the standards and enforcement mechanisms under a title IX analysis or the Age Discrimination Act? Section 1557 recognizes the reality that discrimination "may occur not solely because of the person's race or not solely because of the person's sexual orientation or gender identity, [disability status, or national origin], but because of the combination."[77] Thus, the law aimed to make it easier for people to file complaints of intersectional discrimination in one place. The proposed rule will only make it harder for people to file complaints. Congress explicitly adopted one provision to prohibit all discrimination in health care. It strains the imagination to read that one provision would require agencies and courts to apply a hodgepodge of standards and enforcement mechanisms.

Further, the proposed changes to the regulation do not comport with congressional intent. Congress did not intend that the enforcement mechanisms and standards available under Section 1557 be tethered to the nature of the claim. Rather, in enacting Section 1557, Congress sought to "create a new right and remedy in a new context without altering existing laws."[78] Congress has repeatedly expressed that it intends civil rights laws to be broadly interpreted in order to effectuate their remedial purposes.[79] By narrowly limiting the legal standards and burdens of proof that apply to those who have experienced health care discrimination, HHS's interpretation in the proposed rule would ignore Congress's intent to provide broad remedies to address discrimination. HHS should not finalize the proposed language in § 92.5.

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[75] *United States v. Brown*, 333 U.S. 18, 27 (1948).
[76] See *Rumble*, 2015 WL 1197415, at *11.
[77] Brief for National LGBTQ Task Force as Amici Curiae Supporting Respondents, *Masterpiece Cakeshop v. Col. C.R. Comm'n*, 137 S.Ct. 2290 (2017), http://www.thetaskforce.org/wp-content/uploads/2017/10/16-111-bsac-LGBTQ-Task-Force.pdf.
[78] *Rumble v. Fairview Health Servs*., No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at *11 n.6 (D. Minn. Mar. 16, 2015).
[79] *See Kang v. U. Lim Am., Inc*., 296 F.3d 810, 816 (9th Cir. 2002); *see also* H. Rep. No. 102–40(I), at 88, U.S. Code Cong. & Admin. News at 626 (stating that "remedial statutes, such as civil rights law[s], are to be broadly construed").

As HHS notes, some courts have interpreted Section 1557 to apply different enforcement mechanisms and standards depending on whether someone's claim is based on race, sex, age, or disability. These cases rely on the fact that Congress incorporated the enforcement mechanisms from the four cited civil rights statutes to interpret Section 1557 to limit the standards and enforcement mechanisms available based on the statute that defines the grounds for discrimination.[80] But the courts in these cases miscomprehend the statutory language and context. As discussed above, Section 1557 expressly provides for broad and uniform enforcement, consistent with Congress's intent that civil rights laws provide broad remedies. While Congress could perhaps have more clearly articulated its intent to establish a single statutory standard for determining discrimination and enforcing Section 1557, its failure to perfectly articulate such a standard does not necessitate the narrow reading of the statute articulated in the proposed rule and the cases it cites.[81] These cases overly rely on interpretations of the underlying statutes without recognizing the inherent shifts that ACA made in the health care realm.[82] If Section 1557 were limited by the constraints of the referenced statutes, its passage would have been largely unnecessary, as the four civil rights statutes already apply to organizations "in the business of providing . . . health care."[83] HHS's interpretation of the statute is incorrect and proposed § 92.5 should not be finalized.

Section 1557 is the law. The proposed rule's inconsistency with the statute itself would cause confusion for both health care entities and patients, ultimately increasing confusion about what the law requires and who is protected under it and making it harder for those who are discriminated against to enforce their rights. Many people who

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[80] *See, e.g., Southeastern Pennsylvania v. Gilead*, 102 F. Supp. 3d 688, 699 n.3 (E.D. Pa. 2015); *Briscoe v. Health Care Serv. Corp*., 281 F. Supp. 3d 725, 738 (N.D. Ill. 2017); *see also, e.g., Doe v. BlueCross BlueShield of Tennessee, Inc*., 926 F.3d 235, 241 (6th Cir. 2019).

[81] *See King v. Burwell*, 135 S. Ct. 2480, 2492 (2015) (noting that the ACA "contains more than a few examples of inartful drafting" and thus emphasizing the importance of considering the broader context of the statute).

[82] The Supreme Court has recognized that the broader purpose of the ACA is to "expand insurance coverage. . . . [and] ensure that anyone can buy insurance." *King*, 135 S. Ct. at 2493. An expansive prohibition on discrimination in health care is key to ensuring that *anyone* can buy insurance. Thus other courts have properly concluded that a single standard and burden of proof apply under Section 1557: "looking at Section 1557 and the Affordable Care Act as a whole, it appears that Congress intended to create a new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff's protected class status." *Rumble*, 2015 WL 1197415, at *10.

[83] *See, e.g*., 29 U.S.C. § 794 (2018) (Rehabilitation Act).

experience discrimination cannot access the court system due to cost.[84] When people can afford to bring judicial actions, they generally receive little in the form of compensatory relief.[85] This could make it even more expensive for people to enforce their rights, deterring them from filing complaints of discrimination.

Thus, we particularly oppose HHS's proposal to replace current § 92.301(b) with proposed § 92.5(b). Every court that has ruled on the question has found that the statutory language of Section 1557 confers a private right of action for monetary damages. The existence of such a right is clear from the statutory language in Section 1557, which explicitly references and incorporates the "enforcement mechanisms" of the four civil rights laws listed—all of which contain a private right of action. Once again, this understanding is also consistent with Congress's intent that civil rights laws be broadly interpreted to effectuate the remedial purposes of those laws. Removing the regulatory language that makes clear that private right of action and monetary damages are available to redress violations of 1557 will serve only to confuse. HHS should not finalize proposed § 92.5(b).

§ 92.6 Relationship to Other Laws

HHS proposes to re-designate and combine current § 92.2 and § 92.3 into a new § 92.6, titled "Relationship to Other Laws." These changes are unnecessary, and the proposed revisions conflict with the statutory language and congressional intent.

a. The deletion of current § 92.3(a) and amendments to current § 92.3(b) are unnecessary and confusing

HHS proposes to entirely delete what is now § 92.3(a), which provides a rule of interpretation for Section 1557. HHS also proposes to amend current § 92.3(b) and re-designate the amended language as § 92.6(a). These proposed changes are unnecessary and should not be finalized. The deletion of current § 92.3(a) is likely to cause confusion, since it will leave both entities and courts with less information about

[84] *See* Brittany Kauffman, *Study on Estimating the Cost of Civil Litigation Provides Insight into Court Access*, Inst. for the Advancement of the Am. Legal System (Feb. 26, 2013), https://iaals.du.edu/blog/study-estimating-cost-civil-litigation-provides-insight-court-access; Michelle Chen, *One More Way the Courts Aren't Working for the Poor*, The Nation (May 16, 2016), https://www.thenation.com/article/one-more-way-the- courts-arent-working-for-the-poor.

[85] Maryam Jameel & Joe Yerardi, *Workplace discrimination is illegal. But our data shows it's still a huge problem*, Vox (Feb. 18, 2019), https://www.vox.com/policy-and-politics/2019/2/28/18241973/workplace-discrimination-cpi-investigation-eeoc.

HHS's intent with respect to Section 1557. The current provision makes clear that the four pre-existing civil rights laws referenced by Section 1557 set the floor in terms of the scope of protections afforded by Section 1557. This is consistent with Congress's intent that Section 1557 build and expand upon these existing civil rights laws, while providing broad protection against discrimination in health care. We share HHS's objective of providing clear guidance on Section 1557's scope and application to covered entities and other stakeholders to reduce unnecessary litigation. The deletion of this provision will have the opposite result; creating more confusion among stakeholders that is likely to lead to more litigation over the scope and interpretation of Section 1557. HHS should not finalize the proposed revisions.

b. Section 1557 does not incorporate exemptions beyond those expressly enumerated in the ACA

HHS proposes to substantially amend current § 92.2 and re-designate the amended language as § 92.6(b). We oppose this change. Nothing in the legislative history or language of the regulation itself permits exceptions to Section 1557's prohibition on discrimination. Moreover, existing statutes that allow individuals and entities to refuse to provide certain services are more than sufficient to accommodate any religious objections. HHS's attempt to import some of these statutes into Section 1557 by regulation goes too far. The proposed new language is inconsistent with the statutory text of Section 1557, conflicts with the purpose of the ACA, and will cause confusion among entities.

The proposed rule would impose exemptions, rights, and protections from the following laws into Section 1557:

- Section 1553 of the Patient Protection and Affordable Care Act (42 U.S.C. 18113);
- Section 1303 of the Patient Protection and Affordable Care Act (42 U.S.C. 18023);
- Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.);
- Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.);
- The Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.);
- Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794);
- Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.);
- The Architectural Barriers Act of 1968 (42 U.S.C. 4151 et seq.);
- The Americans with Disabilities Act of 1990, as amended by the Americans with Disabilities Act Amendments Act of 2008 (42 U.S.C. 12181 et seq.);

- Section 508 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794d);
- The Coats-Snowe Amendment (42 U.S.C. 238n);
- The Church Amendments (42 U.S.C. 300a-7);
- The Religious Freedom Restoration Act (42 U.S.C. 2000bb et seq.);
- The Weldon Amendment (Consolidated Appropriations Act, 2019, Pub. L. 115-245, Div. B sec. 209 and sec. 506(d) (Sept. 28, 2018)); and
- Any related, successor, or similar Federal laws or regulations.

Neither statutory nor legislative history supports adding exemptions to Section 1557, and the only exceptions to Section 1557's broad nondiscrimination mandate are specifically and explicitly contained in Title I of the ACA, including §§ 1553 and 1303.[86] Because the exemptions contained in those two provisions are already explicit, there is no need to incorporate them into this regulation.

In addition, while Title VI, Title VII, Title IX, the Age Discrimination Act, and Section 504 of the Rehabilitation Act are referenced in Section 1557, the plain language of the statute does not incorporate any exemptions contained in those statutes. Thus, this regulation goes too far in attempting to import exemptions from these statutes into Section 1557. For example, while it is true that Title IX contains limited exceptions to its protection in certain circumstances, these exceptions are not incorporated into Section 1557. First, because those limited exceptions are not explicitly stated in Section 1557, they cannot be read to apply to it, therefore, Section 1557 does not import any exceptions from Title IX. Section 1557 references Title IX solely for the ground on which it prohibits discrimination, which is sex.[87] Since Title IX has codified pregnancy discrimination as a form of sex discrimination, and in light of Section 1557's expansive and unprecedented antidiscrimination provisions, it is clear that refusals that center on reproductive health care—including contraception, sterilization, abortion, and other reproductive health care services—are not protected under Section 1557, as they comprise a kind of sex discrimination. The sex discrimination provision, therefore, limits the scope of permissible health care refusals.

HHS considered in its 2016 final rule a blanket religious exemption, and determined such an exemption is not needed. In its assessment, HHS concluded that application of

[86] *See* 42 U.S.C. § 18116(a).

[87] The Supreme Court held in a similar context that the incorporation by reference of protections from one civil rights statute into another does not mean that the limitations of the first apply to the second. *See Consolidated Rail Corp. v. Darrone,* 465 U.S. 624 (1984) (holding that Section 504's reference to Title VI's remedies, procedures, and rights did not import limitations from Title VI not expressly provided in Section 504).

Section 1557 would not be required of federally funded programs and entities if doing so would violate existing religious freedom and conscience protections. The Department noted that:

> certain protections already exist in Federal law with respect to religious beliefs, particularly with regard to the provision of certain health related services. For example, [the 2016] rule would not displace the protections afforded by provider conscience laws, RFRA, provisions in the ACA related to abortion services, or regulations issued under the ACA related to preventive health services.[88]

Moreover, the proposal fails to specify exactly what exemptions it would incorporate into Section 1557. For example, the Americans with Disabilities Act (ADA) does not contain a defined list of exemptions, so it is completely unclear what the proposed language would include. The ADA has that list of miscellaneous provisions that, among other things, exempts certain people or conditions from definition of disability – but without additional explanation from HHS it is not clear who or what HHS is proposing to exempt. The ADA also explicitly exempts from its application "an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks," and for "a person or organization [that] establish[es], sponsor[s], observ[es] or administer[s] the terms of a bona fide benefit plan."[89] In addition, Title I of the ADA contains a list of communicable diseases that are exempt from employment protection, and some religious exemptions, and Title III contains other exemptions for private clubs or religious institutions. These exemptions do not appear in Section 1557 and run counter to its purpose. In any event, since HHS has not delineated what exemptions it proposes to import into Section 1557 by referencing the ADA and other statutes, we are not able to provide meaningful comment on this proposal.

Moreover, the Architectural Barriers Act, the ADA, Section 508 of the Rehabilitation Act, the Coats-Snowe Amendment, the Church Amendments, the Religious Freedom Restoration Act, the Weldon Amendment, and any other federal laws are not mentioned at all in Section 1557. Nor is there is anything in the legislative history or language of the ACA that permits additional exceptions to Section 1557's prohibition on discrimination. Any exemption to the antidiscrimination mandate of the ACA would undermine the goal of health reform to combat practices that have negatively and profoundly impacted the health of the protected classes enumerated in Section 1557.

[88] 81 Fed. Reg. 31379.
[89] 42 U.S.C. § 12201(c).

The proposed regulation may affect overall access to care for women and others. Because the proposed regulation incorporates Title IX's religious exemption, a religious provider could say that they do not have to comply with sex discrimination protections. Allowing a religious exemption to Section 1557's protection against sex discrimination could have far-reaching consequences. Incorporating Title IX's religious exemption could create new instances in which health care providers and entities could allow their beliefs to determine patient care and open the door to discrimination. If implemented, this could allow religiously-affiliated hospitals and other health care entities to discriminate against people seeking reproductive health services and LGBTQ people. Providers, hospitals, or clinics could also be permitted to refuse to provide health services to a woman who is not married.

We oppose the inclusion of Title IX exemptions since they do not apply to health care situations and settings. As HHS concluded in the 2016 Final Rule:

> [S]tudents or parents selecting religious educational institutions typically do so as a matter of choice; a student can attend public school (if K–12) or choose a different college. In the healthcare context, by contrast, individuals may have limited or no choice of providers, particularly in rural areas or where hospitals have merged with or are run by religious institutions. Moreover, the choice of providers may be even further circumscribed in emergency circumstances.
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> Second, a blanket religious exemption could result in a denial or delay in the provision of health care to individuals and in discouraging individuals from seeking necessary care, with serious and, in some cases, life threatening results. Thus, it is appropriate to adopt a more nuanced approach in the health care context, rather than the blanket religious exemption applied for educational institutions under Title IX.[90]

c. HHS may not limit the application of Section 1557 when it violates, departs from, or contradicts other, pre-existing laws

HHS lacks the authority to mandate that any requirements of Section 1557 that "violate, depart from, or contradict definitions, exemptions, affirmative rights, or protections" from the laws listed above that pre-date the ACA will not be imposed. This language sharply deviates from the language in Section 1557 which states that Title I of the ACA should

[90] 81 Fed. Reg. 31380.

not be "construed to invalidate or limit the rights, remedies, procedures, or legal standards" from only Title VI, Title VII, Title IX, the Age Discrimination Act, and Section 504 of the Rehabilitation Act.[91] This language makes clear that the ACA establishes a floor in terms of civil rights protections that may be exceeded by certain other civil rights laws. HHS's proposed rule would instead establish Section 1557 as a ceiling by permitting its protections to be abrogated or even completely overridden by other federal laws. This interpretation is impermissible.

In the first place, HHS fails to specify what provisions of Section 1557 violate, depart from, or contradict the listed provisions. We are unable to provide meaningful comment without more information.

Further, it is the role of courts, not administrative agencies, to harmonize potentially conflicting laws, especially where Congress has not delegated the agency the authority to interpret those laws.[92] In addition, the Architectural Barriers Act, the Americans with Disabilities Act, Section 508 of the Rehabilitation Act, the Coats-Snowe Amendment, the Church Amendments, the Religious Freedom Restoration Act, the Weldon Amendment, and any other federal laws are not mentioned at all in Section 1557. Thus, the plain language of the statute cannot be read to allow those laws to automatically limit or supersede its application.

Rather, if anything, Section 1557 should take precedence to the extent that it violates, departs from, or contradicts a provision of one the listed statutes. The ACA represents a sweeping reform to the U.S. health care system that "comprehensively overhauled" the existing legal landscape on health care rights and discrimination.[93] The non-ACA provisions listed in this proposed regulation involve statutes that are not specific to health care. Thus, to the extent that any part of Section 1557 violates, departs from, or contradicts definitions, exemptions, affirmative rights, or protections that exist elsewhere in the law, it must be read to supersede those laws as they apply in the health care space. Such a reading is necessary, since "reconciling many laws enacted over time, and getting them to 'make sense' in combination, necessarily assumes that the implications of a statute may be altered by the implications of a later statute."[94] HHS's proposed regulation improperly attempts the opposite, purporting to constrain the application of the ACA's reforms by limiting its scope to that of pre-existing laws.

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[91] 42 U.S.C. 18116(b).

[92] *See Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 844 (1984).

[93] *United States v. Fausto*, 484 U.S. 439, 443 (1988).

[94] *Id.* at 453.

HHS's proposed rule would lead to absurd results that Congress could not have intended. For example, the ADA currently includes a safe harbor provision for "an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks," and for "a person or organization [that] establish[es], sponsor[s], observ[es] or administer[s] the terms of a bona fide benefit plan."[95] The ACA was specifically intended by Congress to prohibit discrimination in these areas. HHS cannot incorporate the ADA's safe harbor for insurers and other health care entities into Section 1557 by regulation, contrary to Congress's intent. Similarly, the ADA provides a broad exemption from its application to "religious organizations or entities controlled by religious organizations."[96] At least one court has applied this exemption to a religious hospital.[97] The ACA contains no comparable provisions that exempt entities controlled by religious organizations to be exempt from its prohibitions on discrimination, beyond any such exemptions that are set forth elsewhere in Title I of the ACA. Incorporating these contradictory rules into Section 1557 is contrary to the plain language of the ACA, and will create confusion, rather than clarify, about the scope of protection available under the Section 1557. HHS should not finalize proposed § 92.6(b).

Proposed Subpart B – Specific Application to Health Programs or Activities

§ 92.201 Meaningful Access for individuals with limited English proficiency

Language barriers can impede access to and the quality of care that the estimated 25 million people with LEP in the United States receive. The Joint Commission notes that "[i]ndividuals whose care is inhibited due to a communication barrier. . .may be at risk for poor outcomes."[98] The IOM noted, in its report *Unequal Treatment*,

> Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding

[95] 42 U.S.C. § 12201(c).
[96] 42 U.S.C. § 12187.
[97] *Cole v. Saint Francis Med. Ctr*., No. 1:15 CV 98 ACL, 2016 WL 7474988, at *6 (E.D. Mo. Dec. 29, 2016).
[98] Wilson-Stronks, Lee, Cordero, Kopp, and Galvez, *One Size Does Not Fit All: Meeting the Needs of Diverse Populations*, Oakbrook Terrace, IL: The Joint Commission (2008), https://www.jointcommission.org/assets/1/6/HLCOneSizeFinal.pdf.

> of physician instruction, poor shared decision-making, or ethical compromises (e.g. difficulty obtaining informed consent; [citation omitted]).[99]

The cost of these barriers can be deadly. As we found in a study we commissioned in 2010, patients lost their lives and suffered irreparable harm due to language barriers and the failure to provide appropriate language services.[100]

Due to the nature and importance of health care and the consequences that can result from language barriers, the current regulations appropriately include specific requirements to ensure that covered entities understand their obligations to ensure meaningful access and have clear instructions on how to comply with those obligations. We support this approach as it builds on yet is consistent with Title VI and existing HHS LEP Guidance and offer additional recommendations. We also emphasize that, consistent with the current rule, discrimination on the basis of national origin, including limited English proficiency (LEP), creates unequal access to health. LEP is often compounded with the "cumulative effects of race and ethnicity, citizenship status, low education, and poverty," resulting in more barriers to access.[101]

Visiting health care facilities and agencies that administer health programs and activities are often uncomfortable for individuals with LEP who are "unfamiliar with [the system's] cultural norms, vocabulary, and procedures."[102] Unfamiliarity with the health care system often results in inaction that could compromise a basic standard of living for individuals and families. Furthermore, the lack of language assistance services negatively impacts communities at large, not just LEP individuals. When interpreter services are inadequate, children often serve as language brokers for their parents.[103]

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[99] Smedley, Stith, and Nelson, editors, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Board on Health Science Policy, Institute of Medicine, at 17, (2002), available at http://www.nationalacademies.org/hmd/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx.

[100] National Health Law Program, *The High Costs of Language Barriers in Medical Malpractice,* https://healthlaw.org/resource/the-high-costs-of-language-barriers-in-medical-malpractice/.

[101] Kaiser Family Foundation, *Overview of Health Coverage for Individuals with Limited English Proficiency*, at 3, http://kff.org/disparities-policy/fact-sheet/overview-of-health-coverage-for-individuals-with/.

[102] Vikki Katz, *Children as Brokers of their Immigrant Families' Healthcare Connections*, at 24 (2014), https://academic.oup.com/socpro/article-abstract/61/2/194/1672037?redirectedFrom=fulltext.

[103] *Id.* at 31.

The cost of these barriers can be deadly. As we found in a study we commissioned in 2010, patients lost their lives and suffered irreparable harm due to language barriers and the failure to provide appropriate language services.[104] Examples of patient experiences that have resulted in malpractice claims are documented in *The High Costs of Language Barriers in Medical Malpractice*, a joint publication by the National Health Law Program and University of California, Berkeley, School of Public Health.[105]

Our specific comments on the proposed revisions are outlined below.

a. § 92.101(a) – Obligation

We appreciate that the proposed rule properly makes clear that language assistance services required under paragraph (a) must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency. These provisions are consistent with longstanding Supreme Court precedent holding that language assistance services are required to ensure that LEP individuals have meaningful access, and that the denial of such access is a form of national origin discrimination.[106] At least one court has recognized that Section 1557 incorporates this concept of meaningful access.[107] All too often, individuals with limited English proficiency do not understand their rights, and will not know their new rights under Section 1557, and thus believe they have to bring their own interpreter or use a child, other patient, or unqualified individual to interpret. The responsibility for informing individuals must reside with the covered entity. And covered entities should be required to document that this information is provided or it would be assumed the individual with limited English proficiency did not get the information and the covered entity would be not in compliance with Section 1557.

We oppose, however, the proposal in § 92.101(a) to inappropriately switch the emphasis from "each individual with limited English proficiency" as provided in the 2016 Final Rule to the covered entity's program or activities. In Section 1557, Congress declared "an *individual* shall not" be subject to discrimination (emphasis added). Section 1557 regulations cannot offer less protection than the statute that authorizes such

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[104] National Health Law Program, *The High Costs of Language Barriers in Medical Malpractice* (2010) https://healthlaw.org/resource/the-high-costs-of-language-barriers-in-medical-malpractice/.

[105] *Id.*

[106] *See Lau v. Nichols*, 414 U.S. 563, 568 (1974).

[107] *See Esparza v. Univ. Med. Ctr. Mgmt. Corp*., No. CV 17-4803, 2017 WL 4791185, at *17 (E.D. La. Oct. 24, 2017).

regulations. Therefore, the correct emphasis in the 1557 regulations must be on each individual and not programs. As such, this NPRM would weaken meaningful access and runs counter to Congressional intent and the thorough administrative record supporting the 2016 Final Rule. We oppose these changes.

b. § 92.101(b)(1) – Specific applications -- Enforcement Discretion

As recognized in the current regulation, the enforcement standards balance two core principles critical in effectuating Section 1557's prohibition of national origin discrimination. The first principle, as outlined in HHS' 2003 LEP Guidance, is that the Department must "ensure that [health programs and activities] aimed at the American public do not leave some behind simply because they face challenges communicating in English."[108] Safe and quality health care requires an exchange of information between health care provider and patient for purposes of the diagnoses, treatment options, the proper use of medications, obtaining informed consent, and insured coverage of health-related services. This exchange of information is jeopardized when the provider and the patient speak different languages, which may result in adverse health consequences and even death. Indeed, as recognized in the original Section 1557 NPRM, the provision of health care services, by its "very nature[,] requires the establishment of a close relationship with the client or patient that is based on sympathy, confidence and mutual trust."[109] Provider-patient communication is essential to the concept of patient centeredness, which is a core component of quality health care and has been shown to improve patients' health and health care.

The second principle is that the level, type and manner of language assistance services required should vary based on the relevant facts, which may include the operations and capacity of the covered entity. For these reasons, current regulations provide factors that the Director will evaluate to determine whether a covered entity has met the requirement in paragraph (a). Current § 92.201(b)(1) requires the Director to consider, and give substantial weight to, the nature and importance of the health program or activity, including the particular communication at issue. Both Title VI and Section 1557 prohibit national origin discrimination against each person, not based on the total

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[108] *Policy Guidance Document: Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Individuals* (HHS LEP Guidance), 68 Fed. Reg. 47312 (Aug. 8, 2003), https://www.govinfo.gov/content/pkg/FR-2003-08-08/pdf/03-20179.pdf.

[109] *Notice of Proposed Rulemaking: Nondiscrimination in Health Programs and Activities*, 80 Fed. Reg. 54183 (Sep. 8 2015), https://www.govinfo.gov/content/pkg/FR-2015-09-08/pdf/2015-22043.pdf.

number of people. Neither Title VI nor Section 1557 protections are conditioned on the number of people who experience discrimination, and thus utilizing the four factors is insufficient both for entities to determine how to comply with Title VI and Section 1557 and also for HHS to evaluate compliance.

The proposed regulations would change the mandatory "two factor" mandatory test into a "four factor" optional test. We strongly oppose these changes, which are not consistent with Section 1557's intent. The current regulation at § 92.201(b) provides a modified version of the pre-existing four-factor balancing test, first focusing on the existing factor of the "nature and importance of the health program or activity" and requires that the Director evaluate and give substantial weight to that factor. We support beginning the fact-dependent inquiry of what type of meaningful access must be provided by starting with and giving substantial weight to the nature and importance of the health program or activity and the communication at issue. Beginning the inquiry with this factor properly balances Title VI and Section 1557 obligations to ensure LEP persons are meaningfully served by health programs or activities. This approach is consistent with an understanding of the consequences that can result in lack of access to services or information in the health care setting by individuals with LEP, as intended by Congress when it enacted the ACA.

In evaluating comments submitted on the Section 1557 proposed rule in 2015, HHS revised the final Section 1557 regulation (the regulations currently in place) to eliminate the illustrative four factors and to articulate only one factor: whether a covered entity has developed and implemented an effective written language access plan appropriate to its circumstances. HHS stated that it agreed with commenters' concerns that including multiple illustrative factors – such as the four factors – in the regulatory text may create the erroneous impression that the Director will not consider relevant factors absent from § 92.201(b)(2).

In 2016, HHS also demonstrated that the two-factor test imposes no new burden on covered entities. As it stated in the preamble to the final Section 1557 regulations:

> This is because, with regard to recipients of Federal financial assistance, the proposed rule adopted recipients' existing obligations under Title VI to take reasonable steps to provide meaningful access to individuals with limited English proficiency and codified standards consistent with long-standing principles from the HHS LEP Guidance regarding the provision of oral interpretation and written translation services. . .Thus, we do not believe this rule will impose a greater

> burden regarding the costs of language assistance services than exist under Title VI.[110]

Further, HHS specifically addressed why it chose to provide implementing regulations for Section 1557 on the national origin prong in light of Title VI:

> OCR considered remaining silent on covered entities' obligations to comply with Section 1557's prohibition of national origin discrimination as it affects individuals with limited English proficiency. We rejected this approach because we were concerned that OCR's silence would create ambiguity about covered entity's obligations to individuals with limited English proficiency and could jeopardize the access of individuals with limited English proficiency to covered entities' health programs and activities. Clearly explaining the standards also promotes compliance and reduces enforcement costs."[111]

As clearly stated in these quotes, HHS has already considered and rejected using the four-factor test in evaluating compliance with Section 1557 because the four-factor test failed to adequately implement Section 1557's protections against discrimination on the basis of national origin. Now in the NPRM, HHS fails to adequately explain why it is moving away from the two-factor test and back to the four-factor test. It also fails to explain why it would make the four-factor test optional – the Director "*may* assess how such entity balances the following four factors" (emphasis added) – rather than mandatory as under the current regulations.

The proposed rule fails to recognize that flexibility covered entities have under Section 1557 is not be an assessment of *whether* to provide meaningful access, but *how* to provide such language assistance. Because "meaningful access" is already a subjective standard, adding the four factors as an optional enforcement discretion adds an excessive layer of ambiguity and therefore makes meaningful language access all the more remote for individuals with LEP. As HHS has previously reiterated from the Department of Justice's LEP Guidance, Title VI policies advance the longstanding principle that "federally assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English."[112] This regulation must do the same yet the proposed changes fail to recognize this important principle.

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[110] 81 Fed. Reg. 31453-4.
[111] *Id.* at 31461-2.
[112] HHS LEP Guidance, 68 Fed. Reg. 47312.

Further, the proposed section deletes a specific reference to those "eligible to be served" by an entity. The shift again moves away from an individual assessment to a program/activity assessment. Yet both Title VI and Section 1557 require that covered entities not discriminate against any individual. Thus, if an entity determined, using the four factors that it did not have to provide language services it would indeed be in violation of both Title VI and Section 1557. Further, it is insufficient for an entity to only provide language services to those who actually walk in its door (or call its office). Instead, a covered entity must be prepared to provide language services to all those eligible to be served, as has been recognized at least since HHS' 2003 LEP Guidance. That guidance states:

> Ordinarily, persons ''eligible to be served, or likely to be directly affected, by'' a recipient's program or activity are those who are served or encountered in the eligible service population . . . . In certain circumstances, it is important in conducting this analysis to include language minority populations that are eligible for their programs or activities but may be underserved because of existing language barriers.[113]

Unfortunately, by changing the focus from each individual eligible to be served to focus instead on meaningful access to the program or activity, a covered entity may unintentionally discriminate against individuals with LEP.[114] Eligible clients/patients will not go to a covered entity if the client/patient perceives the entity is not prepared to assist the client/patient in his/her language. For example, if a hospital is located in an area with a large Hmong population (e.g. in parts of Minnesota), the hospital likely should have the availability of language services in Hmong. Without having materials and services available, it will be discriminating against Hmong patients who reside in its service area, are eligible to be served, but are not yet actually served.

Further, many who have used the four-factor test incorrectly believe that each factor is weighed equally in evaluating compliance. This misinterpretation will arise again with the rescinding of the existing regulations. For example, some covered entities have used the resources and costs factor as a defense to providing language services to a less frequently encountered language group. Indeed the reverse is true; entities must do something but what they must do is determined on a case-by-case basis, a determination supported by the current regulations. For example, if a covered entity has a small number of patients/clients of a less frequently encountered language, an entity may erroneously think it does not have to provide oral interpreting services. While there

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[113] *Id.* at 47314.

[114] *Compare* 45 C.F.R. § 92.201(a) with proposed 45 C.F.R. § 92.101(a), 84 Fed. Reg. 27892.

may be some particular dialects or languages which are so infrequently encountered that over-the-phone interpreters are not readily available, advance planning would ensure a covered entity can meet the needs of most LEP individuals.

It is often difficult if not impossible to ascertain when a seemingly "routine" doctor's visit may turn into one that affects an individual's day-to-day existence. How many individuals go to the doctor thinking that they may have high blood pressure, diabetes, cancer, or heart disease? Only by the ability to effectively communicate with a provider and having a provider take a full health history from a patient is it likely that the provider will gather all the information necessary to actually determine if a patient may have a condition that could affect his day-to-day existence. Thus the importance of even a seemingly "routine" healthcare visit in diagnosing potentially life-threatening conditions should weigh heavily in favor of the provision of language services and likely outweigh any concerns about costs and resources, particularly when over-the-phone interpreting services can offer a wide variety of languages at a relatively low cost.

Perhaps most importantly, cost-benefit analyses fail to evaluate how professional and industry or agency culture contribute to racial disparities in health care.[115] Because language assistance services can be measured in cost or resources—money, time, staffing—the cost-benefit analysis is skewed towards the quantifiable and does not capture the immeasurable benefits of language access, increased access and participation in underserved communities, improved health outcomes, and compliance with anti-discrimination laws. The cost-benefit analysis also does not explicitly account for the costs to a consumer who is denied or delayed language assistance.

We also oppose the deletion of consideration of a language access plan from this section. Current regulations do not require development of a language access plan but rather require HHS to take into account whether a covered entity has developed and implemented an effective written language access plan. Many covered entities are already required to evaluate the type of language services they are obligated to provide based on the current HHS LEP Guidance. Doing so ensures that covered entities understand the scope of the populations they serve, the prevalence of specific language groups in their service areas, the likelihood of those language groups coming in contact with or eligible to be served by the program, activity or service, the nature and importance of the communications provided and the cost and resources available. Depending on an entity's size and scope, advance planning need not be exhaustive but is used to balance meaningful access with the obligations on the entity.

[115] Ikemoto, L. C., *Symposium: Racial Disparities in Health Care and Cultural Competency*, 48 St. Louis L.J. 75, 119 (2003).

Our experience is that entities are in a better position to meet their obligations to provide language assistance services in a timely manner when those entities identify, in advance, the types and levels of services available in each of the contexts in which the covered entity encounters individuals who are LEP. The current regulations are also consistent with the encouragement of covered entities to create a language access plan from the HHS LEP Guidance.[116] HHS' 2003 LEP Guidance included elements of an effective language access plan.[117] And as noted in the Preamble to the original Section 1557 NPRM, many organizations already develop such plans based on the model described in HHS LEP Guidance. Doing so need not be burdensome and the size and scope of the plan may vary depending on whether the covered entity is a small provider or a Qualified Health Plan issuer.

Given the longstanding recognition of the benefits of creating a language access plan, we oppose the rescission of § 92.101(b)(2) and recommend that the provision remain as an element OCR can consider in evaluating compliance.

c. § 92.101(b)(2) – Language assistance services requirements

As noted above, we oppose using the four-factor test to determine whether language services must be provided. Oral interpreting services should **not** be subject to the four-factor test but rather be available as needed and free of charge. It may be reasonable for an entity to determine whether to provide in-person or phone or video interpreting based on a variety of factors but under Section 1557 a covered entity may not deny language services altogether, as implied by the proposed rule. The proposed language for interpreter services does not meet even the minimum existing standards required by Section 1557, and currently stated under Title VI and HHS LEP Guidance. As HHS LEP Guidance notes, oral interpreting "can range from on-site interpreters for critical services provided to a high volume of LEP persons, to access through commercially-available telephonic interpretation services."[118] In addition, covered entities may, depending on when interpreting is needed and what is reasonable, provide interpretation through: hiring bilingual staff, hiring staff interpreters, contracting for interpreters, using a telephonic interpreter line, using community volunteers or other persons, in limited circumstances.

[116] 80 Fed. Reg. 54185.
[117] 68 Fed. Reg. 47319-21.
[118] HHS LEP Guidance, 68 Fed. Reg. 47311 (Aug. 8, 2003).

Oral interpreting services must be provided in **all** cases where requested or needed to comply with Section 1557 (and Title VI) although the manner of providing these services (in-person, telephonic, video) may differ depending on the entity. Thus, consistent with HHS LEP Guidance, covered entities may provide oral interpreting services through the range of options that are available and evaluate the type and manner using a fact-dependent inquiry. This avoids an overly prescriptive approach, but provides clarity that some form of oral interpreting services must be provided in all cases where needed to constitute meaningful access. This approach provides a reasonable balance and provides covered entities with needed flexibility by adopting existing standards that are already required for some entities. For example, many smaller covered entities may find that contracting with a telephonic interpreter line, such as that required by the Health Insurance Marketplaces and Qualified Health Plans, can provide meaningful access in some cases, while contracting with interpreters or employing staff interpreters may be necessary where communications are likely to affect the health and well-being of an individual and where the covered entity frequently interacts with LEP persons, such as in a hospital. Lastly, in all circumstances when information cannot be translated into multiple languages, taglines should be used to notify limited English proficient individuals that information is available to be interpreted in their primary language.

d. § 92.101(3) – Specific requirements for interpreter and translation services

We appreciate having specific requirements for interpreter and translation services. It is important to specify the particular knowledge, skills and abilities required of interpreters. We note, however, that § 92.101(b)(2)(ii) refers to the need for a "qualified interpreter" and "qualified bilingual or multilingual staff" yet § 92.101(3) fails to replicate the use of the term "qualified." The inclusion of "qualified" in § 92.101(3) is necessary to reiterate the importance of having trained and competent individuals providing language services and also to reinforce § 92.101(4), and to effectuate Congress's intent to protect LEP individuals from discrimination.

We oppose the removal of technical and training requirements for the use of video remote interpreting services for spoken language interpreting. The type of interpreting during a health care visit should not depend on whether the encounter uses telephonic or video connections. In particular, interpreting for trauma, mental health, or death are often inappropriate for telephonic interpreting. Additionally, an interpreter may miss non-verbal cues via telephone. Even with the higher cost in equipment and training, video interpreting has saved costs from in person interpreting as there are no minimums, travel time, or cancellation risks. Keeping the current standard allows providers to determine which technology is appropriate and when an entity uses video, that it is high quality and without lagging. HHS should not set up a dichotomy between video

interpreting for sign language interpreters and video interpreting for foreign language interpreting; once video interpreting is used, the same standards should apply. That is, while a particular entity may determine whether to provide audio or video interpreting, once video interpreting is selected, the same standards should apply to both sign language and foreign language interpreters. We oppose the proposed changes and support continuation of the current requirements.

e. § 92.101(4) – Restricted use of certain persons to interpret or facilitate communication

We support the provision that restricts covered entities from: 1) requiring individuals with limited English proficiency to provide their own interpreter; and 2) relying on an adult accompanying an individual with limited English proficiency to interpret except in emergency situations or where the individual specifically requests for that adult to interpret. We also strongly support the provision that prevents minor children from interpreting or facilitating communications except in emergency situations involving imminent danger. Research has shown that the ability of a provider to accurately diagnose a patient's condition can be jeopardized by untrained interpreters, such as family and friends, especially minor children, who are prone to omissions, additions, substitutions, volunteered opinions, semantic errors, and other problematic practices.

Further, covered entities should be required to document that it provided information about free interpreting is provided and that individuals with LEP do not have to use family members, friends or other ad hoc interpreters. Otherwise, it would be assumed the individual with limited English proficiency did not get the information and the covered entity would be not in compliance with Section 1557. As we noted in our report on malpractice and language access,

> Physicians are taught that if an activity is not documented in the medical record, it did not happen. In reliance on this practice, if the medical chart did not show that a professional interpreter was used, this report concluded that none was used.[119]

The same concept should apply with regards to covered entities documenting compliance with Section 1557. Covered entities must be required to document the

[119] National Health Law Program and University of California, Berkeley School of Public Health, *The High Costs of Language Barriers in Medical Malpractice* (2010) at p. 3, fn. 11, http://www.healthlaw.org/publications/search-publications/the-high-costs-of-language-barriers-in-medical-malpractice#.Vie5GytFpSE.

provision of language services and an individual's decision to use an accompanying adult or it should be presumed not to have happened.

§ 92.102 Effective communication for individuals with disabilities

NHeLP supports HHS' proposal to retain the provisions of 45 C.F.R. § 92.202 (redesignated § 92.102), regarding effective communication for individuals with disabilities. Effective communication is a critical component of accessing and receiving quality health care. We often hear about entities refusing to provide effective communication or relying on communication methods that are the preference of the entity rather than the choice of the individual. Therefore, we commend HHS for holding all covered entities to the higher ADA Title II standards found at 28 C.F.R. §§ 35.160–35.164. Giving primary consideration to the choice of aid or service requested by the individual with a disability helps to ensure actual effective communication and thus equal opportunity in the health care setting.

We are, however, concerned with HHS' proposed changes to the definitions relating to the effective communication regulation. First, we object generally to the deletion of the definitions section at 45 C.F.R. § 92.4. The elimination of this section will cause confusion for covered entities and risk inconsistency among the various Section 1557 regulations. It also makes it more difficult to amend definitions as needed, which is especially important in the context of effective communication, as auxiliary aid technologies are constantly evolving. Second, while we appreciate HHS' efforts to incorporate many of the current ADA definitions, including the definitions of disability, auxiliary aids and services, qualified interpreter, and video remote interpreting, we note that HHS has erred in tracking the language of these longstanding definitions. The problems we have identified are as follows:

- The definition of auxiliary aids and services at proposed § 92.102(b)(1) excludes "acquisition or modification of equipment and devices" and "[o]ther similar services and actions," despite these two items being found in the ADA definition at 28 C.F.R. § 35.104 and the current Section 1557 definition at 45 C.F.R. § 92.4. HHS states in its NPRM that "[t]he list of auxiliary aids and services from 28 CFR 35.104 is incorporated into the proposed rule at § 92.102(b)(1)" and in general that "[t]hese provisions are drawn from regulations implementing Title II of the Americans with Disabilities."[120] This list is incomplete and HHS' statements are misleading. Parts of 28 C.F.R. § 35.104 are incorporated into the NPRM, but the above-quoted language regarding the "acquisition or modification of equipment

[120] 84 Fed. Reg. 27866, 27867, n. 123.

and devices" and "other similar services and actions" is missing. This deletion alters what was an open-ended functional definition, and takes what is clearly a list of examples of auxiliary aids and services in the current regulations and turns it into an exhaustive list in the proposed regulation. Moreover, to the extent that HHS claims it seeks to eliminate inconsistent applications of the law, such as change is neither prudent nor consistent with the law. We strongly oppose these deletions.

- The definition of auxiliary aids and services at proposed § 92.102(b)(1) also excludes the term "Qualified" before "Interpreters" in subsection (i) and before "Readers" in subsection (ii), despite this critical adjective being found in the ADA definition at 28 C.F.R. § 35.104 and the current Section 1557 definition at 45 C.F.R. § 92.4. While we appreciate that HHS does track the content of the ADA definition of *qualified* interpreters at proposed § 92.102(b)(2)–(3), we believe it will enable greater clarity and consistency with the ADA regulations to keep the term "Qualified interpreters" in the auxiliary aids definition at proposed § 92.102(b)(1)(i). Moreover, the word "Qualified" has also been deleted from "readers" in proposed § 92.102(b)(1)(ii), yet the proposal fails to incorporate the ADA definition of qualified readers. We strongly encourage HHS to both include the word "Qualified" in proposed § 92.102(b)(1)(ii), and incorporate the ADA definition of this term, *see* 28 C.F.R. § 351.04 ("Qualified reader means a person who is able to read effectively, accurately, and impartially using any necessary specialized vocabulary."). The change here is not merely theoretical. Covered entities should not, for example, be free to assign the task of reading personal information about healthcare status, medical procedures, and bills to a high school student hired to help with receptionist duties over the summer. The requirement for a defined "qualified reader" helps to ensure effective communication and healthcare for people with disabilities.

NHeLP is also concerned with the narrowing of the "free of charge" and "timely manner" provision at proposed § 92.102(b)(2). The current Section 1557 regulations provide that a covered entity must provide appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner . . ."[121] This language echoes the ADA Title II regulations, which provide that covered entities "may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program

[121] 45 C.F.R. § 92.8.

accessibility... "[122] In proposed § 92.102(b)(2), HHS significantly narrows this provision by only stating that "*interpreting service* shall be provided to individuals free of charge and in a timely manner" (emphasis added). We strongly oppose this change and encourage HHS to replace the words "interpreting service" with "auxiliary aids and services" to be consistent with the ADA and prevent unnecessary confusion over the requirement. Covered health care entities may not legally charge for *any* auxiliary aid provided; this pre-existing legal requirement should be made clear.

Finally, HHS requests comment on whether it should add an exemption from the effective communication requirements for covered entities with fewer than 15 employees.[123] NHeLP strongly opposes this exemption. HHS has not applied such an exemption in nearly 20 years and to apply it now would roll back the clock on the enforcement of effective communication for people with disabilities. To be clear, effective communication requirements profoundly impact threshold access to and the quality of health care that a person with a disability receives. Breakdowns in communication between a health care provider and a patient with a disability are reported across all types of disabilities,[124] and the lack of accurate and effective communication can lead to misdiagnosis, erroneous treatment, and ultimately a negative impact on the health of the patient.[125] The lack of positive health care communication experiences can also lead to a loss of trust or fear of health care providers, leading some people with disabilities to feel as if they have no choice but to rely upon self-diagnosis and treatment.[126] The provision of appropriate auxiliary aids and services can help remedy some of these health care disparities. For example, the provision of ASL interpreters to Deaf patients preferring this type of communication

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[122] 28 C.F.R. § 35.130(f).

[123] *See* 84 Fed. Reg. 27867.

[124] *See, e.g.*, Thilo Kroll, et al., *Primary Care Satisfaction Among Adults with Physical Disabilities: The Role of Patient-Provider Communication*, 11 MANAGED CARE Q., no. 1, 11–19 (2003); Melinda Neri & Thilo Kroll, *Understanding the Consequences of Access Barriers to Health Care: Experiences of Adults with Disabilities*, 25 DISABILITY & REHAB., no. 2, 85–96 (2003); Sara Bachman, et al., *Provider Perceptions of Their Capacity to Offer Accessible Health Care For People With Disabilities,* 17 J. DISABILITY POL'Y STUD., no. 3, 130–36 (2006); Elizabeth H. Morrison, et al., *Primary Care for Adults with Physical Disabilities: Perceptions from Consumer and Provider Focus Groups*, 40 FAM MED., no. 9, 645–51 (2008).

[125] *See* Silvia Yee, Mary Lou Breslin, et al., *Compounded Disparities: Health Equity at the Intersection of Disability, Race, and Ethnicity*, NAT'L ACADS. SCI., ENG'G, & MED. (2017), *available at* http://nationalacademies.org/hmd/Activities/SelectPops/HealthDisparities/Commissioned-Papers/Compounded-Disparities, at 43–44 (summarizing and analyzing the abundance of research on this point).

[126] *Id.*

accommodation has been linked with significantly higher utilization rates of preventative care, including cholesterol screens, colonoscopy, and influenza vaccines.[127] While there are still many improvements to be made, requiring all covered entities to provide effective communication is a vital first step towards ensuring health care equity.

Provider offices with fewer than 15 employees should not be exempted from this basic civil rights requirement. People with disabilities often obtain their health care from local providers or specialists with only a few employees. This is especially true in rural areas, where providers are more likely to have smaller practices, and there may only be one appropriate specialist within a reasonable distance. This exemption could thus function to exclude many people with disabilities from accessing the health care they need. The American Medical Association's (AMA's) Physician Practice Benchmark Survey in the period from 2012-16 found that a majority of physicians still work in small practices, with 57.8% in practices of 10 or fewer physicians, and 37.9% working in practices with fewer than 5 physicians in 2016.[128] Physicians in single specialty practices were even more likely to be in smaller practices. A practice with 10 physicians may or may not have 15 or fewer employees, but a practice with 5 physicians is very likely to have fewer than 15 employees. Exempting these small practices means that people with disabilities will have significantly more difficulty obtaining effective communication from both general and specialty physicians, and sends the message that HHS's latest healthcare-specific civil rights regulations make it harder for people with communication disabilities to obtain needed healthcare. Congress surely did not intend such a result in enacting the ACA and Section 1557.

Moreover, in practice, this exemption would make little sense because public accommodations (including hospitals and provider offices) of any size are already required to provide effective communication under Title III of the ADA. Even HHS, when it originally announced that the 15-employee exemption does not apply to entities receiving HHS funds, recognized this reality:

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[127] Michael M. McKee, et al., *Impact of Communication on Preventive Services Among Deaf American Sign Language Users*, 41 AM. J. PREVENTATIVE MED., no. 1, 75–79 (2011).
[128] Carol K. Cane, *Updated Data on Physician Practice Arrangements: Physician Ownership Drops Below 50 Percent*, Policy Research Perspectives 4-5, AMA (2017), *available at* https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/health-policy/PRP-2016-physician-benchmark-survey.pdf. The Benchmark surveys are of practicing physicians who provide a minimum of 20 hours of patient care/week in one of the 50 states or the District of Columbia, and who are not employed by the federal government.

> This is not a new requirement; Title III of the Americans with Disabilities Act (ADA) already requires public accommodations of all sizes to provide auxiliary aids and services to persons with disabilities where necessary to ensure effective communication and Title II of the ADA extends the same requirement to state and local government entities. The vast majority of entities that receive federal financial assistance from HHS thus are already required to provide auxiliary aids and services to persons with disabilities where necessary to ensure effective communication.[129]

If HHS intends to protect small entities from costs, then the appropriate mechanisms to do so is already in 45 C.F.R. § 92.202, which incorporates the ADA Title II exemptions found in 28 C.F.R. § 35.164 by explicit reference.[130] Adding an exemption for small entities will harm people with disabilities and is not the proper solution.

In summary, HHS should clarify that the list of auxiliary aids and services in proposed § 92.102(b)(1) is not exhaustive by adding the following after subsection (ii):

> (iii) Acquisition or modification of equipment and devices; and
> (iv) Other similar services and actions.

HHS should also put back the term “Qualified” before “Interpreters” in proposed § 92.102(b)(1)(i) and before “Readers” in proposed § 92.102(b)(1)(ii), and it should incorporate the definition of “Qualified readers” found at 28 C.F.R. § 35.104. The requirement to provide services “free of charge and in a timely manner” in proposed § 92.102(b)(2) should be applied to all “auxiliary aids and services,” not just “interpreter services.” Last, no exemption should be added for covered entities with fewer than 15 employees.

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[129] HHS OCR, *Section 504 of the Rehabilitation Act of 1973; Notice of Exercise of Authority Under 45 CFR 84.52(d)(2) Regarding Recipients With Fewer Than Fifteen Employees*, 65 Fed. Reg. 79368 (Dec. 19, 2000).

[130] 28 C.F.R. § 35.164 (“This subpart does not require a public entity to take any action that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens. In those circumstances where personnel of the public entity believe that the proposed action would fundamentally alter the service, program, or activity or would result in undue financial and administrative burdens, a public entity has the burden of proving that compliance with this subpart would result in such alteration or burdens.”).

§ 92.103 Accessibility standards for buildings and facilities

NHeLP supports HHS' proposal to retain the provisions of 45 C.F.R. § 92.203 (redesignated § 92.103), regarding accessibility standards for buildings and facilities. We agree that the 2010 ADA Standards for Accessible Design ("2010 Standards") are the appropriate architectural standards for any facility or part of a facility in which health programs or activities are conducted that is constructed or altered by or on behalf of, or for the use of, a recipient or State Exchange. We appreciate HHS' continued commitment to ensuring that health care facilities and provider offices are physically accessible for people with disabilities.

HHS requests comment on the appropriateness of applying the 2010 ADA Standards' definition of "public building or facility" (i.e., the ADA Title II standards) to all entities covered under Section 1557, specifically with respect to multistory building elevators and text telephone ("TTY") requirements.[131] It is indeed appropriate and *necessary* to hold all health programs and activities that receive federal financial assistance to these standards, and we strongly oppose importing the private multistory building exception found at Section 206.2.3 of the 2010 Standards and the private entity TTY standard found at Section 217.4.3 of the 2010 Standards into Section 1557.

First, by virtue of accepting federal financial assistance from HHS, it is entirely appropriate to hold all covered health programs and activities, including private entities, to the Title II standards. If we look at the ADA in a vacuum, a private entity that operates as a place of public accommodation would only be subject to the lower Title III architectural standards. However, here, the ADA standards function in relation to Section 1557, which notably references and incorporates the grounds of discrimination of Section 504, not the ADA. Section 504 covers programs and activities receiving federal financial assistance. So, in this context, some private health care practices, for example, would be on the hook for not only being a public accommodation under Title III, but also an entity that avails itself to nondiscrimination law (Section 504 and Section 1557) by virtue of choosing to accept federal financial assistance from HHS. This distinction justifies holding private health care entities to a higher standard, which HHS itself recognized in its 2015 NPRM:

> [The] entities covered under the proposed rule are health programs and activities that either receive Federal financial assistance from HHS or are conducted directly by HHS. Although OCR could apply Title II standards to States and local entities and Title III standards to private entities, we believe it is appropriate to

[131] *See* 84 Fed. Reg. 27846, 27867.

> hold all recipients of Federal financial assistance from HHS to the higher Title II standards as a condition of their receipt of that assistance.[132]

Additionally, it is important to consider the context of the buildings and facilities at issue under Section 1557. While we affirm that architectural access is essential in all contexts, we note that it is particularly crucial for people with disabilities to have equal access to health programs and activities. People with disabilities already face significant barriers in accessing needed health care.[133] Exempting a health insurance enrollment center or plan benefit counselor from having an elevator or a small health care practice from providing TTY, for example, will only serve to widen the disparities in health access. By choosing to operate a business that is critical to an individual's health and life, and then by choosing to accept HHS funds, private health entities have also assumed a duty to ensure that their buildings and facilities are accessible for all. These are also obligations that are inevitably included in the contracts that health entities enter when they agree to function as a plan or provider with Medicaid, Medicare, or through an Exchange. Watering down this responsibility is unacceptable and unlawful. It will function to reward those few construction or alteration projects that did not have the foresight to take account of the needs of healthcare consumers with disabilities.

As to the two exemptions that HHS specifically requests comment on, NHeLP strongly opposes them both. Section 206.2.3 of the 2010 Standards provides, in relevant part, that "[i]n private buildings or facilities that are less than three stories or that have less than 3000 square feet (279 m^2) per story, an accessible route shall not be required to connect stories provided that the building or facility is not . . . the professional office of a health care provider . . . or another type of facility as determined by the Attorney General." This private elevator exemption dates back to the 1991 ADA Standards for Accessible Design, a time period in which the concept of widespread architectural accessibility was still relatively recent and when the construction or addition of accessible elevators was still considered extremely burdensome and costly. Today, private entities have had over 50 years to adjust their architectural designs and consider the needs of people with disabilities.[134] Requiring a multi-story building or facility to have

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[132] HHS, *Nondiscrimination in Health Programs and Activities; Proposed Rule*, 80 Fed. Reg. 54172, 54186 (Sept. 8, 2015).

[133] *See, e.g.*, Yee, et al., *supra* note 125; H. Stephen Kaye, *Disability-Related Disparities in Access to Health Care Before (2008–2010) and After (2015–2017) the Affordable Care Act*, 109 AM. J. PUB. HEALTH, no. 7, 1015–21 (July 2019).

[134] The Architectural Barriers Act, the first federal law requiring that facilities designed, constructed, altered, or leased with certain federal funds be accessible for people with disabilities, was signed into law in 1968. *See* 42 U.S.C. §§ 4151–57.

an elevator is no longer the foreign concept or perceived burden it once was. Instead, it is required by the law. Rolling back the standards for having an elevator in private health buildings will only serve to erect a new, additional barrier for individuals with disabilities to access needed health programs.

We also oppose lowering the private entity TTY standard. Section 217.4.3 of the 2010 Standards provides, in relevant part, that "[w]here at least one public pay telephone is provided in a *public building*, at least one public TTY shall be provided in the building" (§ 217.4.3.1) and "[w]here four or more public pay telephones are provided in a *private building*, at least one public TTY shall be provided in the building" (§ 217.4.3.2). The lower 4:1 TTY standard for private entities, which originated 15 years ago,[135] is now outdated given the current widespread availability and affordability of the technology. It takes little effort or cost for covered entities to provide 1:1 TTY, yet the benefits offered to people who are Deaf or have hearing impairments are significant. It enables people with disabilities to communicate with health care providers, their insurance companies, and other similar entities. HHS should not lower the 1:1 TTY standard that has already been in place for three years.

HHS should continue to apply the 2010 ADA Standards' definition of "public building or facility" to all entities covered under Section 1557. HHS should not incorporate the private multistory building elevator exemption or the private entity TTY standard into Section 1557 regulations.

§ 92.104 Accessibility of information and communication technology

NHeLP supports HHS' proposal to retain the provisions of 45 C.F.R. § 92.204 (redesignated § 92.104), regarding information and communication technology ("ICT") for individuals with disabilities. Like effective communication, access to information, communication, and electronic technologies is important to guaranteeing people with disabilities equal access to health care services—and this fact is even more true as U.S. society increasingly relies on digital and web-based communications. Health care providers and health insurance plans are rapidly developing interactive websites, moving their medical recordkeeping online, and communicating with patients through electronic means. We commend HHS' efforts to ensure that people with disabilities are not left behind as technologies evolve.

[135] The 4:1 private TTY standard was first adopted in the 2004 ADA Accessibility Guidelines ("ADAAG").

HHS also requests comment on whether it should cross-reference Section 508 and its applicable implementing regulations in proposed § 92.104. NHeLP supports this proposal. Cross-referencing Section 508 and its regulations will help ensure that the Section 1557 stay up-to-date as the Section 508 regulations are amended, and it will ensure consistency across the civil rights laws.

§ 92.105 Requirement to make reasonable modifications

The proposed text of 45 C.F.R. § 92.105 mirrors the current text of 45 C.F.R. § 92.205 and retains the requirement to make reasonable modifications to policies, practices, or procedures. We support this language. This language of "reasonable modification" conforms to other non-discrimination regulations that apply to state and local government, and therefore is consistent with other regulatory schemes applicable to entities subject to 1557.[136] The 2016 Final Rule specifically applies the definition of "reasonable modification" from Title II of the ADA (state and local governments), which continues to be the appropriate standard for recipients of federal financial assistance, programs established under Title I of the ACA, and programs administered by HHS. The concept of "reasonable modification" is not burdensome. The concept has long applied to a broad swath of entities, whether public or private, and therefore it is clear and familiar to most entities covered by Section 1557.[137] There is no reason to make any changes to this language, nor to import unrelated concepts from other regulatory schemes.

HHS has requested comment on whether the following language should be substituted for the proposed 45 C.F.R. § 92.105: covered entities shall make "reasonable accommodation to known physical or mental limits of an otherwise qualified" individual with a disability. HHS also asks whether an exemption for "undue hardship" should be imported from 45 C.F.R. § 84.12 and 28 C.F.R. § 92.205 into proposed § 92.105. The substitute language is from regulations related to employment, and is unnecessary, ill-

[136] 45 C.F.R. § 92.205.

[137] *See, e.g.,* 28 C.F.R. § 35.130(b)(7)("A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.")(Title II of the ADA). Title III also incorporates a requirement that covered entities make "reasonable modifications in policies, practices, or procedures, when the modifications are necessary to afford goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the public accommodation can demonstrate that making the modifications would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations." 28 C.F.R. § 36.302(a) (Title III).

fitting, and inappropriate for a health care context. The answer to both questions is no. HHS should not make any changes to the language at current 45 C.F.R. § 92.205.

As a preliminary matter, in asking about the imported language, HHS states that the language is taken from HHS Section 504 regulations and the "Department of Justice's Section 504 coordinating regulation."[138] However, both citations to the DOJ Section 504 coordinating regulations are to a non-existent portion of the Code of Federal Regulations.[139] These incorrect citations makes it impossible for public to know with certainty what HHS is proposing, nor does it allow the public to analyze the context of proposed imported, or any case law interpreting such, language.[140] Public comment requires transparency, and the source of any imported language is an integral part of transparency.

Furthermore, new exemptions are unnecessary and contrary to Section 1557. The concept of a "reasonable modification" is not boundless—it is already well-defined by regulation and decades of case law. In fact, the definition of "reasonable modification" is so clear that HHS declined to provide additional explanation of the term in the 2016 Final Rules.[141] The 2016 final regulations track Title II of the ADA, requiring covered entities to make a reasonable modification "unless the covered entity can demonstrate that making the modifications would fundamentally alter the nature of the health program or activity."[142] Continuing to apply the "reasonable modification" analysis to Section 1557 promotes consistency with pre-existing civil rights statutes, one of HHS' stated goals of their proposed rules.[143] Neither Section 504 nor Title II of the ADA would

[138] 84 Fed. Reg. 27868.
[139] *See* 84 Fed. Reg. 27868, citing to 28 C.F.R. § 92.205 two separate times. 28 C.F.R. Part 92 contains regulations regarding the "Office of Community Oriented Policing Services (COPS)," and does not contain a section 92.205.
[140] It appears that HHS seeks to import DOJ's rules for the implementation of Executive Order 12250. *See* 28 C.F.R. § 41.53. It is also possible that HHS intends to refer to DOJ's rules for reasonable accommodation in employment in federally assisted programs pursuant to Section 504. *See* 28 C.F.R. § 42.511. Either way, it is incumbent on HHS to accurately explain the source of any regulations it seeks to substitute.
[141] *See* 81 Fed. Reg. 31382 ("OCR believes that defining the terms ''reasonable modification'' and ''accessibility'' in this rule is unnecessary, given the meaning that these terms have acquired in the long history of enforcement of Section 504 and the ADA in the courts and administratively. We intend to interpret both terms consistent with the way that we have interpreted these terms in our enforcement of Section 504 and the Age and so decline to add these definitions to the final rule").
[142] 45 C.F.R. § 92.205.
[143] 84 Fed. Reg. 27848.

permit an exemption for “undue hardship” in this context, and it is inappropriate to import such an exemption into Section 1557 where none exists in the statute itself.

As noted above, the suggested imported language of “reasonable accommodation,” “known physical or mental limitation,” and “undue hardship” stems directly from employment-related regulations. Such concepts are ill-fitting in the health care context and cannot be applied under Section 1557. For example, the definition of “undue hardship” makes little sense when divorced from the employment context, as it requires consideration of factors often irrelevant to the health care context, such as “(1) The overall size of the recipient's program or activity with respect to number of employees, number and type of facilities, and size of budget; (2) The type of the recipient's operation, including the composition and structure of the recipient's workforce; and (3) The nature and cost of the accommodation needed.”[144] These factors make sense in an employment context; they do not when applied to health care. For example, the composition and structure of a workforce and the number of employees is relevant to common employment-related accommodations, such as changes in job duties or schedules. These factors are much less likely to have bearing on common health care modifications, which may more commonly include requests for alternative evacuation plans for individuals who cannot use stairs, additional training for health care staff on how to provide services to certain individuals, ensuring lab referrals are made to accessible entities when necessary, or altering a policy to allow an individual to remain in a wheelchair and avoid unnecessary transferring while receiving some treatments such as dental care. Because the factors used to analyze “undue hardship” are more appropriate for the employment context, we believe that the appropriate approach is to retain the “reasonable modification” language, which is taken from Title II of the ADA, already applies to many entities subject to Section 1557, and has a clear definition that is flexible enough to provide guidance to health care entities.

We specifically object to the importation of the concept of “known physical or mental limitation” because it could introduce confusion, suggest that covered entities' obligations are limited, and unduly focuses on measures entities must take in response to requests for modifications. Disability discrimination encompasses not just inappropriate responses to requests for modifications, but also a failure of covered entities to take affirmative steps to prevent discrimination. Taken in conjunction with the proposed deletion of Section 92.101 (defining discriminatory actions prohibited), importing the language regarding "known physical or mental limitation" could be read to limit covered entities' obligations. Nothing in Section 1557 permits such limitations, and such a reading would be contrary to the language of Section 1557 and the larger

[144] 45 C.F.R. § 84.12.

Act within which it sits. Nor has HHS provided an explanation of how this concept, which heretofore has been largely limited to the employment context, would be applied in the health care context. Such an application would undermine HHS' stated purpose of the proposed rule, which is to promote consistency in the application of rules and to adhere to the enforcement mechanisms available in the underlying statutes.[145]

Furthermore, while we disagree with HHS' statement that Congress only intended to permit disparate impact claims if such claims were permissible prior to 1557, HHS admits that many courts have permitted disparate impact claims under Section 504.[146] Importing language regarding "known" limitations could be interpreted as limiting plaintiffs' ability to bring systemic disparate impact claims, or other substantive claims. If HHS intends to create such a limitation, it must be explicit about its intent, and do so via a transparent rulemaking process. HHS should retain the language in proposed 45 C.F.R. § 92.105.

For the reasons stated above, we urge HHS to retain the language proposed in Section 92.105 as drafted, and not to import any new exemptions or language regarding "reasonable accommodations for known physical and mental impairments."

§§ 92.102 through 92.105

In these four sections, HHS asks broadly whether it has struck the "appropriate balance" with respect to Section 504 rights and obligations imposed on the "regulated community." We agree generally that to the extent that HHS has retained protections from the 2016 Final Regulations, such protections are appropriate. More broadly, however, the question should not be "whether the benefits of these provisions exceeds the burdens imposed by them." Such a balancing exercise is not called for by the statute, and inserts an inappropriate regulatory finesse on a remedial scheme created by Congress and intended to be interpreted broadly and to correct decades of harm.[147] The task of the agency is to interpret and implement the statute. The proposed balancing of interests may be an appropriate role for Congress, but not for the administrative branch.

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[145] 84 Fed. Reg. 27849-51.

[146] *See, e.g., McWright v. Alexander*, 982 F.2d 222, 229 (7th Cir. 1992); *Smith v. Barton*, 914 F.2d 1330, 1340 (9th Cir. 1990).

[147] *See, e.g.* 42 U.S.C. § 12101 (ADA findings and purposes). The ADA built upon Section 504, and Section 1557 follows in their footsteps.

Although we disagree with the premise of the question, we do note that the harm that people with disabilities would suffer if Section 1557 and the current regulatory scheme were not upheld is immense.[148] People with disabilities already experience significant disparities in health outcomes and access to health care.[149] For example, adults with disabilities are 58% more likely to experience obesity, three times more likely to be diagnosed with diabetes, and nearly four times more likely to have early-onset cardiovascular disease.[150] Moreover, they are nearly three times more likely to have not accessed needed health care because of cost and twice as likely to have unmet mental health needs.[151] The ACA's reforms worked to reduce some of these disparities by, for example, reducing the uninsurance rate and increasing the likelihood of a person with a disability having a regular health care provider.[152] However, there are still large gaps in health access.[153] Persistent attitudinal and programmatic barriers to care are ongoing.[154] Section 1557 provides an avenue through which people with disabilities can identify and challenge discriminatory policies.

HHS also asks generally whether regulations for Section 1557 are consistent with the regulatory scheme for entities that are not covered by Section 1557 regulations, such as human services grantees, or whether underlying regulations for other civil rights statutes need to be modified. In general, we have commented on contexts where it is inappropriate to import regulations created for the employment into Section 1557's regulatory scheme. While there are clearly other areas of nondiscrimination law where importing or exporting other regulatory regimes would be inappropriate, HHS has not provided sufficient clarity in both the questions and the context to allow us to provide additional meaningful comment outside of the comments raised above.

To propose changes in existing regulations, HHS must provide its own justification for the changes. Given that the public must be provided an opportunity to comment on HHS' alleged explanations and rationale for these proposed changes, HHS' attempt to

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[148] *See generally, e.g*. Valarie K. Blake, *An Opening for Civil Rights in Health Insurance After the Affordable Care Act*, 36 B.C. J.L. & SOC. JUST. 235 (2016) (describing pre-ACA health insurance discrimination and how the ACA addressed those issues).
[149] *See, e.g.*, Yee, et al., supra note 125.
[150] *Id.* at 32.
[151] *Id.* at 31.
[152] Kaye, supra note 133 at 1015–21 (July 2019); Gloria L. Krahn, *Drilling Deeper on the Impact of the Affordable Care Act on Disability-Related Health Care Access Disparities*, 109 AM. J. PUB. HEALTH, no. 7, 956–58 (July 2019).
[153] *See* Kaye, *supra* note 133, at 1019–21 (for example, across the population of people with disabilities, there has been "much greater delayed or forgone care" post-ACA).
[154] *See id.*; Yee, et al., *supra* note 125, at 31–32; 39–44.

solicit feedback on unspecified underlying regulations that it may then use to promulgate unanticipated changes in a final rule violates requirements of public notice and comment as required by the Administrative Procedures Act. These issues would be more appropriate to inform agency decisions prior to issuing an NPRM, such as through a Request for Information, than in response to an NPRM. We thus decline to provide additional feedback on the question of whether Section 1557 is generally aligned with underlying but unspecified regulations, but have provided our explanations, justifications and evidence supporting our comments in the sections above.

III.B. Current Section 1557 Regulations Proposed for Repeal

§ 92.4 Definitions

HHS proposes to eliminate the definitions section of the current regulations and to drastically limit the scope of Section 1557's protections. We strongly oppose these changes. (See also the discussion above on §§ 92.2 Nondiscrimination Requirements & 92.3 Scope of Application).

The scope of Section 1557's protected classes and characteristics extend broadly. The plain text of Section 1557 and the current implementing regulations establish the broad scope of its nondiscrimination protections. This is consistent with Congress's intent that Section 1557 build and expand upon existing civil rights laws, while providing broad protection against discrimination in health care. However, the proposed rule eliminates key definitions describing who is protected under Section 1557 and ignores HHS' own findings in the 2016 Final Rule on the harms of discrimination in health programs or activities. We oppose these proposed changes which seem to be based more on animus than fact or law.

a. Protections based upon gender identity

Twenty-nine percent of transgender individuals were refused to be seen by a health care provider on the basis of their perceived or actual gender identity and the same percent experienced unwanted physical contact from a health care provider.[155]

[155] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for American Progress, (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-for-discrimination&email_referrer=&email_subject=rx-for-discrimination.

Additionally, the 2015 U.S. Transgender Survey found that twenty-three percent of respondents did not see a provider for needed health care because of fears of mistreatment or discrimination.[156]

Under current law and regulations, Section 1557 prohibits discrimination on the basis of sex, including someone's gender identity.[157] In addition, current regulations expressly prohibit coverage exclusions for gender-affirming care, and prohibit plans from imposing limits or restrictions on health services provided to transgender persons, for services traditionally provided to persons of one sex.[158]

Despite the stark need for protection against discrimination on the basis of gender identity, however, the proposed rule completely eliminates gender identity as part of the definition of sex discrimination. It also removes sections of the existing regulations that prohibit health plans from excluding gender-affirming care.

HHS argues that gender identity protections and the prohibition of coverage exclusions imposes a new and costly burden for plans. However, issuers have been on notice since 2012 that they are obliged to follow Section 1557's protections against gender identity discrimination.[159] In any case, the 2016 Final Rule did not establish any new obligations that exist separate from Section 1557.

As explained above, HHS provides no rationale for relying on the preliminary injunction issued in *Franciscan Alliance* as the justification for eliminating regulatory protections against discrimination based upon gender identity. In addition, HHS fails to address numerous other court decisions finding that Section 1557's gender identity protections are statutory, instead cherry picking a handful of cases to the contrary. Discrimination based on gender identity, gender expression, gender transition, transgender status, or sex-based stereotypes is necessarily a form of sex discrimination.[160] Numerous federal

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[156] Nat'l Ctr. for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* 5 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[157] 45 C.F.R. § 92.4.

[158] 45 C.F.R. §§ 92.206, 92.207(b)(3)-(5). See, *e.g.*, Rebekah Rollston, MD, MPH, PROMOTING CERVICAL CANCER SCREENING AMONG FEMALE-TO-MALE TRANSMASCULINE PATIENTS, The Fenway Institute (May 22, 2019), https://fenwayhealth.org/wp-content/uploads/TFIP-28_TransMenCervicalCancerScreeningBrief_web.pdf.

[159] 81 Fed. Reg. 31387, citing Letter from Leon Rodriguez, Director, U.S. Dep't of Health & Human Servs., Office for Civil Rights, to Maya Rupert, Federal Policy Director, National Center for Lesbian Rights (Jul. 12, 2012), https://www.nachc.com/client/OCRLetterJuly2012.pdf.

[160] *See, e.g.*, *EEOC v. R.G. & G.R. Harris Funeral Homes*, No. 16-2424 (6th Cir. Mar. 7, 2018); *Whitaker v. Kenosha Unified Sch. Dist.*, 858 F.3d 1034 (7th Cir. 2017) (Title IX and Equal

courts have found that federal sex discrimination statutes reach these forms of gender-based discrimination.[161] Moreover, the scope of sex discrimination in Title VII is currently pending before the Supreme Court.[162] It is premature to change the regulations now before the Supreme Court has spoken to this precise interpretive issue.

Regardless, it is clear that discrimination based on gender identity or transgender status is sex discrimination because it treats people differently from otherwise similarly situated people based on their transition from one gender to another, because it treats them

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Protection Clause); Doddsv. U.S. Dep't of Educ., 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); Smith v. City of Salem, 378 F.3d 566 (6th Cir. 2004) (Title VII); *Rosa v. Park West Bank & Trust Co*., 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *A.H. ex rel. Handling v. Minersville Area School District*, 3:17-CV-391, 2017 WL 5632662 (M.D. Pa. Nov. 22, 2017) (Title IX and Equal Protection Clause); *Stone v. Trump*, ---F.Supp.3d ---, No. 17–2459 (D. Md. Nov. 21, 2017) (Equal Protection Clause); Doe v. Trump, ---F.Supp.3d ---, 2017 WL 4873042 (D.D.C. Oct. 30, 2017) (Equal Protection Clause); *Prescott v. Rady Children's Hospital-San Diego*, ---F.Supp.3d ---, 2017 WL 4310756 (S.D. Cal. Sept. 27, 2017) (Section 1557); *E.E.O.C. v. Rent-a-Center East, Inc*., ---F.Supp.3d ---, 2017 WL 4021130 (C.D. Ill. Sept. 8, 2017) (Title VII); *Brown v. Dept. of Health and Hum. Serv.*, No. 8:16DCV569, 2017 WL 2414567 (D. Neb. June 2, 2017) (Equal Protection Clause); *Smith v. Avanti*, 249 F.Supp.3d 1194 (D. Colo. 2017) (Fair Housing Act); *Students & Parents for Privacy v. U.S. Dep't of Educ.*, No. 16-cv-4945, 2016 WL 6134121 (N.D. Ill. Oct. 18, 2016) (Title IX); *Mickens v. Gen. Elec. Co.* No. 16-603, 2016 WL 7015665 (W.D. Ky. Nov. 29, 2016) (Title VII); *Fabian v. Hosp. of Cent. Conn*., 172 F.Supp.3d 509 (D. Conn. 2016) (Title VII); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. Jul. 5, 2016) (Section 1557); *Doe v. State of Ariz*., No. CV-15-02399-PHX-DGC, 2016 WL 1089743 (D. Ariz. Mar. 21, 2016) (Title VII); *Dawson v. H&H Elec., Inc.*, No. 4:14CV00583 SWW, 2015 WL 5437101 (E.D. Ark. Sept. 15, 2015) (Title VII); *U.S. v. S.E. Okla. State Univ*., No. CIV–15–324–C, 2015 WL 4606079 (W.D. Okla. 2015) (Title VII); *Rumble v. Fairview Health Serv.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (Section 1557); *Finkle v. Howard Cty*., 12 F.Supp.3d 780 (D. Md. 2014) (Title VII); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); *Lopez v. River Oaks Imaging & Diagnostic Grp*., Inc., 542 F.Supp.2d 653 (S.D. Tex. 2008) (Title VII); *Mitchell v. Axcan Scandipharm,* Inc., No. Civ.A. 05-243, 2006 WL 456173 (W.D. Pa. 2006) (Title VII); *Tronettiv. Healthnet Lakeshore Hosp*., No. 03–CV–0375E, 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003) (Title VII).

[161] *See, e.g*., *Smith v. City of Salem*, 378 F.3d 566, 572-75 (6th Cir. 2004); *Rosa v. Park West Bank & Trust Co*., 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act). *See also* Statement of Interest of the United States at 14, *Jamal v. Saks*, No. 4:14-cv-02782 (S.D. Tex. Jan. 26, 2015).

[162] *See Altitude Exp., Inc. v. Zarda*, 139 S. Ct. 1599 (2019); *R.G. & G.R. Harris Funeral Homes*, Inc. v. E.E.O.C., 139 S. Ct. 1599 (2019).

differently based on sex stereotypes, and because it treats them differently based on gender identity and transgender status. The First, Sixth, Seventh, Ninth, and Eleventh Circuits have found transgender individuals to be protected by Title VII and other federal sex discrimination laws.[163] Numerous district courts have also held that gender identity discrimination is prohibited by Title VII, either as *per se* sex discrimination because it is based on sex stereotypes, or because it is based on their gender transition.[164] Numerous agency administrative decisions and regulations have also made clear that "sex" includes gender identity and transgender status.[165]

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[163] *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, No. 16-3522, 2017 WL 2331751, at *9 (7th Cir. May 30, 2017); *Chavez v. Credit Nation Auto Sales, LLC*, 641 F. App'x 883, 884 (11th Cir. 2016); *Chavez v. Credit Nation Auto Sales, LLC*, 641 F. App'x 883, 884 (11th Cir. 2016); *Barnes v. City of Cincinnati*, 401 F.3d 729, 737 (6th Cir. 2005); *Smith v. City of Salem, Ohio*, 378 F.3d 566, 575 (6th Cir. 2004); *Schwenk v. Hartford*, 204 F.3d 1187, 1201-02 (9th Cir. 2000); *Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213, 215 (1st Cir. 2000).

[164] *Evancho v. Pine-Richland Sch. Dist.*, 2017 WL 770619, at *13 (W.D. Pa. Feb. 27, 2017); *Smith v. Avanti*, 2017 WL 1284723, at *4 (D. Colo. Apr. 5, 2017); *Valentine Ge v. Dun & Bradstreet, Inc.*, 2017 WL 347582, at *4 (M.D. Fla. Jan. 24, 2017); *Baker v. Aetna Life Ins.*, 228 F. Supp. 3d 764, 771 (N.D. Tex. Jan. 13, 2017); *Roberts v. Clark Cty. Sch. Dist.*, 215 F. Supp. 3d 1001, 1011, 1015 (D. Nev. 2016); *Bd. of Educ. of the Highland Local Sch. Dist. v. United States Dep't of Educ.*, 208 F. Supp. 3d 850, 869 (S.D. Ohio 2016); *Mickens v. General Electric Co.*, 2016 WL 7015665, at *3 (W.D. Ky. Nov. 29, 2016); *Fabian v. Hosp. of Cent. Connecticut*, 172 F. Supp. 3d 509, 526-27 (D. Conn. 2016); *Doe v. Ariz.*, 2016 WL 1089743, at *2 (D. Ariz. Mar. 21, 2016); *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015); *E.E.O.C. v. R.G. & G.R. Harris Funeral Homes, Inc.*, 100 F. Supp. 3d 594, 603 (E.D. Mich. 2015); *Rumble v. Fairview Health Servs.*, 2015 WL 1197415, at *2 (D. Minn. Mar. 16, 2015); *Finkle v. Howard Cty.*, Md., 12 F. Supp.3d 780, 788 (D. Md. 2014); *Parris v. Keystone Foods*, 959 F. Supp. 2d 1291, 1303 (N.D. Ala. 2013), *appeal dismissed*, No. 13-14495-D (11th Cir. Dec. 26, 2013); *Radtke v. Miscellaneous Drivers & Helpers Union Local #638 Health, Welfare, Eye, & Dental Fund*, 867 F. Supp. 2d 1023, 1031 (D. Minn. 2012); *Lopez v. River Oaks Imaging & Diagnostic Grp., Inc.*, 542 F. Supp. 2d 653, 660 (S.D. Tex. 2008); *Schroer v. Billington*, 577 F. Supp. 2d 293, 305 (D.D.C. 2008); *Mitchell v. Axcan Scandipharm, Inc.*, 2006 WL 456173, at *2 (W.D. Pa. Feb. 17, 2006); *Tronetti v. TLC HealthNet Lakeshore Hosp.*, 2003 WL 22757935, at *4 (W.D.N.Y. Sept. 26, 2003).

[165] See*, e.g.*, *Lusardi v. Dep't of the Army*, 2015 WL 1607756, at *11 (E.E.O.C. Apr. 1, 2015); *Macy v. Holder*, 2012 WL 1435995, *10 (E.E.O.C. Apr. 20, 2012) ("Thus, we conclude that intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination 'based on . . . sex,' and such discrimination therefore violates Title VII."); U.S. Department of Education - 34 C.F.R. § 270.7 ("Sex desegregation means the assignment of students to public schools … without regard to their sex (including transgender status; gender identity; sex stereotypes, such as treating a person differently because he or she does not conform to sex-role expectations because he or she is attracted to or is in a

There is a split of authority whether the rationale of the Title VII cases discussed above extends to the context of Title IX. Courts generally hold that the sex discrimination provisions of Title IX protect transgender individuals from discrimination.[166]

For example, in *M.A.B. v. Board of Education of Talbot County*, a transgender male student was required to use "neutral" locker rooms to change his clothes for activities requiring it.[167] Deciding the student's claim under Title IX, the court considered and relied upon Title VII precedents because the operative language is the same in both statutes. The neutral locker room did not have the same amenities as the boys' locker rooms though including a lack of showers and benches. Additionally, the student was the only student in the school that had to use the designated locker room causing embarrassment as other students gave him odd looks when he went to use his designated locker room. Discrimination based on gender identity had to incorporate consideration of the student's biological sex and stereotypes associated with the student's particular biological sex, so gender identity discrimination is unlawful sex discrimination.

HHS acknowledges other cases in which federal courts have upheld gender identity protections under § 1557, but characterizes them as "pending."[168] The court in *Prescott v. Rady Children's Hosp.*, concluded: "Because Title VII, and by extension Title IX,

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relationship with a person of the same sex; …)…."); U.S. Department of Health and Human Services - 45 C.F.R. § 92.4 ("On the basis of sex includes, but is not limited to, discrimination on the basis of . . . sex stereotyping, and gender identity.").

[166] See *Whitaker v. Kenosha Unified Sch. Dist. No. 1*, 858 F.3d 1034, 1049 (7th Cir. 2017) (granting a preliminary injunction and holding that the plaintiff had established a likelihood of success under Title IX where the school denied a transgender boy access to the boy's restroom); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1099 (S.D. Cal. 2017). In *G.G. ex rel. Grimm v. Gloucester Cty. Sch. Bd.*, 822 F.3d 709, 723 (4th Cir.), the Fourth Circuit reversed a district court ruling interpreting Title IX narrowly in contravention of properly-adopted regulations, remanding the case to the district court for the application of proper deference. The United States Supreme Court vacated and remanded the Fourth Circuit's decision, however, 137 S. Ct. 1239, 197 L. Ed. 2d 460 (2017), with instructions to consider the matter further "in light of the guidance document issued by the Department of Education and Department of Justice on February 22, 2017."

[167] 1:16-cv-02622-GLR (D. Md. March 12, 2018).

[168] 84 Fed. Reg. 27855.

recognize that discrimination on the basis of transgender identity is discrimination on the basis of sex, the Court interprets the ACA to afford the same protections."[169]

In *Flack* v. *Wis. Dept of Health Servs.,* the court held that Wisconsin's coverage exclusions for gender affirming care in Medicaid is "text-book discrimination based on sex." The court explained: "the Challenged Exclusion prevents the [plaintiffs] from getting medically necessary treatments on the basis of both their natal sex and transgender status, which surely amounts to discrimination on the basis of sex in violation of the ACA."[170]

HHS mischaracterized the status of *Flack* in the NPRM, claiming the petition for class certification is still pending.[171] The court granted class certification on April 23, 2019, nearly two months before HHS published its NPRM.[172]

In *Boyden v. Conlin,* the court similarly held: "Whether because of differential treatment based on natal sex, or because of a form of sex stereotyping where an individual is required effectively to maintain his or her natal sex characteristics, the Exclusion on its face treats transgender individuals differently on the basis of sex, thus triggering the protections of… the ACA's anti-discrimination provision."[173]

HHS also misrepresents the current status of *Boyden* in the NPRM. HHS claims the case is still pending appeal with the 7th Circuit.[174] This is false. The U.S. Court of Appeals for the 7th Circuit dismissed the case on March 26, 2019, three months before HHS published its NPRM.[175]

In *Tovar v. Essentia Health*, the court concluded: "Because Title VII, and by extension Title IX, recognize that sex discrimination encompasses gender-identity discrimination, the Court concludes that Section 1557 also prohibits discrimination on the basis of gender identity."[176]

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[169] 265 F. Supp. 3d 1090, 1099 (S.D. Cal. 2017). See also *Rumble v. Fairview Health Servs*., No. 14-CV-2037 (SRN/FLN), 2017 WL 401940, at *2 (D. Minn. Jan. 30, 2017) ("Section 1557 protects plaintiffs who allege discrimination based on gender identity").
[170] 328 F. Supp. 3d 931 (W.D. Wis. 2018).
[171] 84 Fed. Reg. 27855.
[172] *Flack v. Wis. Dept of Health Servs*., 2019 WL 1772403 (2019).
[173] 341 F. Supp. 3d 979, 997 (W.D. Wis. 2018).
[174] 84 Fed. Reg. 27855.
[175] Order to Dismiss, *Boyden v. Conlin* Nos. 18-3408, 18-3485 (7th Cir.) (March 26, 2019).
[176] 2018 U.S. Dist. LEXIS 16065 (D. Minn., Sept. 20, 2018)

The fact that HHS acknowledges these cases, but ignores these courts' conclusions, brings into question the rigor of the agency's analysis and undermines the very premise upon which HHS bases this regulatory rollback. Furthermore, HHS misstates the status of these important federal court cases that upheld Section 1557 protections against discrimination based upon someone's gender identity, which shows that HHS' proposed revision and elimination of current regulations is not based upon fact or law. HHS should not finalize these proposals.

b. Protections against discrimination based on sex stereotyping

According to one survey, eight percent of lesbian, gay, and bisexual individuals had an experience within the year prior to the survey where a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation and seven percent experienced unwanted physical contact and violence from a health care provider.[177] The study *When Health Care Isn't Caring* found that fifty-six percent of LGB people reported experiencing discrimination from health care providers – including refusals of care, harsh language, or even physical abuse – because of their sexual orientation.[178] HHS' Healthy People 2020 initiative recognizes, "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[179]

Current Section 1557 regulations protect against discrimination based on sex stereotypes.[180] While regulations do not expressly include discrimination on the basis of sexual orientation, HHS stated that Section 1557's prohibition of discrimination on the basis of sex includes, at a minimum, sex discrimination related to an individual's sexual

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[177] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for American Progress, (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-for-discrimination&email_referrer=&email_subject=rx-for-discrimination.

[178] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV,* 5 (2010), http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf.

[179] *Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health*, U.S. Dept. Health & Human Serv., https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health.

[180] 45 C.F.R. § 92.4.

orientation where the evidence establishes that the discrimination is based on sex stereotypes. The definition of sex stereotypes includes stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms or body characteristics.[181] Sex stereotypes also include gendered expectations related to the appropriate roles of a certain sex.[182]

Moreover, it is well-established that sex discrimination encompasses discrimination based on sex stereotypes. Three decades ago, the Supreme Court held that Title VII prohibits discrimination against workers for their failure to conform to sex-based stereotypes in *Price Waterhouse v. Hopkins*.[183] In cases since then, courts have concluded that Title VII's nondiscrimination protections based upon sex stereotyping applies to sexual orientation.

In *Oncale v. Sundowner Offshore Services,* the Court recognized that same-sex sexual harassment can constitute discrimination because of sex and thus violate Title VII.[184] The Court focused on differential treatment of similarly situated men and women, and away from the specific goals of Congress in passing Title VII. *Oncale* has been read to preclude courts from creating their own exceptions to Title VII coverage based on speculation about the primary intent of Congress in passing the legislation. The Court in *Oncale* observed that "[S]tatutory prohibitions often go beyond the principal evil to cover reasonably comparable evils, and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed."[185] According to the Court, whatever evidentiary route a plaintiff chooses, so long as a plaintiff's claim "meets the statutory requirements" – i.e., is "discrimination because of sex" – the claim is cognizable.[186]

Since 2015, the Equal Employment Opportunity Commission ("EEOC") has opined that "[s]exual orientation discrimination is sex discrimination because it necessarily entails

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[181] *Id*.
[182] *Id*.
[183] 490 U.S. 228, 251 (1989) ("As for the legal relevance of sex stereotyping, we are beyond the day when an employer could evaluate employees by assuming or insisting that they match the stereotype associated with their group.")
[184] 523 U.S. 75 (1998).
[185] *Id.* at 79.
[186] *Id.* at 80.

treating an employee less favorably because of the employee's sex."[187] Numerous federal district courts have agreed.[188]

However, the proposed rule eliminates sex stereotyping from the definitions section of the current regulations.[189] It goes even further, by purging references to "sexual orientation" appearing in other HHS regulations, including those preventing discrimination in Essential Health Benefits, Qualified Health Plan marketing and design, outreach and enrollment activities, as well as Medicaid managed care and Programs for All-inclusive Care of the Elderly (PACE).[190]

Deleting sex stereotyping and other definitions may set the stage for HHS to refuse to enforce these important nondiscrimination protections. However, the proposed rule cannot eliminate thirty years of case law finding that sex stereotyping is part of nondiscrimination protections based on sex. We urge HHS to maintain current definitions for Section 1557, including sex stereotyping.

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[187] *Baldwin v. Department of Transportation* (Federal Aviation Administration), EEOC Appeal No. 0120133080 (July 15, 2015), 2015 WL 4397641, at 5, 10.

[188] See *Burnett v. Union R.R. Co.*, No. CV 17-101, 2017 WL 2731284, at *4 (W.D. Pa. June 26, 2017); *Philpott v. N.Y.*, 2017 WL 1750398, at *2 (S.D.N.Y. May 3, 2017); *Smith v. Avanti*, No. 2017 WL 1284723, at *4 (D. Colo. Apr. 5, 2017); *Smith v. Avanti*, No., 2017 WL 1284723, at *4 (D. Colo. Apr. 5, 2017); *U.S. Equal Employment Opportunity Comm'n v. Scott Med. Health Ctr., P.C.*, 217 F. Supp. 3d 834, 841 (W.D. Pa. 2016); *Tinory v. Autozoners,* No. CV 13-11477-DPW, 2016 WL 320108, at *5 (D. Mass. Jan. 26, 2016); *Boutillier v. Hartford Pub. Sch.*, 221 F. Supp. 3d 255, 268 (D. Conn. 2016); *U.S. Equal Employment Opportunity Comm'n v. Scott Med. Health Ctr., P.C.*, 217 F. Supp. 3d 834, 841 (W.D. Pa. 2016); *Videckis v. Pepperdine Univ.*, 150 F. Supp. 3d 1151, 1160 (C.D. Cal. 2015); *Isaacs v. Felder Servs.,* LLC, 143 F. Supp. 3d 1190, 1194 (M.D. Ala. 2015); *Hall v. BNSF Ry. Co.*, 2014 WL 4719007, at *3 (W.D. Wash. Sept. 22, 2014); *Koren v. Ohio Bell Tel. Co.*, 894 F. Supp. 2d 1032, 1038 (N.D. Ohio 2012); *Perry v. Schwarzenegger*, 704 F. Supp. 2d 921, 996 (N.D. Cal. 2010); *Heller v. Edgewater Country Club*, 195 F. Supp. 2d 1212, 1223 (D. Or. 2002); *Terveer v. Billington*, 34 F. Supp. 3d 100, 114 (D.D.C. 2014); *Centola v. Potter*, 183 F. Supp. 2d 403, 410 (D. Mass. 2002).

[189] 84 Fed. Reg. 27855, 27869

[190] Proposal to amend 45 C.F.R. §§ 147.104(e), 155.120(c)(ii), 155.220(j)(2), 156.200(e), 156.1230(b)(3); 42 C.F.R. §§ 438.3(d)(4) 438.206(c)(2), 438.262; 42 C.F.R. §§ 460.98(b)(3), 460.112(a). Note, the EHB nondiscrimination requirements at 45 C.F.R. § 156.125(b) cross reference 45 C.F.R. § 156.200(e).

c. Protections against sex discrimination, including pregnancy and termination of pregnancy

Sex discrimination takes many forms and has the potential to occur at every step in the health care system—from obtaining insurance coverage to receiving a diagnosis and treatment by a provider. Such discrimination has serious adverse impacts on the lives of women, causing them to pay more for health care and to risk receiving improper diagnoses and less effective treatments. The effects of sex discrimination for women of color may be compounded by other forms of discrimination they face, including racial discrimination and discrimination based on limited English language proficiency.

Before the ACA, women experienced pervasive discrimination in health care settings and by insurers. For example, women paid more than men for their insurance and were often unable to find coverage for necessary services, such as maternity care. In 2011, one year before qualified health plans were available in the ACA insurance marketplaces, sixty-two percent of individuals with individual market plans did not have maternity care coverage.[191]

Section 1557 prohibits discrimination on the basis of sex, including pregnancy status, termination of pregnancy, childbirth and related medical conditions, gender identity, and sex stereotyping. Any discrimination on the basis of pregnancy is specifically prohibited in Title IX regulations, and Section 1557 adopted these same restrictions.[192] Moreover, the 2016 final regulations implementing Section 1557 made clear that Section 1557 did not displace existing federal refusal laws and did not include new refusals.[193]

The proposed rule attempts to roll back these protections. Although HHS acknowledges in the preamble to the proposed rule that the prohibition against sex discrimination includes termination of pregnancy, it refuses to state whether the Department would enforce those protections and proposes to rescind the 2016 final rule's clarification that the ban on sex discrimination includes all pregnancy related care. In doing so, the Department illegally attempts to eliminate the express protections that apply to someone who has had an abortion or has experienced a miscarriage or ectopic pregnancy and needs care for those conditions. While the scope of protection under

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[191] Sarah Lueck, Ctr. on Budget & Policy Priorities, *If Essential Health Benefit Standards Are Repealed, Health Plans Would Cover Little*, (Mar. 23, 2017), https://www.cbpp.org/blog/if-essential-health-benefits-standards-are-repealed-health-plans-would-cover-little.

[192] See 45 C.F.R. § 86.40(b) (prohibiting discrimination on the basis of "pregnancy, childbirth, false pregnancy, termination of pregnancy, or recovery therefrom").

[193] 45 C.F.R. § 92.2(b)(2).

Section 1557 is clear, without unambiguous implementing regulations and enforcement, illegal discrimination is likely to flourish.

The proposed rule also seeks to unlawfully incorporate Title IX's "Danforth Amendment", which carves out abortion care and coverage from the ban on discrimination of sex in the education context.[194] Congress did not include the Title IX exceptions, including the Danforth Amendment, either explicitly or by reference, in Section 1557. The proposed rule's unlawful incorporation of the Danforth Amendment is yet another Trump-Pence Administration attack on abortion care. These attacks on abortion access could embolden illegal discrimination that will fall heaviest on those least able to seek health care elsewhere, including women living in rural areas and women of color, who already face disparities in care and provider discrimination during pregnancy.

The impact of these changes could directly harm many people of color. For example, pregnancy-related complications remain one of the ten leading causes of death for Black women aged 15-34 years.[195] Black women are three-to-four times more likely to die from pregnancy related complications than white women. Rescinding portions of the 2016 final rule that expressly define and prohibit sex discrimination based on pregnancy status could put Black women at increased risk of pregnancy-related complications. Similarly, Asian American and Pacific Islander ("AAPI") women could be denied access to crucial services such as emergency contraceptives and prenatal care. AAPI women already face challenges accessing culturally and linguistically appropriate reproductive health care. Some studies show that AAPI women use less effective, but more easily accessible contraceptive methods at higher rates compared to women of other races and ethnicities, placing AAPI women at greater risk of unintended pregnancy.[196] Disparities also exist among AAPI women regarding utilization of prenatal care; Laotian and Cambodian women are less likely than other racial and ethnic groups to receive early and adequate prenatal care.[197] One study found AAPI women are twice as likely to

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[194] Proposed 45 C.F.R. §86.18 (codifying the abortion exemption in Title IX and "relevant laws" including laws cited in *Franciscan Alliance*, RFRA, the Weldon Amendment, Coats-Snowe, and the Church Amendments).
[195] Cynthia Prather, et al., *The Impact of Racism on the Sexual and Reproductive Health of African American Women*, 25(7) J. Women's Health 664, 664-671 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4939479/.
[196] Jo Jones, et al., U.S. Dep't of Health & Human Servs., *Current Contraceptive Use in the United States, 2006-2010, and Changes in Patterns of Use Since 1995*, 60 Nat'l Health Statistics Report 1, 5 (Oct. 18, 2012), https://www.cdc.gov/nchs/data/nhsr/nhsr060.pdf.
[197] Lora Jo Foo, The Ford Found., Asian American Women: Issues, Concerns, and Responsive Human and Civil Rights Advocacy 106 (2002).

die from pregnancy-related causes, including embolism and pregnancy-related hypertension.[198] For the Latina and Latinx population, lack of access to comprehensive, affordable insurance coverage means sporadic, if not non-existent, access to desperately needed treatment and services. Due to this and other factors, Latinas experience disproportionately high rates of unintended pregnancy, sexually transmitted infections including HIV, diabetes, asthma, and other health issues. Latinas have the highest incidence of cervical cancer; and Latinas are diagnosed with cervical cancer at nearly twice the rate of non-Latina white women. Immigrant Latinas also experience inequities because they have fewer employment opportunities that provide insurance coverage, may be ineligible for federally funded health coverage, face extreme poverty, and lack culturally and linguistically appropriate health care providers and services. The proposed rule also has the potential to place Native American women at risk of being denied treatment because of illegal pregnancy-based discrimination. According to one study of geographically diverse urban areas, Native American women are already 4.5 times more likely to die during or immediately after pregnancy than non-Hispanic white women.[199] Instead of rolling back nondiscrimination protections that will create more barriers to care, the Trump-Pence Administration should be creating policies that ensure Native women receive all of the pregnancy-related care they need.

We strongly oppose HHS proposal to rollback nondiscrimination protections based on sex, including pregnancy status and termination of pregnancy. This proposal is not consistent with Section 1557.

d. Other Definitions

HHS requested comment on whether definitions should be included in the regulatory text.[200] We are concerned about the elimination of an overarching definition section as well as the elimination of specific definitions. Having one section that provides all the relevant definitions for the proposed rule makes it easier for entities and the public to identify relevant definitions rather than having to find definitions within each section. This is especially the case in sections where definitions are not the first subsection of

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[198] Marcus T. Smith, *Fact Sheet: The State of Asian American Women in the United States*, Ctr. for Am. Progress (Nov. 7, 2013, 5:33 PM), https://www.americanprogress.org/issues/race/reports/2013/11/07/79182/fact-sheet-the-state-of-asian-american-women-in-the-united-states/.

[199] Adrian Dominguez, et al., Urban Indian Health Inst., Seattle Indian Health Bd., Community Health Profile: National Aggregate of Urban Indian Health Program Service Areas 37 (2016), http://www.uihi.org/wp-content/uploads/2017/08/UIHI_CHP_2016_Electronic_20170825.pdf.

[200] 84 Fed. Reg. 27860-1.

the proposed regulation (e.g. definition of qualified interpreter/translator in § 92.101 and definition of qualified interpreter for individuals with disabilities as well as the definition of auxiliary aids and services in § 92.102).

In particular, we oppose the elimination of the following definitions from the current regulations:

- Covered entity;
- Electronic and information technology;
- Employee health benefit program;
- Federal financial assistance;
- Individual with a disability;
- Individual with LEP;
- National origin;
- Qualified bilingual/multilingual staff;
- Qualified individual with a disability; and
- Recipient.

HHS says that it eliminates some terms and will interpret them "naturally and consistent" with the Final Rule. This includes "individual with limited English proficiency," "qualified bilingual/multilingual staff," and "individual with a disability." We disagree with this conclusion because it is the very lack of definitions for covered entities that often leads to erroneous determinations about what type of services are required or who can provide those services. For example, in the language access context, we continue to hear about unqualified bilingual/multilingual staff attempting to provide interpreting services or services directly in a non-English language. In our report, *The High Costs of Language Barriers in Medical Malpractice*, we described numerous examples of individuals who believed they had sufficient language skills to communicate with LEP patients but the resulting ineffective communication led to serious patient harm.[201] In one case detailed in the report:

> the patient was a Spanish-speaking pregnant woman in her second trimester who died from complications caused by pork tapeworms. Her neurologist testified that he did not require the use of an interpreter. He admitted that while his Spanish was "somewhat limited," he said that he spoke "medical Spanish" and could take a medical/neurological history in Spanish. He spoke with the patient in Spanish and asked all of his questions in Spanish. Notwithstanding the

[201] *See* https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/09/Language-Access-and-Malpractice.pdf.

> neurologist's self-assessment of his Spanish-proficiency, Mrs. Garcia still complained that she was unable to effectively communicate her condition to the treating physicians because they did not provide her with an interpreter.[202]

An individual may self-assess sufficient fluency in a non-English language to provide services in that language but more often than not, that individual does not have the sufficient fluency for interacting in health care encounters let alone the requisite knowledge of specialized medical terminology essential. Given the goal of Section 1557 to prohibit discrimination and a major goal of the ACA is to reduce disparities, having a definition that clarifies when someone who identifies as bilingual or multilingual can actually provide services directly in a non-English language is critical.

The same reasons support having a definition of individual with a disability, qualified individual with a disability, individual with limited English proficiency and qualified individual with limited English proficiency. Covered entities need to understand the full scope of individuals protected by Section 1557 and for whom assistance in the form of language services or auxiliary aids and services must be provided.

We also support including the definition of "electronic and information technology." Given that the underlying civil rights statutes on which Section 1557 builds were all enacted prior to adoption of much of today's electronic and information technology, we believe it is important that regulations proposed in response to a statute adopted in the 2000's include specific reference to this technology.

Finally, HHS specifically requested comment on whether it should define "recipient'' according to the current rule or by incorporation by reference to definitions in the underlying statutes, and whether such a definition of recipient should include subrecipients. We strongly recommend that HHS should define the term recipient and subrecipient according to the covered rule. As we have discussed throughout these comments, Section 1557 has broader applicability than the underlying civil rights statutes on which it builds. Therefore, new entities are subject to Section 1557 and need to understand the full scope of expectations for compliance.

§ 92.7 Designation of responsible employee and adoption of grievance procedures

We oppose the deletion of requirements related to designation of a responsible employee and adoption of grievance procedures. We believe that the requirements for a

[202] *Id.* at 14.

responsible employee and adoption of a grievance procedure is very important to holding covered entities responsible for the protections provided by § 1557. Without a designated employee and defined grievance procedure, many individuals protected by Section 1557 may not receive the information needed to prevent discrimination or seek redress for discrimination faced. Other federal civil rights laws require designation of a responsible employee and creation of grievance procedures so many covered entities will already have processes in place; expanding them to cover Section 1557 discrimination should be an easy process and HHS could also determine that processes in place to support Section 1557 are evidence of compliance with other pre-existing requirements.

§ 92.8 Notice Requirements

We strongly support the notice and tagline requirements in current regulations that ensure covered entities inform beneficiaries, enrollees, applicants, or members of the public of the availability of language services and auxiliary aids and services, and that the entity does not discriminate on the basis of race, color, national origin, sex, age or disability. The proposed changes are inconsistent with Section 1557 and should not be finalized.

a. Notices

The elimination of notices is problematic on many levels. The importance of this notice is in part due to Section 1557's recognition of the intersectionality of individuals and the discrimination they may face. Prior to Section 1557, an individual facing discrimination could have different rights and remedies based on the relevant underlying civil rights law covering that discrimination. For example, a woman who is limited English proficient would not have any redress for sex discrimination and would likely only have an ability to file an administrative complaint to address national origin discrimination. One of the goals of Section 1557 was to provide the same rights and remedies to all individuals facing discrimination, whether the discrimination be due to race, color, national origin, sex, disability or age. Having one notice covering all the rights under Section 1557 is critical in informing individuals who may face discrimination due to multiple factors of all their rights in one place and notice.

The proposed elimination of notices compromises and diminishes the primacy of the non-discrimination message of Section 1557. To clearly communicate a covered entity's non-discrimination obligations and consumers' right to access services, a notice must be posted in physical locations, on websites and sent with significant documents as the current regulations provide.

The current required elements of the notice cover a broad range of requirements for compliance with Section 1557. The notice requirement ensures that each covered entity notifies beneficiaries, enrollees, applicants and members of the public of the following:

(1) The covered entity does not discriminate on the basis covered by Section 1557;
(2) The covered entity provides auxiliary aids and services for people with disabilities;
(3) The covered entity provides language assistance services for individuals with LEP;
(4) How to obtain auxiliary aids and services;
(5) How to obtain language services;
(6) The availability of the grievance procedure; and
(7) How to file a discrimination complaint with OCR.[203]

Second, the notice requirements under Section 1557 are not duplicative of any other requirements, especially Section 504 or Title VI. The notice requirements in the current regulations are explicit and designed to adequately inform individuals of the scope of their rights under Section 1557. By not fully explaining why repeal of the notices is necessary, HHS fails to justify the repeal. Further, HHS recognizes that eliminating the notice requirement will result in some individuals not knowing of their rights and how to enforce them. Since the Section 1557 notice is more comprehensive than other requirements, HHS has previously determined that the Section 1557 notice would satisfy the Title VI notice requirement as outlined in 45 C.F.R. § 80.6(d) so that these notices are not duplicative. It has also done so for other required notices as long as the combined notice clearly informs individuals of their rights under Section 1557.[204] That is, the current notice requirements provides the most comprehensive yet concise summary of an individual's rights under Section 1557, building on Section 504, Title VI, Title IX and the Age Discrimination Act such that the Section 1557 notice is more comprehensive but not duplicative of other notices.

The notice requirement is also important because Section 1557 applies to a broader array of covered entities than the civil rights laws on which it builds. Section 1557 applies specifically to federally administered programs and activities as well as entities created under Title I of the Affordable Care Act. By eliminating the notice requirements, HHS has effectively exempted a large swath of covered entities from informing individuals about their rights under Section 1557.

[203] 45 C.F.R. § 92.8.
[204] 45 C.F.R. § 92.8(h).

Further, the costs of providing this notice are not prohibitive for covered entities. HHS provided a sample notice and translated it into 64 languages, alleviating covered entities of the responsibility and cost of developing one on their own.[205] Any burdens of wall space and use of information technology staff and resources to post the notice and include it on a website are greatly outweighed by the benefit of having the notice visible and conspicuous so that consumers may see and access the services promised in the notice.

While we recognize that some covered entities have raised concern about how often they have to send this notice (as well as taglines) with significant documents, the wholesale elimination of the notice is not justified by these concerns. Rather, HHS could consider a variety of options including an explanation of what constitutes significant documents or how often a covered entity has to send a notice if the covered entity sends multiple significant documents to individuals over the course of a year. Indeed, in comments submitted by insurers and medical associations in response to the original NPRM, the overriding question was about the frequency of sending notices or taglines rather than the need to send them at all. This was reiterated during a listening session convened by HHS' Office for Civil Rights in 2017 which we attended, where insurers and provider associations did not request a repeal of tagline requirements but rather sought clarification on the frequency with which notices and taglines should be sent.

HHS did not specifically calculate the costs of providing notices or the costs and harm individuals will suffer by not knowing about their rights. Further, HHS failed to explain why completely eliminating notice requirements is justified given the prior analysis HHS has already undertaken in adopting these requirements just a few short years ago. We thus oppose the repeal of requirements related to notices.

b. Taglines

We strongly support the existing tagline requirements and oppose their repeal. The current regulations requires that the English notice and taglines be included in "significant publications and significant communications targeted to beneficiaries, enrollees, applicants or members of the public."[206]

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[205] Appendix A to Part 92 – Sample Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Sample Nondiscrimination Statement: Discrimination is Against the Law, *see also* OCR, Translated Resources for Covered Entities, https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html.

[206] 45 C.F.R. § 92.8(f)(1).

As HHS noted in the preamble to the final rule, taglines are important in part because HHS decided not to require translation of notices or other documents. The preamble states:

> Given that we are not requiring covered entities to post notices in non-English languages, having taglines available in multiple languages is even more important to provide notice to individuals with limited English proficiency of the availability of language assistance services.[207]

HHS also considered alternatives to the tagline requirements. HHS declined to adopt these alternatives, stating "We decline to eliminate the tagline requirement because such an approach would not provide adequate notice of language assistance services."[208] It specifically noted that the mere **availability** of language services or auxiliary aids and services does not provide adequate **notice** about the availability of services, how to request services or file a complaint.[209]

Tagline requirements also exist in other regulations so many of those entities that raised cost concerns with the taglines in the Section 1557 regulations will likely still have to comply with tagline requirements elsewhere. For example, marketplace regulations require taglines on documents and websites.[210] Qualified health plan issuers must comply with tagline requirements applicable to group health plans and issuers which requires taglines on certain notices and the Summary of Benefits and Coverage.[211]

While the Preamble and Regulatory Impact Analysis (RIA) attempt to provide a cost justification for repealing the tagline requirements, much of the data HHS relies on is old and irrelevant. In addition, HHS does not explain the methodology it used to draw these conclusions based on information provided by only a few entities. To the extent we can infer the methodology used by HHS to reach its conclusions, that methodology appears flawed. Additional information provided by a handful of insurers and pharmacy benefit managers cannot be extrapolated to the entire health care system since different entities have different interpretations of what a "significant" document is. Indeed, rather than consider any alternatives – such as clarifying the definition of "significant document" or examining whether taglines could be included in fewer documents if the

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[207] 81 Fed. Reg. 31398.
[208] *Id.*
[209] *Id.*
[210] 45 C.F.R. § 155.205(c)(2)(iii)(A).
[211] 45 C.F.R. § 147.136€(2)(iii), (e)(3); 29 C.F.R. §2590.715-2719(e)(2)(iii), (3).

same document is sent multiple times a year – HHS instead concluded that the costs outweighed any benefit. The repeal of taglines considered in connection with HHS' adoption of the four-factor test for evaluating compliance (which includes consideration of costs) leaves us even more concerned that HHS' enforcement activities will regularly but erroneously conclude that covered entities may not have to provide any language services.

Some of the examples provided to the Office of Management and Budget by entities complaining about the costs of taglines, and which HHS relied on in the RIA, actually go far beyond the expectations and requirements of the Section 1557 regulations. For example, HHS' sample English tagline consists of 19 words (including TTY information in the word count). Some of the taglines provided to OMB and HHS were much longer than HHS' sample and included in many more languages than the 15 expected in the current regulations. The following chart includes the information provided to OMB, extrapolated on the assumption that the length of the tagline would stay relatively similar in different languages (or that the variances would result in similar results across the examples):[212]

Source	**Tagline Length**	**Language**	**Number of Taglines**	**Estimated Total Words[213]**
§ 1557 Final Rule[214]	19	English	15	285
Example 1[215]	31	Spanish	65	2015
Example 2	85	English	18	1530
Example 3	11	English	66	726
Example 4	36	Spanish	15	540

[212] Completed 18166 Meeting, Rin 0945-AA11, May 9, 2018, Handout #1, *available at* https://www.reginfo.gov/public/do/viewEO12866Meeting?viewRule=false&rin=0945-AA11&meetingId=3184&acronym=0945-HHS/OCR.

[213] Please note that this total is a rough extrapolation as different languages will use more or less words than an English or Spanish tagline. However, we believe it is useful as a guide given the estimates HHS relied on are much longer than what is expected under current Section 1557 regulations.

[214] This estimate uses the length of HHS' sample tagline included in the Section 1557 final regulation.

[215] These examples are taken from the information submitted to OMB, https://www.reginfo.gov/public/do/viewEO12866Meeting?viewRule=false&rin=0945-AA11&meetingId=3184&acronym=0945-HHS/OCR.

Even with this rough estimate, the examples provided consist of two to seven times the number of words expected under the Section 1557 current rule. Thus any cost estimates using those examples would vastly overestimate the costs of providing taglines. While we certainly appreciate the inclusion of a longer, more descriptive tagline in more languages, HHS cannot rely on inflated costs from an extremely small sample as justification to repeal this provision. In the only examples provided, the costs end up inflated because the added length and number of taglines increases the costs to covered entities beyond what HHS originally contemplated. If instead the covered entities utilized a shorter tagline and only provided the tagline in the top 15 languages in the state (which a covered entity likely could do by tailoring notices per state rather than aggregating languages among multiple states), the costs of compliance would be significantly less. It does not seem that HHS conducted any analysis of the costs of using its shorter tagline in only 15 languages.

Additionally, HHS estimates the cost using the current application of the tagline requirement. While we oppose the NPRM's proposed limitations on the scope of Section 1557 as outlined in proposed § 92.2, limiting the number of covered entities, particularly by reducing the number of insurers or products covered, would further reduce the expected costs of providing notices and taglines. That is, HHS currently proposes that only insurers providing health plans in the marketplaces would be covered by Section 1557, excluding these insurer's non-marketplace products (including short-term limited duration plans and employer-sponsored plans). Thus, many fewer entities would be subject to providing taglines to fewer enrollees, further reducing the likely costs.

The combination of inflated costs for providing longer taglines and notices, the reduction in covered entities, and the lack of an independent analysis results in a failure of HHS to accurately estimate and assess the costs and costs savings in proposing to eliminate taglines (as well as notices). As noted by the Center for American Progress, HHS relies solely on selected data provided by insurers and pharmacy benefit managers to make these changes, yet the survey results provided do not contain any information about the reaction individuals with LEP had to the taglines or the impact on this population. In the proposed rule, HHS never mentions receiving input from individuals with LEP and entirely relies on insurance company and pharmacy benefit managers' analyses to determine that notices are not necessary.[216] HHS's methods are not sound.

[216] Center for American Progress, *Attack on the ACA: Undermining Protections for LGBTQ Patients and Language Accessibility Requirements* (July 19, 2019), https://www.americanprogress.org/issues/lgbt/news/2019/07/19/472332/attack-on-the-aca/.

By completely repealing the tagline requirements, HHS failed to consider any alternatives that could balance the potential costs with the need for individuals to be informed about their rights. As HHS noted in the preamble to the final Section 1557 regulations, not having taglines "would not provide adequate notice of language assistance services"[217] and thus would not ensure entities comply with the statutory nondiscrimination requirements of Section 1557. Yet HHS did not consider the costs to individuals with LEP of the loss of taglines or all individuals covered by the protections of Section 1557 who will suffer by the elimination of notices.

As HHS recognized in the Preamble to the Section 1557 final regulations, tagline requirements

> may impose some limited burdens on covered entities. However, these burdens are outweighed by the benefits . . . for individuals with limited English proficiency by making them aware, in their own languages, of the availability of language assistance services. Notifying individuals of their rights under Section 1557 and this part, including the availability of language assistance services for individuals with limited English proficiency and the availability of auxiliary aids and services for persons with disabilities, is critical to providing an equal opportunity to access health care and health coverage.[218]

As we mentioned above regarding notices, comments submitted by insurers and medical associations in response to the original NPRM did not generally dispute the tagline requirement but the overriding question was about the frequency of sending notices or taglines. This was reiterated during a listening session convened by HHS' Office for Civil Rights in 2017 which we attended, insurers and provider associations did not request a repeal of tagline requirements but rather sought clarification on the frequency with which notices and taglines should be sent.

HHS has also failed to explain why completely eliminating tagline requirements is justified given the prior analysis HHS has already undertaken in adopting these requirements just a few short years ago.

§ 92.101 Discrimination Prohibited

HHS proposes to delete § 92.101 of the current rule, claiming it will be replaced by "provisions addressing Section 1557's purpose, nondiscrimination requirements, scope

[217] *Id.*

[218] 81 Fed. Reg. 31401.

of application, enforcement mechanisms, relationship to other laws, and meaningful access for LEP individuals."[219] However, § 92.101 contains important prohibitions on discrimination that the NPRM now fails to incorporate.

In the preamble to the current final regulations, HHS noted:

> We considered harmonizing each of the specific discriminatory actions prohibited across each civil rights law addressed by Section 1557. We noted that although harmonization could reduce redundancy in the specific discriminatory actions incorporated that are similar to one another, harmonization would likely lead to confusion and unintended differences in interpretation that are subtle yet significant. We therefore proposed that paragraphs (b)(1)–(4) incorporate the specific discriminatory actions prohibited under each civil rights law on which Section 1557 is grounded.[220]

Yet the deletion of this section in the current NPRM will cause the very result HHS has previously determined untenable. Both the overall deletion and the deletion of specific protections of each protected class will result in a murkier understanding of Section 1557's scope as well as the protections afforded each protected class.

By deleting § 92.101(b)(1), HHS deletes references to important regulatory definitions of discrimination on the basis of race, color and national origin. For example, the current regulation states that "Each covered entity must comply with the regulation implementing Title VI, at § 80.3(b)(1) through (6) of this chapter."[221] The regulations prohibit discrimination on the basis of race, color or national origin such as: denying or providing different services; restricting access or subjecting an individual to segregation or separate treatment; or treating an individual differently than others for the purposes of admission, enrollment, eligibility, membership or other requirement/condition needed to receive a service or other benefit.

The current regulations also provide that no covered entity may aid or perpetuate discrimination against any person by providing significant assistance to any entity/person that discriminates on the basis of race, color or national origin in providing any aid, benefit or service to beneficiaries.[222] Given that many covered entities fail to understand the requirements of Title VI, it is important to reiterate those requirements in

[219] 84 Fed Reg. 27856, 27860.
[220] 81 Fed. Reg. 31404.
[221] 45 C.F.R. § 92.101(b)(1)(i).
[222] 45 C.F.R. §92.101(b)(1)(ii).

this regulation, given that many entities have paid more attention to implementation of the ACA than with complying with longstanding civil rights laws. Thus, having these provisions in the current regulations can bring much needed attention to the pre-existing provisions on which Section 1557 is built.

HHS deletes § 92.101(b)(2) which references important regulatory definitions of disability discrimination, and incorporates the relevant provisions of 504 implementing regulations for federal assisted and federally administered programs and activities.[223] For example, the current regulation states that "Each recipient and State-based Marketplace[SM] must comply with the regulation implementing Section 504, at §§ 84.4(b), 84.21 through 84.23(b), 84.31, 84.34, 84.37, 84.38, and 84.41 through 84.52(c) and 84.53 through 84.55 of this subchapter."[224] It also states that

> [t]he Department, including the Federally-facilitated Marketplaces, must comply with the regulation implementing Section 504, at §§ 85.21(b), 85.41 through 85.42, and 85.44 through 85.51 of this subchapter.[225]

These cross-references clarify that covered entities have an affirmative obligation to ensure that their health care is accessible to individuals with disabilities in a myriad of ways that are not captured in other sections of the NPRM. For example, sections 84.4(b) and § 85.21(b) prohibit discrimination by a variety of factors. These include:

- denying an individual with a disability the opportunity to participate in or benefit from the aid, service, or benefit;
- affording an individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;
- providing an individual with a disability a less effective aid, benefit or service;
- providing an individual with a disability different or separate aids, benefits, or services;
- otherwise limiting a person with a disability in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service.[226]

[223] 81 Fed. Reg. 31404.
[224] 45 C.F.R. § 92.101(b) (2) (i).
[225] 45 C.F.R. § 92.101(b)(2)(ii).
[226] 45 C.F.R. §§ 84.4(b), 85.21(b).

It also prohibits covered entities from:

> utiliz[ing] criteria or methods of administration (i) that have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap, (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program or activity with respect to handicapped persons, or (iii) that perpetuate the discrimination of another recipient if both recipients are subject to common administrative control or are agencies of the same State."[227]

In short, without the inclusion of § 92.101, the NPRM's description of prohibited discrimination under Section 504 is incomplete. It is also contrary to the statutory language and intent of Section 1557, which explicitly specifies that the grounds for discrimination are defined by reference to Section 504 and other civil rights laws.

HHS also proposes deleting § 92.101(b)(3), which references to important regulatory definitions of sex discrimination. For example, the current regulation states that "Each covered entity must comply with the regulation implementing Title IX, at § 86.31(b)(1) through (8) of this chapter."[228] These regulatory sections outline the specific prohibitions of Title IX, including:

- Treating a person differently in determining whether a person satisfies any requirement or condition for receiving aid, benefit or service;
- Providing different aid, benefits or services (or providing them in a different manner);
- Denying any aid, benefit or service;
- Subjecting any person to separate or different rules of behavior, sanctions, or other treatment;
- Discriminating against any person in the application of any rules of appearance;
- Applying any rule concerning the domicile/residence of a student/applicant, including eligibility for in-state fees and tuition;
- Aiding or perpetuating discrimination against any person by providing significant assistance to any agency, organization, or person which discriminates on the basis of sex in providing any aid, benefit or service to students or employees;
- Otherwise limiting any person in the enjoyment of any right, privilege, advantage, or opportunity.[229]

[227] 45 C.F.R. § 84.4(b); 45 C.F.R. § 85.21(b).
[228] 45 C.F.R. § 92.101(b)(3)(i).
[229] 45 C.F.R. § 86.31(b)(1)-(8).

It also states that

> a covered entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration that have the effect of subjecting individuals to discrimination on the basis of sex, or have the effect of defeating or substantially impairing accomplishments of the objectives of the program with respect to individuals on the basis of sex.[230]

Additional subsections specify that site location may not exclude individuals on the basis of sex and that sex-specific health programs or activities may only be permitted if there is an "exceedingly persuasive" justification.[231] These provisions clarify that covered entities have an affirmative obligation to ensure that their health care is accessible regardless of one's sex (or sex stereotypes or gender identity, per the definition of "on the basis of sex" in the current regulations) in a myriad of ways that is not captured in other sections of the NPRM. Given the fact that sex discrimination is only newly prohibited in health care by Section 1557, since Title IX had only applied to educational contexts, it is extremely important to provide information to health care providers about the scope of Title IX's protections and how to prevent sex discrimination.

By deleting these provisions, the NPRM's description of prohibited discrimination under Title IX, and thereby Section 1557, is incomplete. These provisions are necessary to the statutory language and intent of Section 1557, which explicitly specifies that the grounds for discrimination are defined by reference to Title IX and other civil rights laws.

And by deleting § 92.101(b)(4), HHS deletes references to important regulatory definitions of age discrimination. For example, the current regulation states that "Each covered entity must comply with the regulation implementing the Age Discrimination Act, at § 91.11 of this subchapter."[232] This provision outlines the general rule for protecting against age discrimination as well as specific rules such as not using age to deny benefits or subject an individual to discrimination under any program/activity receiving federal financial assistance and denying or limiting the ability to participate in any program/activity receiving federal financial assistance. In its NPRM, HHS fails to provide any specific information about complying with the Age Discrimination Act and its implementing regulations. Indeed, the only way HHS attempts to recognize the relevance of the Age Discrimination Act for the purposes of Section 1557 is to limit

[230] 45 C.F.R. § 92.101(b)(3)(ii).
[231] 45 C.F.R. § 92.101(b)(3)(iii), (iv).
[232] 45 C.F.R. § 92.101(b)(4)(i).

enforcement mechanisms rather than recognize any additional or new requirements for covered entities. The elimination of these provisions is not consistent with Section 1557 and is likely to create confusion.

The current section also contains important information with regard to applicable and non-applicable exceptions as well as how to adopt other regulations' terminology to the context of Section 1557.[233] These important clarifications have helped covered entities to understand the depth and breadth of Section 1557's application, both where it parallels pre-existing civil rights laws on which it builds but also more importantly where it departs and has a broader application. Eliminating this explicit information leaves covered entities without guidance as to the scope of Section 1557, which is likely to cause confusion, and result in entities engaging in prohibited discrimination. The current provisions are consistent with Section 1557 and should be retained.

§ 92.207 Nondiscrimination in health-related insurance and other health-related coverage

Section 1557 and the 2016 implementing regulations prohibit health insurance companies from discriminating through marketing practices and benefit design. These protections are especially important for people with disabilities and those with other serious or chronic conditions. The proposed rule seeks to exempt most health insurance plans from Section 1557's nondiscrimination protections and eliminates, without explanation, the regulation prohibiting discriminatory benefit design and marketing. This proposed change is contrary to Section 1557's express language and intent.

Before the ACA, health insurers routinely discriminated against people with HIV/AIDS and other serious or chronic conditions by charging them exorbitant premiums, excluding coverage for their conditions, or refusing to provide health coverage at all. Although the ACA ended these practices, some insurers still sought ways to discourage people with significant health needs from enrolling in their plans.

For example, the National Health Law Program and The AIDS Institute filed a complaint with HHS Office for Civil Rights (OCR) charging that four Florida health insurers discriminated against persons living with HIV/AIDS by placing all drugs used in the treatment of HIV, including generics, in the highest cost sharing tiers.[234] Researchers at

[233] 45 C.F.R. § 92.101(c), (d).
[234] National Health Law Program & The AIDS Institute, *Re: Discriminatory Pharmacy Benefits Design in Select Qualified Health Plans Offered in Florida, Administrative Complaint filed with*

the Harvard School of Public Health found that the practice of placing HIV drugs in the highest cost sharing tier, which they called "adverse tiering," to be widespread.[235] The Pharmaceutical Research and Manufacturers Association (PhRMA) contracted for an analysis of the formularies for 123 silver-level Marketplace plans and found similar problems regarding medications for multiple sclerosis and cancer. PhRMA concluded that there was a "lack of adequate formulary scrutiny on the part of state and federal regulators" because "[r]equiring high cost sharing for all medicines in a class is exactly the type of practice the ACA was designed to prevent."[236]

Section 1557 was passed as part of the ACA to specifically address discrimination in benefit design. As an integral component of these reforms, Congress mandated comprehensive health benefit coverage and explicitly prohibited discriminatory practices in the content of those plan designs. Most pertinent, it prohibited limitations or exclusions of benefits based on pre-existing conditions; it mandated coverage, on a nondiscriminatory basis, of ten categories of essential health benefits ("EHBs"); and it prohibited QHP "marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs," among other protections.[237]

Section 1557 of the ACA is the key to enforcing these statutory mandates. Section 1557 prohibits discrimination, including discrimination in the design of a benefit package, in health programs or activities receiving federal financial assistance.[238] By statute, it creates a private right of action for individuals to enforce their civil rights in the health care context.[239] The scope of actionable discrimination under Section 1557 logically covers discrimination in enrollment, equal access to benefits, and benefit design.[240]

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the HHS Office for Civil Rights (May 28, 2014), https://healthlaw.org/resource/nhelp-and-the-aids-institute-complaint-to-hhs-re-hiv-aids-discrimination-by-fl/.

[235] Douglas B. Jacobs, ScB, and Benjamin D. Sommers, MD, PhD, *Using Drugs to Discriminate — Adverse Selection in the Insurance Marketplace*, N ENGL J MED 2015; 372:399-402 (Jan. 29, 2015).

[236] PhRMA, Coverage Without Access: An Analysis of Exchange Plan Benefits for Certain Medicines, http://www.phrma.org/affordable-care-act/coverage-without-access-an-analysis-of-exchange-plan-benefits-for-certain-medicines#sthash.o0bB3Xh0.pdf.

[237] 42 U.S.C. §§ 300gg-3(b)(1), 18022, 18031(c)(1)(A).

[238] *See* 42 U.S.C. § 18116(a).

[239] See*, e.g.*, *Rumble v. Fairview Health Servs.*, No. 14-cv-2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (finding that Section 1557 creates a private right of action).

[240] See*, e.g.*, National Health Law Program & The AIDS Institute, *Re: Discriminatory Pharmacy Benefits Design in Select Qualified Health Plans Offered in Florida, Administrative Complaint filed with the HHS Office for Civil Rights* (May 28, 2014), https://healthlaw.org/resource/nhelp-and-the-aids-institute-complaint-to-hhs-re-hiv-aids-discrimination-by-fl/.

Recognizing this statutory requirement, the 2016 final rule reiterates that Section 1557 prohibits "marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age, or disability in a health-related insurance plan or policy."[241] In guidance, HHS provided examples of practices that would contravene Section 1557 and this regulation. Plans that, for example, "cover bariatric surgery in adults but exclude such coverage for adults with particular developmental disabilities place[e] most or all drugs that treat a specific condition on the highest cost tiers or exclude bone marrow transplants regardless of medical necessity would run afoul of Section 1557, HHS explained.[242]

HHS' 2016 regulation logically follows the letter and intent of the ACA. Without explicit acknowledgement of, and a resulting prohibition on, discriminatory benefit design, Section 1557's nondiscrimination protections would be rendered illusory. By not reaching the structure of a benefit package, a health insurer could always manipulate their benefit design to elude discrimination law, despite maintaining the same discriminatory effects.

For illustration, consider cancer benefits. Without the ACA reaching benefit designs, a health insurer could not deny an individual with cancer enrollment in a QHP or equal access to the treatments, services, and prescription drugs the plan chooses to cover; however, it could exclude from its coverage all cancer-related surgery, chemotherapy, radiation, and post-treatment drugs. It could also limit beneficiaries to provider networks that fail to include key oncology specialists, thus avoiding coverage of the expensive treatments they may prescribe. For a person with cancer, access to a health plan would be deemed virtually meaningless in the absence of cancer-related coverage. The effect of these exclusions would be the same as an outright denial of enrollment. Elimination of the benefit design regulation perversely encourages this result. It incentivizes insurers to find roundabout ways to deter people with pre-existing conditions from their plans. This is impermissible under Section 1557 of the ACA and Section 504 of the Rehabilitation Act.[243]

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[241] 45 C.F.R. § 92.207.

[242] HHS Nondiscrimination in Health Programs and Activities; Final Rule, 81 Fed. Reg. 31,376, 31,429 (May 18, 2016); *HHS Notice of Benefit and Payment Parameters for 2016*, 80 Fed. Reg. 10,750, 10,822 (Feb. 17, 2015); CMS CCIIO, QHP Master Review Tools for 2015, Non-Discrimination in Benefit Design (2015), http://insurance.ohio.gov/Company/Documents/2015_Non-Discriminatory_Benefit_Design_QHP_Standards.pdf.

[243] *See* 29 U.S.C. § 794; 42 U.S.C. §§ 18116(a), 18031(c)(1)(A); 45 C.F.R. § 92.207(b)(2).

The proposed rule removes the current prohibition on discriminatory plan benefit design and marketing in the Section 1557 regulations at 45 C.F.R. § 92.207. These protections are especially important for people with disabilities and those with serious or chronic conditions. This could result in health insurers excluding important benefits, designing their prescription drug formularies in a way that limits access to medically necessary care, or cherry-picking healthier enrollees through marketing practices. Eliminating these regulatory provisions may make it harder for people who experience discrimination to enforce their rights through administrative and judicial complaints.

However, HHS fails to provide any explanation regarding the elimination of these regulatory protections. Therefore, we are unable to adequately comment and strongly oppose HHS' proposed action.

§ 92.208 Employer liability for discrimination in employee health benefit programs

We oppose the repeal of this provision. HHS has not provided any reason or explanation as to why it seeks to repeal this provision. To justify proposed changes in existing regulations, HHS must provide its own explanation and rationale for the changes, documenting a need for these changes based not on an opposition to the policy undergirding a particular regulation but based on reason and data. Given that the public must be provided an opportunity to comment on HHS' alleged justifications for these proposed changes, HHS' attempt to repeal this provision is legally insufficient and violates requirements of public notice and comment as required by the Administrative Procedures Act.

§ 92.209 Nondiscrimination on the basis of association

Current regulations expressly prohibit discrimination on the basis of association with a protected class.[244] Without explanation, the proposed rule eliminates this provision. Congress intended Section 1557 to protect against discrimination by association, and these provisions should be retained.

In the 2016 Final Rule, HHS explains that the statute does not restrict "the prohibition to discrimination based on the individual's own race, color, national origin, age, disability or sex. Further, we noted that a prohibition on associational discrimination is consistent with longstanding interpretations of existing antidiscrimination laws, whether the basis of

[244] 45 C.F.R. § 92.209.

discrimination is a characteristic of the harmed individual or an individual who is associated with the harmed individual.[245]

The current regulation's language mirrors that of Title I and Title III of the ADA, which protect against discrimination based on association or relationship with a person with a disability.[246] Congress intended that Section 1557 provide at least the same protections for patients and provider entities. In accord with the ADA, the current regulation recognizes this protection extends to providers and caregivers, who are at risk of associational discrimination due to their professional relationships with patients, including those patient classes protected under Section 1557.[247]

For example, an individual in an interracial marriage who experiences discrimination would be protected under Section 1557 because of the individual's association with a protected class.[248] Similarly, a HIV-negative person in a sero-discordant relationship could not be denied access to pre-exposure prophylaxis (PrEP) to prevent HIV infection.[249] Denying access to this treatment or other health care services would be prohibited associational discrimination, and would adversely affect vulnerable, highest risk populations including gay and bisexual men.

By eliminating regulatory provisions expressly prohibiting discrimination on the basis of association, HHS will create uncertainty and confusion regarding the responsibilities of

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[245] 81 Fed. Reg. 31439.

[246] 42 U.S.C. §§ 12112, 12182 (2012).

[247] 28 C.F.R. pt. 35, app. B (2015) (interpreting Title I and Title III of the ADA to protect "health care providers, employees of social service agencies, and others who provide professional services to persons with disabilities").

[248] *Id*., citing *Parr v. Woodmen of the World Life Ins*., 791 F.2d 888, 892 (11th Cir. 1986).

[249] Press Release, FDA Approves First Drug for Reducing the Risk of Sexually Acquired HIV Infection, FOOD & DRUG ADMIN. (July 16, 2012), https://wayback.archive-it.org/7993/20170112032741/http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm312210.htm. *Pre-exposure Prophylaxis (PrEP) for HIV Prevention*, CTRS. FOR DISEASE CONTROL AND PREVENTION 1 (May 2014), https://www.cdc.gov/hiv/pdf/PrEP_fact_sheet_final.pdf; *PrEP*, CTRS. FOR DISEASE CONTROL AND PREVENTION (March 23, 2018), https://www.cdc.gov/hiv/basics/prep.html. While a generic version of Truvada was approved by the FDA in 2017, it appears likely that it will not become commercially available until 2021, when Gilead's patent on emtricitabine (one of the two HIV antiretroviral drugs Truvada is composed of) expires. See *The FDA Has Approved Generic PrEP – but Access May Remain Difficult*, PROJECT INFORM (June 16, 2017), https://www.projectinform.org/hiv-news/the-fda-has-approved-generic-prep-but-access-may-remain-difficult/.

providers and the rights of persons who experience discrimination. However, because HHS provides no explanation of its reasons for removing 45 C.F.R. § 92.209, we cannot adequately comment, and urge HHS to retain the current regulatory protections.

§ 92.302 Procedures for health programs and activities conducted by recipients and State-based marketplaces &
§ 92.303 Procedures for health programs and activities administered by the Department

We oppose the repeal of these provisions as discussed above in section II.A.2.

IV. Need for Conforming Amendments

NHeLP opposes the proposed amendments to:

- 45 C.F.R. §§ 155.120(c)(1)(ii), 155.220(j)(2) (nondiscrimination provisions concerning how States and Exchanges carry out PPACA requirements and how agents or brokers market to individuals they assist with Exchange enrollment or related applications);
- § 147.104(e) (nondiscrimination provision concerning marketing or benefit design practices of health insurance issuers under the PPACA);
- §§ 156.200(e), 156.1230(b)(3) (nondiscrimination provision concerning the administration of QHPs by issuers and concerning marketing and other conduct by QHP issuers engaged in direct enrollment);
- 42 C.F.R. §§ 460.98(b)(3), 460.112(a) (nondiscrimination provisions for organizations operating Programs for All-inclusive Care of the Elderly (PACE) programs and participants receiving PACE services under Medicare); and
- §§ 438.3(d)(4), 438.206(c)(2), 440.262 (nondiscrimination provisions concerning Medicaid beneficiary enrollment, and promotion and delivery of access and services).

These amendments would remove sexual orientation and gender identity as enumerated prohibited bases of discrimination. HHS's attempt to stylize these amendments as necessary to conform these provisions to HHS' new interpretation of Section 1557 and the civil rights laws referenced in it is incorrect. As a preliminary matter, the scope of sex discrimination in Title VII is currently pending before the

Supreme Court.[250] It is premature to change the regulations now before the Supreme Court has spoken to this precise interpretive issue.

For several of the proposed provisions, the regulations listed above were promulgated under a statutory basis other than, or in addition to, Section 1557, as requiring protection against discrimination on the basis of gender identity and sexual orientation.[251] HHS completely fails to address the statutory grounds or these provisions outside of Section 1557. In fact, those statutes independently provide for prohibitions against discrimination on the basis of gender identity and sexual orientation. HHS may not finalize the proposed revisions to these regulations.

As discussed in more detail above (*supra* Section III.B), the plain language of Section 1557 provides for protection from discrimination based on gender identity. The majority of courts to consider the question have found that the statutory language of Section 1557 prohibits discrimination based on gender identity.[252] As one court has explained: "discriminating on the basis that an individual was going to, had, or was in the process of changing their sex — or the most pronounced physical characteristics of their sex — is still discrimination based on sex."[253] Discrimination on the basis of gender identity is prohibited by 1557. Removing the words "gender identity" from the various regulations listed will not change that fact, but will serve to confuse the entities covered by those regulations, and the stakeholders entitled to protection under them, as to the scope of their legal obligations and rights. This confusion will likely lead to more complaints and litigation over gender identity-based discrimination. HHS should not adopt the proposed changes to these sections.

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[250] *See Altitude Exp., Inc. v. Zarda*, 139 S. Ct. 1599 (2019); *R.G. & G.R. Harris Funeral Homes*, Inc. v. E.E.O.C., 139 S. Ct. 1599 (2019).

[251] Specifically, 45 C.F.R. § 155.120(c)(1)(ii) was promulgated pursuant to ACA section 1321(a)(1)(A). *See Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans*, 76 Fed. Reg. 41865, 41897 (2011). 45 § 156.200(e) was promulgated pursuant to ACA section 1321(a)(1)(B). *See Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans*, 76 Fed. Reg. 41865, 41897 (2011). The protections at 42 C.F.R §§ 438.3(d)(4), 438.206(c)(2), 440.262 are based on Social Security Act §§ 1902(a)(19) and 1902(a)(4). *Medicaid and Children's Health Insurance Program (CHIP) Programs*, 81 Fed. Reg. 27498, 27538 (2016).

[252] *See, e.g., Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 953 (D. Minn. 2018); *Boyden v. Conlin*, 341 F. Supp. 3d 979, 997 (W.D. Wis. 2018); *Flack v. Wis. Dep't of Health Servs*., 328 F. Supp. 3d 931, 951 (W.D. Wis. 2018); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090, 1098-1100 (S.D. Cal. 2017); *Rumble v. Fairview Health Servs*., No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at *18 (D. Minn. Mar. 16, 2015).

[253] *Flack v. Wis. Dept. of Health Servs*., 328 F. Supp. 3d 931, 949 (W.D. Wis. 2018).

In addition, as discussed above (*supra* Section III.B), section 1557 prohibits discrimination based on sexual orientation. To date, no court has specifically addressed whether sexual orientation discrimination is encompassed under section 1557's prohibition against discrimination on the basis of sex. Numerous courts, however, have held that sexual orientation discrimination is a type of sex discrimination, both because it is based on the sex of the individuals to whom a person is attracted, and because it relies on sex stereotypes about romantic pairings and attraction.[254] For the same reason, Section 1557 prohibits discrimination on the basis of sexual orientation. Removing the words "sexual orientation" from the listed regulations will not change the statutory text of Section 1557 or other statutory non-discrimination provisions such that sexual orientation discrimination is allowed, but, as described above, it will serve to confuse the entities covered by those regulations, and the stakeholders entitled to protection under them, as to the scope of their legal obligations and rights. This confusion will likely lead to more complaints and litigation over sexual orientation-based discrimination. HHS should not adopt the proposed changes to these sections.

V. Interim Treatment of Subregulatory Guidance

We oppose HHS' suspension of all subregulatory guidance related to Section 1557 while the rulemaking is in process, and in particular the preamble to the current Section 1557 regulation. HHS is bound by the Administrative Procedures Act to provide justification for its proposed changes and cannot change current regulations without going through the notice and comment period, considering those comments, and then providing justification for its changes in a new final regulation. Particularly with respect to the preamble to the current regulations, the information provided helps covered entities understand the parameters of the regulations, how to comply, and what HHS considered in evaluating comments. Rescinding the subregulatory guidance while the current regulations remain will only sow confusion for covered entities as well as

[254] *See, e.g., Zarda v. Altitude Express, Inc.*, 883 F.3d 100, 119 (2d Cir. 2018), *cert. granted sub nom. Altitude Exp., Inc. v. Zarda*, 139 S. Ct. 1599, 203 L. Ed. 2d 754 (2019); *Christiansen v. Omnicom Grp., Inc*., 852 F.3d 195, 201 (2d Cir. 2017); *Hively v. Ivy Tech Cmty. Coll. of Indiana*, 853 F.3d 339, 345 (7th Cir. 2017); *Spencer v. Town of Bedford*, No. 6:18-CV-31, 2018 WL 5983572, at *5 (W.D. Va. Nov. 2, 2018); *Boutillier v. Hartford Pub. Sch*., 221 F.Supp.3d 255, 269 (D. Conn. 2016); *Videckis v. Pepperdine Univ*., 150 F.Supp.3d 1151, 1160 (C.D. Cal. 2015); *Terveer v. Billington*, 34 F.Supp.3d 100, 116 (D.D.C. 2014); *Centola v. Potter*, 183 F.Supp.2d 403, 410 (D. Mass. 2002); *Heller v. Columbia Edgewater Country Club*, 195 F.Supp.2d 1212, 1224 (D. Or. 2002).

individuals protected by Section 1557. The harm of suspending the guidance and the preamble greatly outweighs any benefit.

HHS cites to the Attorney General's memorandums of November 16, 2017 and January 25, 2018 as justification for the suspension. While HHS states that Department of Justice litigators cannot use ***noncompliance*** with guidance documents as the basis for proving violations, the guidance can certainly be used by covered entities to help ensure ***compliance*** with Section 1557. It can also be used by the courts to understand HHS' intent in promulgating the current regulations. Suspending this guidance, especially while the current regulations remain in effect, will cause confusion amongst covered entities who have been relying on this guidance and the preamble for a number of years.

Given the time it will take for HHS to proceed through the required steps to finalize revisions, and that the current Section 1557 regulation remains in effect until that process is completed, HHS should not suspend any existing guidance that offers information on interpreting and applying Section 1557.

VI. Regulatory Impact Analysis

a. The Regulatory Impact Analysis (RIA) is insufficient and fails to justify the proposed changes

The NPRM provides a RIA that is wholly insufficient to justify the extensive scope of the proposed changes to language access and entirely fails to identify and to quantify costs to protected individuals. As we discussed above, we believe the cost estimates considered by HHS as justification for the proposed changes are outdated, overestimated and fail to consider the cost and harm to individuals covered by Section 1557. In general, HHS fails to provide the underlying data or methodology that would support its claims.

HHS's estimate of the burden to covered entities for compliance with the nondiscrimination notice and tagline requirements is based on voluntary actions by covered entities. HHS based the elimination of the notice and taglines on these estimates, but did not consider whether alternatives, such as further clarification about the requirements, was warranted in the form of FAQs or other guidance. That is, HHS failed to consider alternatives to a complete repeal of notices and taglines that could have appropriately balanced the need to inform individuals of their rights while recognizing the 2016 Final Rule may not have been clear in its expectations.

Similarly, the majority of the costs are associated with the provision of a single type of document -- the Explanation of Benefits (EOB). HHS did not consider alternatives as to how it would consider enforcement and interpretation of the "significant document" standard with respect to the provision of multiple EOBs sent during a coverage year.

HHS states it has received little evidence that more beneficiaries are seeking language assistance and uses this claim as a justification to remove the notice and taglines. This claim, which relies on reports from health plans, is insufficient to justify the repeal of these important requirements. The regulation has been in effect for three years in which HHS, by its own admission, has had limited resources to conduct public outreach. Second, the protections guaranteed by Section 1557 are both continuing and expanded, warranting a public effort to conduct outreach. Third, the notices and taglines were specifically selected as to balance the needs of LEP individuals against requiring covered entities to translate large numbers of documents. Fourth, LEP persons are uniquely at risk of facing barriers to knowing and asserting their rights. Lack of uptake of services raises questions about the extent to which the public knows its rights and what covered entities are doing to communicate those rights, as opposed to justifying elimination of notices and taglines.

More broadly, however, we take issue with HHS' evaluation of costs to covered entities. The question should not be "whether the benefits of these provisions exceeds the burdens imposed by them." Such a balancing exercise is not called for by the statute, and inserts an inappropriate regulatory finesse on a remedial scheme created by Congress and intended to be interpreted broadly and to correct decades of harm.[255] The task of the agency is to interpret and implement the statute. The proposed balancing of interests may be an appropriate role for Congress, but not for the administrative branch.

b. Language Access Requirements in the 2016 final rule are justified by need

HHS has provided no tangible analysis of the costs and burdens of repealing the notice and tagline requirement. Instead, HHS provides only acknowledgment that repeal "may impose costs, such as decreasing access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services."[256] HHS perfunctorily labels the impact as "negligible" while providing no evidentiary basis.[257]

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[255] *See, e.g.* 42 U.S.C. § 12101 (ADA findings and purposes). The ADA builds upon Section 504, and Section 1557 follows in their footsteps.
[256] 84 Fed. Reg. 27882.
[257] *Id.*

The costs are not only reduced awareness of language services by individuals with LEP, but also reduced awareness by the general public about their rights as protected by 1557, especially regarding the notices which include information about the broader nondiscrimination requirements of Section 1557. HHS's only acknowledgement of this impact is one statement about the "unknown number of persons are likely not aware of their right to file complaints."[258]

Discrimination of all kinds creates unequal access to health care. HHS' proposed changes fly in the face of the letter and spirit of Section 1557 and its RIA fails to provide any legal justification for these changes.

See also our discussion above regarding § 92.8 about the repeal of provisions related to notices and taglines.

IX. Request For Comment

HHS provides an extensive list of issues on which it solicits comments, in addition to seeking comment on all issues raised by the proposed regulation. The list of issues in Section IX, however, provides insufficient clarity in both the questions and the context such that we do not think we can provide meaningful comment outside of the comments we are providing elsewhere.

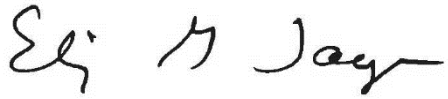
To justify proposed changes in existing regulations, HHS must provide its own explanation and rationale for the changes, documenting a need for these changes based not on an opposition to the policy undergirding a particular regulation but based on reason and data. Given that the public must be provided an opportunity to comment on HHS' alleged justifications for these proposed changes, HHS' attempt to solicit feedback on a list of additional issues that it may then use to promulgate unanticipated changes in a final rule violates requirements of public notice and comment as required by the Administrative Procedures Act. These issues would be more appropriate to inform agency decisions prior to issuing an NPRM, such as through a Request for Information, than in response to an NPRM. We thus decline to provide feedback on these issues in Section IX but have provided our explanations, justifications and evidence supporting our comments in the sections above.

[258] 84 Fed. Reg. 27883.

Conclusion

We appreciate the opportunity to provide comments on the NPRM. We oppose all the proposed changes and instead urge HHS not to finalize its proposals but instead to leave the current regulations, as well as subregulatory guidance, in place. If you have any questions, please contact us at (202) 289-7661 or via email -- Mara Youdelman (youdelman@healthlaw.org), Wayne Turner (turner@healthlaw.org) or Jennifer Lav (lav@healthlaw.org).

Sincerely,



Elizabeth G. Taylor
Executive Director

EXHIBIT D-43

CALLEN-LORDE

August 7, 2019

Secretary Alex Azar
Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F,
200 Independence Avenue SW,
Washington, DC 20201

Re: Section 1557 NPRM, RIN 0945-AA11, "Nondiscrimination in Health and Health Education Programs or Activities"

On behalf of Callen-Lorde Community Health Center (Callen-Lorde), we submit these comments to the federal Department of Health and Human Services ("Department") in **vehement opposition to the proposed rule entitled "Nondiscrimination in Health and Health Education Programs or Activities" and we urge HHS to withdraw it.**

Callen-Lorde is a federally qualified health center (FQHC) with three locations in New York City and a mission to serve lesbian, gay, bisexual and transgender communities and people living with HIV in addition to its geographic service areas. As a community-based health center, Callen-Lorde is open to all regardless of ability to pay. Callen-Lorde provides primary care, dental care, behavioral health care, care coordination and case management, as well as health education services, and its current primary care patient base nearly 18,000 people, approximately 25 percent of whom are patients of transgender or gender non-binary experience and 20% of whom are people living with HIV.

Callen-Lorde Community Health Center opposes the proposed rule. If finalized, this proposed rule would severely threaten LGBT patients' access to all forms of health care, create confusion among patients and providers about their rights and obligations, and promote discrimination. The proposed rule would encourage hospitals to deny care to LGBT people, and enable insurance companies to deny transgender people coverage for health care services that they cover for non-transgender people. The rule would also make it harder for other people experiencing discrimination in health care to know and exercise their rights, including people with Limited English Proficiency (LEP) and people suffering from chronic health conditions, like HIV. Callen-Lorde urges the Department of Health and Human Services (HHS) to withdraw the proposed rule.

The proposed rule will threaten LGBT patients' access to health care and coverage

Most important, the regulations fail to account for the significant burden that will be imposed on patients, a burden that will fall disproportionately and most harshly on women, people of color, people living with disabilities, and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) individuals. These communities already experience severe health disparities and discrimination, conditions that will be exacerbated by the proposed rule, possibly ending in in poorer health outcomes.

The proposed rule will compound the barriers to care that LGBTQ individuals face, particularly the effects of ongoing and pervasive discrimination by potentially allowing providers to refuse to provide services and information vital to LGBTQ health.

LGBTQ people continue to face discrimination in many areas of their lives, including health care, on the basis of their sexual orientation and gender identity. The Department's Healthy People 2020 initiative recognizes, "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of

their civil and human rights."[1] LGBTQ people still face discrimination in a wide variety of services affecting access to health care, including reproductive services, adoption and foster care services, child care, homeless shelters, and transportation services – as well as physical and mental health care services.[2] In a recent study published in *Health Affairs*, researchers examined the intersection of gender identity, sexual orientation, race, and economic factors in health care access.[3] They concluded that discrimination as well as insensitivity or disrespect on the part of health care providers were key barriers to health care access and that increasing efforts to provide culturally sensitive services would help close the gaps in health care access.[4]

a. Discrimination against the transgender community

Discrimination based on gender identity, gender expression, gender transition, transgender status, or sex-based stereotypes is necessarily a form of sex discrimination.[5] Numerous federal courts have found that federal sex discrimination statutes reach these forms of gender-based discrimination.[6] In 2012, the Equal Employment Opportunity Commission (EEOC) likewise held that "intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination based on sex and such discrimination therefore violates Title VII."[7]

Twenty-nine percent of transgender individuals were refused to be seen by a health care provider on the basis of their perceived or actual gender identity and 29 percent experienced unwanted physical contact from a health care provider.[8] Additionally, the 2015 U.S. Transgender Survey found that 23 percent

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[1] *Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health*, U.S. DEPT. HEALTH & HUMAN SERV., https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health, (last accessed on Mar. 8, 2018).

[2] HUMAN RIGHTS WATCH, *All We want is Equality: Religious Exemptions and Discrimination against LGBT People in the United States*, (Feb. 2018), https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people.

[3] Ning Hsieh and Matt Ruther, HEALTH AFFAIRS, *Despite Increased Insurance Coverage, Nonwhite Sexual Minorities Still Experience Disparities In Access To Care* (Oct. 2017) 1786–1794.

[4] *Id*.

[5] *See, e.g.*, *EEOC v. R.G. & G.R. Harris Funeral Homes*, No. 16-2424 (6th Cir. Mar. 7, 2018); *Whitaker v. Kenosha Unified Sch. Dist.*, 858 F.3d 1034 (7th Cir. 2017) (Title IX and Equal Protection Clause); Doddsv. U.S. Dep't of Educ., 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); Smith v. City of Salem, 378 F.3d 566 (6th Cir. 2004) (Title VII); *Rosa v. Park West Bank & Trust Co*., 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *A.H. ex rel. Handling v. Minersville Area School District*, 3:17-CV-391, 2017 WL 5632662 (M.D. Pa. Nov. 22, 2017) (Title IX and Equal Protection Clause); *Stone v. Trump*, ---F.Supp.3d ---, No. 17–2459 (D. Md. Nov. 21, 2017) (Equal Protection Clause); Doe v. Trump, ---F.Supp.3d ---, 2017 WL 4873042 (D.D.C. Oct. 30, 2017) (Equal Protection Clause); *Prescott v. Rady Children's Hospital-San Diego*, ---F.Supp.3d ---, 2017 WL 4310756 (S.D. Cal. Sept. 27, 2017) (Section 1557); *E.E.O.C. v. Rent-a-Center East, Inc*., ---F.Supp.3d ---, 2017 WL 4021130 (C.D. Ill. Sept. 8, 2017) (Title VII); *Brown v. Dept. of Health and Hum. Serv.*, No. 8:16DCV569, 2017 WL 2414567 (D. Neb. June 2, 2017) (Equal Protection Clause); *Smith v. Avanti*, 249 F.Supp.3d 1194 (D. Colo. 2017) (Fair Housing Act); *Students & Parents for Privacy v. U.S. Dep't of Educ.*, No. 16-cv-4945, 2016 WL 6134121 (N.D. Ill. Oct. 18, 2016) (Title IX); *Mickens v. Gen. Elec. Co.* No. 16-603, 2016 WL 7015665 (W.D. Ky. Nov. 29, 2016) (Title VII); *Fabian v. Hosp. of Cent. Conn*., 172 F.Supp.3d 509 (D. Conn. 2016) (Title VII); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. Jul. 5, 2016) (Section 1557); *Doe v. State of Ariz*., No. CV-15-02399-PHX-DGC, 2016 WL 1089743 (D. Ariz. Mar. 21, 2016) (Title VII); *Dawson v. H&H Elec., Inc.*, No. 4:14CV00583 SWW, 2015 WL 5437101 (E.D. Ark. Sept. 15, 2015) (Title VII); *U.S. v. S.E. Okla. State Univ*., No. CIV–15–324–C, 2015 WL 4606079 (W.D. Okla. 2015) (Title VII); *Rumble v. Fairview Health Serv*., No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (Section 1557); *Finkle v. Howard Cty*., 12 F.Supp.3d 780 (D. Md. 2014) (Title VII); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); *Lopez v. River Oaks Imaging & Diagnostic Grp*., Inc., 542 F.Supp.2d 653 (S.D. Tex. 2008) (Title VII); *Mitchell v. Axcan Scandipharm,* Inc., No. Civ.A. 05-243, 2006 WL 456173 (W.D. Pa. 2006) (Title VII); *Tronettiv. Healthnet Lakeshore Hosp*., No. 03–CV–0375E, 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003) (Title VII).

[6] *See, e.g*., *Smith v. City of Salem*, 378 F.3d 566, 572-75 (6th Cir. 2004); *Rosa v. Park West Bank & Trust Co*., 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act). *See also* Statement of Interest of the United States at 14, *Jamal v. Saks*, No. 4:14-cv-02782 (S.D. Tex. Jan. 26, 2015).

[7] *Macy v. Holder*, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, *12 (Apr. 20, 2012).

[8] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, CTR. FOR AMERICAN PROGRESS, (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-

CALLEN-LORDE

respondents did not see a provider for needed health care because of fears of mistreatment or discrimination.[9]

Callen-Lorde's very existence is a response to provider and systemic discrimination in healthcare as experienced by LGBTQ individuals and communities. So profound was the need for non-judgmental, quality primary care for LGBTQ populations, that we created our own center. Now, nearly 50 years later – when so many human and civil rights advances having been made – LGB and TGNB people still are being mistreated by providers. Sadly, Callen-Lorde's capacity to serve its communities is consistently being stretched. We firmly believe that the care we provide should be the norm and that true liberation will only come when the LGBTQ community and our families can adequately access culturally competent and comprehensive health care in all forms.

In 2018, Callen-Lorde administered a short on-line survey to its patients, staff and community members. The survey confirmed what we know already: **LGB and TBNB individuals still face discrimination in health care and are denied care as a result**. We surveyed 58 individuals ranging in age from 22- 83 years old and more than 20 percent of respondents indicated that they either may have – or were – denied care by a provider because of the provider's religious or moral objections.

A select few of the written testimonies pulled from the survey are included in these comments.

Testimonies of Transgender Discrimination

Kyle, 22-year-old transgender man and Callen-Lorde staff person stated: ***"I have had psychiatrists refuse to see me because they are uncomfortable with my gender identity and transition. I also had a primary care provider who delayed referral to transition specialists for the same reason. It was very distressing to have my transition delayed and feel like my provider isn't there to help me progress. The psychiatrist denying care makes me worried about mental health professionals more generally and have to be very careful when seeking mental health services. As a person of transgender experience, if I saw signs up in health practices notifying patients of their ability to discriminate if they choose, I would be very hesitant to return. I would feel like I had no protection and a chance of not receiving adequate healthcare."***

Aaron, a, 29 transgender man and patient of Callen-Lorde stated: ***"Where I grew up I could not find a provider to prescribe me hormones and during high school I was sent for a psych ER visit for suicidal ideation. One of the clinicians refused to see me and none of the hospital staff knew what transgender was. This was in 2005 in rural New Jersey. I did not receive treatment for my gender dysphoria and depression for many years because there were no providers who would work with me."***

Anonymous, 25 gender non-conforming person, stated: ***"Doctors would either completely avoid my gender or would tell me they didn't "understand it" and to go find a place that does. I was scared by that and never followed up on a different doctor until much later. Freedom of Speech doesn't mean freedom to oppress or discriminate."***

people-accessing-health-care/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-for-discrimination&email_referrer=&email_subject=rx-for-discrimination.

[9] NAT'L CTR. FOR TRANSGENDER EQUALITY, *The Report of the 2015 U.S. Transgender Survey* 5 (2016), *available at* https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf [hereinafter *2015 U.S. Transgender Survey*].

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The 2016 implementing rule is sound, has been crucial for LGBT patients to be able to access the care that they need, and promotes equal access to medically necessary health services.

Callen-Lorde also opposes proposed changes to roll back other, long-standing rules that prohibit discrimination on the basis of gender identity and sexual orientation.[10] These changes are outside of the Office for Civil Rights' jurisdiction and are unrelated to Section 1557 of the ACA."

It is not appropriate for these rulemakings to be combined, and it is arbitrary and capricious for HHS to characterize them as "conforming amendments" without offering any legal, policy or cost-benefit analysis about them and their impacts on various CMS programs. In particular, HHS offers no analysis of the impact these regulations have had during the years—in some cases over a decade—that they have been in effect or the impact of changing them now."

Section 1557 of the Affordable Care Act and the 2016 implementing rule provided many LGBT people with meaningful health care options where they previously had few or none at all, have helped address the pervasive discrimination LGBT people often face in health care and coverage, and have made it possible for many transgender and non-transgender people alike to access essential care. And, overall, New York State citizens have benefited from the Affordable Care Act and its own New York State of Health Marketplace.

New York State saw record 'Obamacare' enrollment last year. Nearly 272,000 people enrolled in private health insurance plans through New York State of Health, the exchange created by the Affordable Care Act, up from 253,000 at the end of last year's open enrollment period. The state's basic health program, which offers insurance to low-income New Yorkers who do not qualify for Medicaid, enrolled more than 790,000 people, up from 739,000 one year ago.

The state also reported that nearly 114,000 people purchased an insurance plan without any federal subsidies, up about 10 percent from last year, despite average monthly premiums increasing roughly 9 percent this year.

New York's strong showing comes the week after California — the only state larger than New York to run its own exchange — reported a 0.5 percent drop in enrollment, blaming the disappointing figures on Republicans' repeal of the individual mandate penalty. It is suspected the lack of the mandate penalty is one of several factors that contributed to enrollment falling 4 percent on healthcare.gov, the federal exchange that manages enrollment for 39 states.[11]

New York also has a long Open Enrollment period, and is the only state to extend its open enrollment period through January.

In New York State, we have also worked hard to put regulations and laws in place to prevent discrimination in healthcare. This proposed rule will cause confusion for providers and patients about people's rights under state and federal law, and how it could dissuade people from seeking care despite the state-level protections remaining clearly in place.

[10] These are: 45 CFR 155.120(c)(1)(ii) and 155.220(j)(2), 45 CFR 147.104(e), 45 CFR 156.200(e) and 156.1230(b)(3),
42 CFR 460.98(b)(3) and 460.112(a), 42 CFR 438.3(d)(4), 438.206(c)(2), and 440.262.
[11] *Obamacare enrollment sets record in New York*, Dan Goldberg, Politico Pro, February 4, 2019.

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The proposed rule will impede health care access for people with HIV/AIDS and other serious or chronic conditions.

Section 1557 and the 2016 implementing regulations prohibit health insurance companies from discriminating through marketing practices and benefit design. These protections are especially important for people with HIV/AIDS or other serious/chronic condition. The proposed rule seeks to exempt most health insurance plans from Section 1557's nondiscrimination protections and eliminate the regulation prohibiting discriminatory benefit design and marketing, which could result in health insurers excluding benefits or designing their prescription drug formularies in a way that limits access to medically necessary care for those living with HIV and other chronic conditions.

The proposed rule will make it much harder for people to understand their legal rights and will disproportionately harm LGBT people who are limited English proficient (LEP), or who need access to reproductive care.

The proposed rule will make it more challenging for LGBT patients—including LGBT, people who are also limited English proficient (LEP) or have LEP family members—to understand their health care rights under federal law. Many individuals may not know about their rights, how to request language services, or how to file a complaint if they face discrimination. By eliminating tagline requirements and notice standards, the proposed rule will undermine access to health care, health insurance, and legal redress for vulnerable communities.

Conclusion

For all the reason stated above, Callen-Lorde Community Health Center opposes this proposed rule. If finalized, this proposed rule would severely threaten LGBT patients' access to all forms of health care, create confusion among patients and providers about their rights and obligations, and promote discrimination. The proposed rule would encourage hospitals to deny care to LGBT people, and enable insurance companies to deny transgender people coverage for health care services that they cover for non-transgender people. The rule would also make it harder for other people experiencing discrimination in health care to know and exercise their rights, including people with Limited English Proficiency (LEP) and people suffering from chronic health conditions, like HIV. Callen-Lorde urges the Department of Health and Human Services (HHS) to withdraw the proposed rule.

Thank you for the opportunity to comment. Please feel free to contact us directly with any questions or comments.

Submitted By:

Kimberleigh Joy Smith, MPA
Senior Director for Community Health Planning and Policy
ksmith@callen-lorde.org
212-271-7184

EXHIBIT D-44

THE FENWAY INSTITUTE

August 13, 2019

U.S. Department of Health and Human Services, Office for Civil Rights
ATTN: Section 1557 NPRM, RIN 0945-AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Ave. SW
Washington, DC 20201

RE: Nondiscrimination in Health and Health Education Programs or Activities Proposed Rule (HHS-OCR-2019-0007)

We are submitting public comment on behalf of the Fenway Institute at Fenway Health, a federally qualified health center in Boston, MA that serves 32,000 patients each year. We are joined in this comment by Senator Patricia Jehlen and Representative Ruth Balser, Co-chairs of the Massachusetts Special Legislative Commission on LGBT Aging. Leaders from three major research and teaching hospitals that provide care to LGBT patients—Beth Israel Deaconess Medical Center, Boston Medical Center, and Massachusetts General Hospital—are also signing this comment, as are several local LGBT organizations. We write to strongly oppose the proposed rule titled, "Nondiscrimination in Health and Health Education Programs or Activities Proposed Rule (HHS-OCR-2019-0007)."

This proposed rule would reverse the 2016 final rule implementing Section 1557, the nondiscrimination provision of the Affordable Care Act (ACA). The 2016 Section 1557 rule explicitly prohibits gender identity discrimination, including discrimination against intersex and non-binary people, in health care facilities and programs receiving federal funding.[1] The 2016 Section 1557 rule also prohibits discriminatory coverage exclusions for transgender people in health insurance plans, expanding access to medically necessary gender affirmation services for transgender people. Sexual orientation discrimination that takes the form of sex stereotyping is also prohibited by the 2016 rule. This could include, for example, denying fertility treatment to a lesbian couple based on the stereotypical belief that women should only be in relationships with men, or that every child should be raised by a mother and a father. In the final 2016 rule, the Office of Civil Rights at the Department of Health and Human Services stated:

> OCR concludes that Section 1557's prohibition of discrimination on the basis of sex includes, at a minimum, sex discrimination related to an individual's sexual orientation where the evidence establishes that the discrimination is based on gender stereotypes. Accordingly, OCR will evaluate complaints alleging sex discrimination related to an individual's sexual orientation to determine whether they can be addressed under Section 1557.[2]

The nondiscrimination provisions in the 2016 Section 1557 rule are necessary in order to reduce LGBT health disparities and expand health care access for LGBT people. LGBT people face

[1] U.S. Department of Health and Human Services. Nondiscrimination in health programs and activities. *Federal Register*. May 18, 2016. Vol. 81, No. 96, Page 31387. https://www.federalregister.gov/articles/2016/05/18/2016-11458/nondiscrimination-in-healthprograms-and-activities
[2] Ibid. Pages 31389-31390.

widespread discrimination in health care, such as being verbally or physically harassed or being denied treatment altogether.[3] This discrimination acts as a barrier to seeking necessary routine, preventive care as well as emergency care. For example, the 2015 U.S. Transgender Survey of nearly 28,000 transgender people found that in the last year, 33% of respondents had experienced anti-transgender discrimination in health care, and 23% of respondents chose to forego necessary health care due to fear of discrimination.[4] A 2018 survey by the Center for American Progress found that 14% of LGBT respondents who had previously experienced discrimination in health care avoided seeking necessary medical care, and 17% avoided seeking preventive care in the past year.[5] This is why The Joint Commission has required SOGI nondiscrimination policies as a prerequisite to accreditation for health care programs since 2011. The Section 1557 final rule is necessary to address discrimination in health care, which in turn helps to reduce LGBT health disparities.

If finalized, the proposed rule would also revise several other important health care regulations that explicitly prohibit both sexual orientation and gender identity (SOGI) discrimination, including:

- Regulations governing the health insurance exchanges, including 34 federally facilitated exchanges and 17 state exchanges;
- Regulations governing Qualified Health Plans;
- Medicaid regulations, including language that explicitly prohibits sexual orientation and gender identity discrimination in Medicaid enrollment (42 CFR § 438.3(d)(4)) and availability of services (42 CFR § 438.206), and language highlighting the importance of access and cultural considerations that calls on states to care for LGBT patients and others in a culturally competent manner (42 CFR § 440.262);
- Regulations governing the access to services provided by the Program of All-Inclusive Care for the Elderly (PACE) (42 CFR § 460.98)

The proposed removal of SOGI nondiscrimination provisions from these regulations governing Medicaid enrollment and services, state and federal health insurance exchanges, insurance coverage, Qualified Health Plans, and PACE Program would hurt LGBT people who have disproportionately benefited from many of these programs. LGBT elders experience high rates of social isolation,[6] and many LGBT elders have experienced discrimination in accessing health, aging, and disability services.[7] Rescinding nondiscrimination provisions from the PACE program

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[3] Lambda Legal. (2010.) *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination against LGBT People and People with HIV*. New York: Lambda Legal.

[4] James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality.

[5] Mirza S and Rooney C. (2018). *Discrimination Prevents LGBTQ People from Accessing Health Care*. Center for American Progress.

[6] Fredriksen-Goldsen K, Kim H, Barkan S, Muraco A, Hoy-Ellis C. (2013). Health disparities among lesbian, gay, and bisexual older adults: Results from a population-based study. *American Journal of Public Health*, 103(10), 1802–1809. doi:10.2105/AJPH.2012.301110

[7] Fredriksen-Goldsen K, Kim H, Emlet C, Muraco A, Erosheva E, Hoy-Ellis C, Petry H. (2011). *The aging and health report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults*. Seattle, WA: Institute for Multigenerational Health.

will likely make many LGBT elders more fearful of discrimination in accessing elder services. This will likely exacerbate social isolation among LGBT older adults.

Medicaid is a critical program that expands health care access to LGBT people because of high prevalence of poverty among LGBT communities, especially among people of color and transgender people. A 2016 report by the Center for American Progress found that in 2014, Medicaid covered a significant portion (39%) of LGBT adults with incomes of 139% of the federal poverty level or less, and the uninsurance rate among low- and middle-income LGBT adults was much lower in Medicaid expansion states (18%) compared to non-expansion states (34%).[8] Currently, Medicaid also explicitly covers transgender health care in 18 states and Washington D.C.[9] Removing nondiscrimination provisions from regulations governing Medicaid enrollment and services, insurance exchanges, and Qualified Health Plans would undermine progress that has been made in expanding insurance coverage and access to care for LGBT people.

The proposed rule argues that the revisions to the 2016 Section 1557 rule are necessary due to a lawsuit that blocked the implementation of the rule. However, the other health care regulations that would be stripped of explicit SOGI nondiscrimination provisions never had those provisions challenged or blocked by lawsuits. Instead, the rule argues that these crucial nondiscrimination provisions must be removed from the other health care regulations simply for the sake of "conformity" with the revised Section 1557 rule. This is a specious argument.

Overall, the proposed rule would be harmful to the health and wellbeing of LGBT people. It threatens to undermine the progress that has been made over the past decade to address and reduce anti-LGBT discrimination in health care. The removal of nondiscrimination provisions from the Section 1557 rule and regulations governing Medicaid and other health insurance and elder service programs would disproportionately hurt transgender people as well as LGBT elders, disabled LGBT people, LGBT people of color, and low-income LGBT people. This would also undermine the federal government's current efforts to reduce new HIV infections by 75% in 5 years and by at least 90% in 10 years.[10] Some 66% of HIV diagnoses in 2017 were among gay and bisexual men,[11] and reversing nondiscrimination protections in health care could reduce access to health care, including prevention and screening for HIV and other sexually transmitted infections. The proposed rule contradicts numerous rulings by federal courts and the Equal Employment Opportunity Commission that have found that federal prohibitions on sex discrimination prohibit discrimination based on sexual orientation and gender identity.[12]

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[8] Baker K, McGovern A, Gruberg S, and Cray A. (2016). *The Medicaid Program and LGBT Communities: Overview and Policy Recommendations*. Center for American Progress. Available online at: https://cdn.americanprogress.org/wp-content/uploads/2016/08/08125221/2LGBTMedicaidExpansion-brief.pdf

[9] Movement Advancement Project. (2019). *Healthcare Laws and Policies: Medicaid Coverage for Transition-Related Care*. Available online at: https://www.lgbtmap.org/img/maps/citations-medicaid.pdf

[10] U.S. Department of Health and Human Services. *Ending the HIV Epidemic: A Plan for America*. Available online at: https://files.hiv.gov/s3fs-public/ending-the-hiv-epidemic-flyer.pdf

[11] Centers for Disease Control and Prevention. (January 2019). *HIV in the United States and Dependent Areas*. Available online at: https://www.cdc.gov/hiv/pdf/statistics/overview/cdc-hiv-us-ataglance.pdf

[12] U.S. Equal Employment Opportunity Commission (updated 2017). *Examples of court decisions supporting coverage of LGBT-related discrimination under Title VII*. https://www.eeoc.gov/eeoc/newsroom/wysk/lgbt_examples_decisions.cfm

Removing these nondiscrimination provisions runs counter to the mission of the HHS to ensure the health and wellbeing of all Americans, including LGBT Americans. We strongly urge you to reject this proposed rule.

Sincerely,

Jane Powers, MSW, LICSW
Acting Chief Executive Officer
Fenway Health

Kenneth Mayer, MD, FACP
Co-chair and Medical Research Director, The Fenway Institute
Director of HIV Prevention Research, Beth Israel Deaconess Medical Center
Professor of Medicine, Harvard Medical School

Jennifer Potter, MD
Co-Chair and LGBT Population Health Program Director
The Fenway Institute

Carl Sciortino, MPA
Vice President of Government and Community Relations
Fenway Health

Senator Patricia Jehlen
Co-Chair, Massachusetts Special Legislative Commission on Lesbian, Gay, Bisexual, Transgender Aging

Representative Ruth Balser
Co-Chair, Massachusetts Special Legislative Commission on Lesbian, Gay, Bisexual, Transgender Aging

Peter Healy
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Jenny Siegel, MD, Medical Director
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Carl G Streed Jr, MD, MPH, FACP, Research Lead
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Robert Goldstein, MD, PhD
Medical Director, MGH Transgender Health Program
Massachusetts General Hospital

Rebecca Jeen McDonald
Vet2Vet/Boston Trans* Peer Support Group

Arline Isaacson
Gary Daffin
Co-Chairs
Massachusetts Gay and Lesbian Political Caucus

John Gatto, LICSW
Senior Vice President of Community Health
Justice Resource Institute

EXHIBIT D-45

August 13, 2019

Mr. Roger Severino
Director
U.S. Department of Health and Human Services, Office for Civil Rights
Hubert H. Humphrey Building, Room 509F, 200
Independence Avenue, SW
Washington, DC 20201

Submitted electronically via www.regulations.gov

Re: **Section 1557 NPRM, RIN 0945–AA11**
Proposed Rule on Nondiscrimination in Health and Health Education Programs or Activities
84 Fed. Reg. Vol. 115 (June 14, 2019) | eRulemaking Docket ID No. HHS-OCR-2019-0007-0001

Dear Director Severino:

The Massachusetts League of Community Health Centers ("MLCHC"), appreciates the opportunity to provide comments to the U.S. Department of Health and Human Services (HHS) Department of Health and Human Services (HHS) Office for Civil Rights (OCR) on the proposed rule, "Nondiscrimination in Health and Health Education Programs or Activities," 84 Fed. Reg. Vol. 115 (June 14, 2019). MLCHC hopes that HHS OCR will ultimately withdraw this proposal, as we oppose these proposed changes, and instead hope HHS will work with stakeholders to establish clear guidance that fully realizes the genuine intent of Section 1557.

MLCHC is a state membership organization for federally qualified health centers ("FQHCs" or "health centers") in the Commonwealth of Massachusetts. Massachusetts community health centers care for 988,000 patients of all ages and racial and ethnic backgrounds with 42% better served in a language other than English. Nationwide and in the commonwealth health centers serve as the largest primary care network, providing comprehensive services. For more detailed information on health centers, please see **Attachment A**.

MLCHC's Comments

Health Centers Are Pioneers in Providing High-Quality, Value Based Care to All Americans

Health centers, by long-standing mission and mandate, provide comprehensive primary and preventative care to all who come through their doors, regardless of insurance status or ability to pay for services. The vastly diverse and growing health center patient population includes: low-income working families; the medically underserved and uninsured; and high-risk and vulnerable populations (e.g. LGBTQ and immigrant communities)

In addition to primary and preventative care, health centers provide nonclinical services, known as "enabling services," that facilitate access to needed care. Health center enabling services include: health education; case management; interpretation; transportation; and other mechanisms to eliminate barriers

to care. Enabling services may include eligibility assistance or peer recovery support provided through a community health worker.

Health centers have become trusted community providers for more than 50 years, because both policymakers and communities know that they are able to provide a wide array of high-quality evidence-based services to diverse communities in culturally and linguistically appropriate care settings.

We are proud that health centers have been lauded by HHS Secretary Alex Azar as "vital partners in [HHS'] movement toward a health system that delivers quality, affordable care for all Americans," and "pioneers in this value effort already."[1]

By eliminating key protections against discrimination, the proposed rule poses significant risks to those vulnerable individuals seeking primary and reproductive care. These populations include LGBTQ communities, people of color, people with chronic or complex conditions, and those whose primary language is not English. This addition of barriers to accessing healthcare will likely result in worsening health outcomes, increase costs in the health care system, and have a disparate impact on individuals living at the intersections of these identities.

Section 1557 Statute and Regulations Reinforce the Health Center Mission and Mandates

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age or disability in health programs or activities that receive federal financial assistance, or under any program or activity that is administered by an executive agency under Title I of the ACA or by an entity established under such Title. As HHS OCR stated in 2016, "a fundamental purpose of the [Affordable Care Act] is to ensure that health services are available broadly on a nondiscriminatory basis to individuals throughout the country."[2]

As entities participating in Medicare and Medicaid, and often receiving grant funds from the Health Resources and Services Administration (HRSA), all Section 330[3] health centers (both grantees and lookalikes) are required to comply with Section 1557 and the implementing rules finalized in 2016 (2016 Final Rules). Indeed, the 2016 Final Rule added a new layer of complexity to an already intricate regulatory environment for health centers. Notwithstanding the additional compliance efforts, NACHC observed in its previous comments to OCR that Section 1557 rulemaking presented an important opportunity to update the application of our existing civil rights laws to our country's evolving healthcare system.

The Proposed Changes Undermine the Mission of Health Centers and HHS, and Weaken Enforcement of Protections against Discrimination for Vulnerable Patient Populations.

MLCHC believes in the critical importance of ensuring that all people, including immigrants, those with Limited English Proficiency (LEP), chronic or complex condition patients, and LGBTQ communities, can

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[1] HHS Secretary Alex Azar's Speech to NACHC P&I Conference Attendees in March 2018. See, also, *Secretary Applauds Health Center "Pioneers."* HRSA. March 2018. Available at https://www.hrsa.gov/enews/past-issues/2018/april-5/secretary-applauds-health-center-pioneers.html. Accessed Aug. 7, 2019.

[2] 81 Fed. Reg. 31379.

[3] Section 330 of the Public Health Service Act (42 U.S.C. §254b) is the section of federal statute that creates and authorizes the Health Center Program

obtain quality affordable healthcare without facing discriminatory barriers. MLCHC has been pleased to see efforts by both Congress and this Administration to put patients first by boldly tackling the opioid addiction and overdose crisis as well as the high costs of prescription drugs. Given the Administration's commitment to address the opioid crisis, drug pricing, and the HIV epidemic, we are excited about the progress we can make to address these public health challenges in a bipartisan way. However, we are concerned that the proposal by OCR to narrow the scope of the 2016 Final Rule to cover only the specific programs and activities that receive federal funding, and not broader health care operations will result in a decline in the important progress being made to address access to needed health care services.

Health centers believe that applying nondiscrimination rules across the health system consistently will better serve the goal of ensuring access to high-quality primary and preventative care and other services in a way that selective enforcement would not.

We cannot support a proposal which will result in health plans or pharmacy benefit managers operating so that the public is unable to identify options to seek redress for unfair practices, such as discriminatory plan benefit design. We are concerned this proposal, if finalized, could leave the most vulnerable aforementioned individuals with inconsistent protection of their civil rights.

The proposed changes to the 2016 Final Rule, i.e., to scale back well-guided enforcement mechanisms for Section 1557:

1. Represent an abrupt departure from HHS OCR's previous considerations of the public input it received on the rules
2. Is counterproductive to the various initiatives undertaken by HHS as "the Federal government's lead agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves." [4]

The Proposed Changes Inappropriately Narrow the Scope of Applicability of Section 1557

Discrimination in health care takes various forms, ranging from plan benefit design and to disparate panel policies. As such, the rules must be comprehensive in scope and application to address real barriers to care for the protected classes.

Given how opaque the practices of health insurers and plan benefit managers, e.g. pharmacy benefit managers, continue to be despite policies enacted under the ACA to combat insidious forms of discriminatory risk-adjustment or benefit tiers, MLCHC opposes HHS OCR's proposal to narrow the scope of the 2016 Final Rules. More specifically, MLCHC is opposed to the proposed changes in § 92.1 - 92.3 that would narrow the scope of application of Section 1557, as they would have a detrimental effect on health center patients and recommends:

[4] 83 Fed. Reg. 58019

1. That HHS OCR maintain the 2016 Final Rule's application to *all* health programs or activities administered by HHS (as well as other federal Departments) *plus* those established under Title I of the ACA.

2. That, similar to Title VI, HHS OCR maintain the 2016 Final Rule's application to *all* parts of the covered entity, not only the portion receiving federal financial assistance.

Given the inextricable link between health care and coverage, MLCHC believes that health insurance is a "health program or activity" subject to Section 1557 requirements. OCR's proposal to apply Section 1557 only to federal health programs and activities administered by an agency established by Title I of the ACA, is counter to the statutory text and intent of the law.

The Proposed Changes Attempt to Narrow the Definition of Sex Discrimination

The definition of sex discrimination laid out in Section 1557 was the first broad prohibition against sex-based discrimination in US health care. This attempt to narrow the definition would have a profound impact on provider's ability to refuse treatment to patients based on their gender identity, while allowing insurance companies to categorically exclude or deny coverage for gender-affirming care. Massachusetts specific data shows that within our transgender community 28% of individuals have experienced a problem with their insurance related to being transgender. As well as 31% of individuals who saw a health provider within the last year having reported having at least one negative experience related to being transgender.[5]

The Commonwealth of Massachusetts has taken state level action to ensure such discrimination does not occur.

1. If the rule is finalized, the Health Connector can continue to provide additional assurances of non-discrimination beyond the federal floor.

2. State law prohibits discrimination on the basis of gender and the Division of Insurance has clarified that health insurance carriers are prohibited from discrimination on the basis of gender identity or gender dysphoria, which is still in effect.

However, even with state level protections, removal of federal protections against non-discrimination on the basis of gender identity weakens access and equity for targeted populations.

The Proposed Rule Attempts to Eliminate Language Access Protections

Discrimination on the basis of national origin, which encompasses discrimination on the basis of language, often leads to unequal access to health care for the over 25 million Americans who are limited English proficient. Language assistance is necessary for LEP persons to access federally funded programs and activities in the healthcare system. For LEP individuals, language differences often compound existing

[5] 2015 U.S. Transgender Survey: Massachusetts State Report. (2017). Washington, DC: National Center for Transgender Equality.

barriers to access and appropriate care, making it difficult for many to navigate an already complicated healthcare system, especially when it comes to medical or insurance terminology.

The proposed rule states that the nondiscrimination notice, taglines, and language access plan were not justified by need and were overly burdensome creating inconsistent requirements. In this the MLCHC does not agree. Without the notices, members of the public will have limited knowledge of the availability of language services and auxiliary aids, how to request them, and how to file a complaint in the face of possible discriminatory actions. The removal of these notices shifts the burden of inquiry for services onto the patient and weakens the quality of care.

Conclusion

Our 52 health centers are staffed by and offer services to all individuals, regardless of their diverse characteristics or ability to pay for services. Health Centers have enjoyed bipartisan Congressional and Administration support for many years.

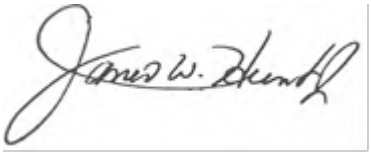
As the state representative for health centers and their patients, MLCHC is deeply concerned by the proposed revisions that seek to significantly scale back the 2016 Final Rule, rather than further strengthen it in ways that would put patients first. The 2016 Final Rule provides meaningful ways to ensure that the nondiscrimination protections are known, monitored and enforced. A scaling back of the 2016 Final Rule could result in increased health care disparities, increased health system costs, and reduced access to care for historically marginalized and vulnerable populations.

This proposed rule will also erect barriers to care for transgender individual; people seeking reproductive care, including abortion services; individuals with LEP, including migrants; those with disabilities and people of color. While also emboldening compounding levels of discrimination against those who live at the intersection of these identities. The proposed rule is dangerous and contravenes the plain language of section 1557, specifically, and the ACA broadly.

MLCHC hopes that HHS OCR will ultimately withdraw this proposal and instead work with stakeholders to establish clear guidance that fully realizes the intent of the Section 1557.

Thank you for the opportunity to comment on this proposed rule. MLCHC is willing to provide clarification or answer any follow up information on our comments, please contact Kerin O'Toole at kotoole@massleague.org.

Sincerely,



James W. Hunt, Jr. PhD
President & CEO
Massachusetts League of Community Health Centers

EXHIBIT D-46

August 13, 2019

Roger Severino
Director, Office for Civil Rights
U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Section 1557 NPRM, RIN 0945-AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW, Washington, DC 20201

Re: Section 1557 NPRM, RIN 0945-AA11, Comments in Response to Proposed Rulemaking: Nondiscrimination in Health and Health Education Programs or Activities

Dear Mr. Severino,

We write with grave concerns regarding the proposed rule to revise the current regulations implementing Section 1557 of the Patient Protection and Affordable Care Act (the "PPACA"). The current regulations implementing Section 1557 (the "Final Rule") prohibit discrimination based on race, color, national origin, sex, age, and disability in key children's health programs and activities receiving federal financial assistance. If implemented, the newly proposed rule (the "Proposed Rule") would create significant negative effects on some of society's most vulnerable populations, particularly with respect to their access to comprehensive, child and family-centered health care services and programs. Specifically, and as described in further detail below, the Proposed Rule would: (1) create barriers and access issues for vulnerable populations, including lesbian, gay, bisexual and transgender (LGBT) individuals and people whose primary language is not English; (2) open the door to discriminatory benefit designs and marketing practices by eliminating the applicability of Section 1557 protections to all health insurers; (3) terminate key grievance and compliance procedures and requirements. We ask that you withdraw the rule.

Boston Children's Hospital is a safety net provider for children and the only acute freestanding pediatric hospital in the Commonwealth of Massachusetts. We are one of the largest pediatric medical centers in the United States, a teaching hospital fully engaged in the training of the next generation of pediatric providers, a leading research institution and a civic leader in our region. Our institution frequently provides medical care to children from all over the world covered by both public and private payers. As a leader in pediatric health care, we are responsible for helping develop and advance public policies that align with our mission and meet the needs of the children and families in New England, the United States and beyond. This includes ensuring that all children have access to culturally appropriate and equitable health services, programs and coverage to ensure their physical and mental health. We are concerned that the proposed reduction in scope of Section 1557 under the Proposed Rule would weaken key aspects of nondiscrimination protections afforded to children and youth in need of health care and put many at serious risk. Below, we have described our greatest concerns regarding implementation of the Proposed Rule.

1. **The Proposed Rule would create barriers and access issues for vulnerable populations,** including lesbian, gay, bisexual and transgender (LGBT) individuals and people whose primary language is not English.

   At Boston Children's Hospital, we are committed to providing comprehensive and affirming treatment to our LGBT patients and families. It is our mission to enhance the health and wellbeing of children and families in our community, including people who are transgender. We are dedicated to protecting people from discrimination and creating a welcoming hospital environment inclusive of the entire LGBT community. The need for an affirming environment for transgender and gender non-conforming children is clear, as research has shown that a supported social transition in childhood correlates not only with an increase in positive health outcomes for this vulnerable population but also with a decrease in negative outcomes.

   Under the Final Rule, Section 1557 clarified that health care providers cannot refuse to treat someone because of their gender identity. The Final Rule also confirmed that insurance companies cannot categorically exclude or deny coverage for gender affirming care. The proposed changes to the rule would disproportionately impact LGBT patients - especially transgender, non-binary and gender nonconforming patients - seeking specialized care. Under the Proposed Rule, a health care provider could refuse to treat a transgender patient, simply because of the patient's gender identity – thereby limiting this population's access to services such as well child visits and immunizations. Transgender, non-binary and gender nonconforming people could also be denied coverage for medically necessary care, such as a pap smear for an individual assigned female at birth but whose gender marker is male or non-binary.

   The United States' LGBT population already faces unique barriers to care, such as higher rates of uninsurance, discrimination and harassment. Accessing culturally competent care and overcoming outright discrimination is an even greater challenge for LGBT youth living in areas with already limited access to health providers. The Proposed Rule threatens to make access even harder and for some people, nearly impossible.

   The Proposed Rule would also have a significant negative impact on the more than 25 million Americans who are Limited in English Proficiency (LEP) and who are seeking medical care. At Boston Children's Hospital, we understand that all families need to communicate clearly about their child's hospital experience, and LEP patients and families experience difficulty navigating an already complex medical system. Language Access Plans, requirements around taglines on significant documents and remote interpreting standards ensure meaningful access to the health care system for those who are LEP. The information conveyed in a hospital setting is often the basis for medical decisions that can have serious and life-altering consequences.

   In our experience as an institution that offers care to children and families from around the world, the language access protections and recommendations currently in the Final Rule are not burdensome, but rather improve our ability to deliver effective care. The Proposed Rule states that the nondiscrimination notice, taglines and language access

plans in the current regulations are not justified by need and are overly burdensome. We disagree. Additionally, as a referral center, who often sees patients that also receive care from other providers and institutions, we can attest to the importance of patient understanding of information conveyed to them throughout their experiences of care. The Proposed Rule would roll back requirements for the inclusion of taglines on significant documents, remove interpreting standards and eliminate recommendations that entities develop language access plans. These changes would leave our LEP population with limited means of knowing that language services and auxiliary aids are available, how to request them and what to do if they face discrimination.

2. **The Proposed Rule would eliminate the applicability of Section 1557 protections to all health insurers, opening the door for discriminatory benefit designs and marketing practices.** Under the Final Rule, covered entities are prohibited from designing benefits that discourage enrollment by persons with significant health needs. Additionally, covered entities are prohibited from using discriminatory marketing practices. The Proposed Rule attempts to eliminate these provisions and reduce the number of health insurance plans that are covered.

   Boston Children's Hospital is concerned that under the Proposed Rule, insurers will design plans that exclude benefits or design prescription drug formularies or provider networks in ways that impede access to medically necessary and age appropriate care for children with serious, complex or chronic medical conditions. In addition, plans could exclude specialty providers, such as children's hospitals, from a provider network or tier those providers into higher costs-sharing tiers, thereby limiting access to children with serious medical conditions.

   Furthermore, we are troubled that the Proposed Rule would eliminate existing prohibitions on discriminatory marketing practices that might target or exclude certain populations on the basis of race, color, national origin, gender or gender identity, age or disability.

3. **The Proposed Rule would eliminate key grievance and compliance procedures and requirements.** The Proposed Rule would limit the enforcement mechanisms under Section 1557 available to patients who have experienced discrimination by abolishing patients' Right to Private Action in federal court, and by eliminating the current requirements that covered entities establish grievance procedures and designate a responsible employee to coordinate compliance efforts. These changes would create significant and harmful barriers to individuals seeking remedies against discriminatory actions. It is important for families to have protection and recourse when they face obstacles to comprehensive and medically necessary care, and the Proposed Rule would strip families of these safeguards.

The PPACA's non-discrimination protections are important for ensuring that all patients, especially those most vulnerable, can access necessary health care without discrimination. Without the protections guaranteed in the Final Rule, patients could be denied care and treatment by some health care providers and by some insurers, putting their health at risk and potentially

the health of those around them. Boston Children's Hospital believes that the resulting impact of the Proposed Rule would have a lasting and negative influence on our nation; perhaps for generations to come.

For these reasons, we urge the administration to withdraw this Proposed Rule and work together with us to improve equitable access to timely and appropriate health care for our nation's children and youth. If we may provide further information or otherwise be of assistance, please contact me or Amy DeLong (amy.delong@childrens.harvard.edu) of our Government Relations staff at 617-919-3070.

Thank you for your consideration.

Sincerely,

Joshua Greenberg, JD
Vice President of Government Relations
Boston Children's Hospital

EXHIBIT D-47

Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

Wylie C. Hembree,[1] Peggy T. Cohen-Kettenis,[2] Louis Gooren,[3] Sabine E. Hannema,[4] Walter J. Meyer,[5] M. Hassan Murad,[6] Stephen M. Rosenthal,[7] Joshua D. Safer,[8] Vin Tangpricha,[9] and Guy G. T'Sjoen[10]

[1]New York Presbyterian Hospital, Columbia University Medical Center, New York, New York 10032 (Retired); [2]VU University Medical Center, 1007 MB Amsterdam, Netherlands (Retired); [3]VU University Medical Center, 1007 MB Amsterdam, Netherlands (Retired); [4]Leiden University Medical Center, 2300 RC Leiden, Netherlands; [5]University of Texas Medical Branch, Galveston, Texas 77555; [6]Mayo Clinic Evidence-Based Practice Center, Rochester, Minnesota 55905; [7]University of California San Francisco, Benioff Children's Hospital, San Francisco, California 94143; [8]Boston University School of Medicine, Boston, Massachusetts 02118; [9]Emory University School of Medicine and the Atlanta VA Medical Center, Atlanta, Georgia 30322; and [10]Ghent University Hospital, 9000 Ghent, Belgium

*Cosponsoring Associations: American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health.

Objective: To update the "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline," published by the Endocrine Society in 2009.

Participants: The participants include an Endocrine Society–appointed task force of nine experts, a methodologist, and a medical writer.

Evidence: This evidence-based guideline was developed using the Grading of Recommendations, Assessment, Development, and Evaluation approach to describe the strength of recommendations and the quality of evidence. The task force commissioned two systematic reviews and used the best available evidence from other published systematic reviews and individual studies.

Consensus Process: Group meetings, conference calls, and e-mail communications enabled consensus. Endocrine Society committees, members and cosponsoring organizations reviewed and commented on preliminary drafts of the guidelines.

Conclusion: Gender affirmation is multidisciplinary treatment in which endocrinologists play an important role. Gender-dysphoric/gender-incongruent persons seek and/or are referred to endocrinologists to develop the physical characteristics of the affirmed gender. They require a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender. Hormone treatment is not recommended for prepubertal gender-dysphoric/gender-incongruent persons. Those clinicians who recommend gender-affirming endocrine treatments—appropriately trained diagnosing clinicians (required), a mental health provider for adolescents (required) and mental health

ISSN Print 0021-972X ISSN Online 1945-7197
Printed in USA
Copyright © 2017 Endocrine Society
Received 24 July 2017. Accepted 24 August 2017.
First Published Online 13 September 2017

Abbreviations: BMD, bone mineral density; DSD, disorder/difference of sex development; DSM, Diagnostic and Statistical Manual of Mental Disorders; GD, gender dysphoria; GnRH, gonadotropin-releasing hormone; ICD, International Statistical Classification of Diseases and Related Health Problems; MHP, mental health professional; VTE, venous thromboembolism.

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professional for adults (recommended)—should be knowledgeable about the diagnostic criteria and criteria for gender-affirming treatment, have sufficient training and experience in assessing psychopathology, and be willing to participate in the ongoing care throughout the endocrine transition. We recommend treating gender-dysphoric/gender-incongruent adolescents who have entered puberty at Tanner Stage G2/B2 by suppression with gonadotropin-releasing hormone agonists. Clinicians may add gender-affirming hormones after a multidisciplinary team has confirmed the persistence of gender dysphoria/gender incongruence and sufficient mental capacity to give informed consent to this partially irreversible treatment. Most adolescents have this capacity by age 16 years old. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to age 16 years, although there is minimal published experience treating prior to 13.5 to 14 years of age. For the care of peripubertal youths and older adolescents, we recommend that an expert multidisciplinary team comprised of medical professionals and mental health professionals manage this treatment. The treating physician must confirm the criteria for treatment used by the referring mental health practitioner and collaborate with them in decisions about gender-affirming surgery in older adolescents. For adult gender-dysphoric/gender-incongruent persons, the treating clinicians (collectively) should have expertise in transgender-specific diagnostic criteria, mental health, primary care, hormone treatment, and surgery, as needed by the patient. We suggest maintaining physiologic levels of gender-appropriate hormones and monitoring for known risks and complications. When high doses of sex steroids are required to suppress endogenous sex steroids and/or in advanced age, clinicians may consider surgically removing natal gonads along with reducing sex steroid treatment. Clinicians should monitor both transgender males (female to male) and transgender females (male to female) for reproductive organ cancer risk when surgical removal is incomplete. Additionally, clinicians should persistently monitor adverse effects of sex steroids. For gender-affirming surgeries in adults, the treating physician must collaborate with and confirm the criteria for treatment used by the referring physician. Clinicians should avoid harming individuals (via hormone treatment) who have conditions other than gender dysphoria/gender incongruence and who may not benefit from the physical changes associated with this treatment. **(*J Clin Endocrinol Metab* 102: 3869–3903, 2017)**

Summary of Recommendations

1.0 Evaluation of youth and adults

1.1. We advise that only trained mental health professionals (MHPs) who meet the following criteria should diagnose gender dysphoria (GD)/gender incongruence in adults: (1) competence in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or the ICD for diagnostic purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

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doi: 10.1210/jc.2017-01658

1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 |⊕⊕◯◯)

1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 |⊕⊕⊕◯)

2.0 Treatment of adolescents

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 |⊕⊕◯◯)

2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 |⊕⊕◯◯)

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕◯◯)

2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 |⊕⊕◯◯).

2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕◯◯◯)

2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 |⊕⊕◯◯)

3.0 Hormonal therapy for transgender adults

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕◯)

3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment. (1 |⊕⊕⊕◯)

3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕◯◯)

3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 |⊕◯◯◯)

4.0 Adverse outcome prevention and long-term care

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 |⊕⊕◯◯)

4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 |⊕⊕◯◯)

4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕◯◯)

4.4. We recommend that clinicians obtain bone mineral density (BMD) measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕◯◯)

4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for non-transgender females. (2 |⊕⊕◯◯)

4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 |⊕◯◯◯)

4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

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5.0 Surgery for sex reassignment and gender confirmation

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 ⊕⊕◯◯)

5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)

5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)

5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 ⊕◯◯◯)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 ⊕⊕◯◯).

5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 ⊕◯◯◯)

Changes Since the Previous Guideline

Both the current guideline and the one published in 2009 contain similar sections. Listed here are the sections contained in the current guideline and the corresponding number of recommendations: Introduction, Evaluation of Youth and Adults (5), Treatment of Adolescents (6), Hormonal Therapy for Transgender Adults (4), Adverse Outcomes Prevention and Long-term Care (7), and Surgery for Sex Reassignment and Gender Confirmation (6). The current introduction updates the diagnostic classification of "gender dysphoria/gender incongruence." It also reviews the development of "gender identity" and summarizes its natural development. The section on clinical evaluation of both youth and adults, defines in detail the professional qualifications required of those who diagnose and treat both adolescents and adults. We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional. We recommend against puberty blocking followed by gender-affirming hormone treatment of prepubertal children. Clinicians should inform pubertal children, adolescents, and adults seeking gender-confirming treatment of their options for fertility preservation. Prior to treatment, clinicians should evaluate the presence of medical conditions that may be worsened by hormone depletion and/or treatment. A multidisciplinary team, preferably composed of medical and mental health professionals, should monitor treatments. Clinicians evaluating transgender adults for endocrine treatment should confirm the diagnosis of persistent gender dysphoria/gender incongruence. Physicians should educate transgender persons regarding the time course of steroid-induced physical changes. Treatment should include periodic monitoring of hormone levels and metabolic parameters, as well as assessments of bone density and the impact upon prostate, gonads, and uterus. We also make recommendations for transgender persons who plan genital gender-affirming surgery.

Method of Development of Evidence-Based Clinical Practice Guidelines

The Clinical Guidelines Subcommittee (CGS) of the Endocrine Society deemed the diagnosis and treatment of individuals with GD/gender incongruence a priority area for revision and appointed a task force to formulate evidence-based recommendations. The task force followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines (1). A detailed description of the grading scheme has been published elsewhere (2). The task force used the best available research evidence to develop the recommendations. The task force also used consistent language and graphical descriptions of both the strength of a recommendation and the quality of evidence. In terms of the strength of the recommendation, strong recommendations use the phrase "we recommend" and the number 1, and weak recommendations use the phrase "we suggest" and the number 2. Cross-filled circles indicate the quality of the evidence, such that ⊕◯◯◯ denotes very low–quality evidence; ⊕⊕◯◯, low quality; ⊕⊕⊕◯, moderate quality; and ⊕⊕⊕⊕, high quality. The task force has confidence that persons who receive care according to the strong recommendations will derive, on average, more benefit than harm. Weak recommendations require more careful consideration of the person's circumstances, values, and preferences to determine the best course of action. Linked to each recommendation is a description of the evidence and the

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doi: 10.1210/jc.2017-01658

values that the task force considered in making the recommendation. In some instances, there are remarks in which the task force offers technical suggestions for testing conditions, dosing, and monitoring. These technical comments reflect the best available evidence applied to a typical person being treated. Often this evidence comes from the unsystematic observations of the task force and their preferences; therefore, one should consider these remarks as suggestions.

In this guideline, the task force made several statements to emphasize the importance of shared decision-making, general preventive care measures, and basic principles of the treatment of transgender persons. They labeled these "Ungraded Good Practice Statement." Direct evidence for these statements was either unavailable or not systematically appraised and considered out of the scope of this guideline. The intention of these statements is to draw attention to these principles.

The Endocrine Society maintains a rigorous conflict-of-interest review process for developing clinical practice guidelines. All task force members must declare any potential conflicts of interest by completing a conflict-of-interest form. The CGS reviews all conflicts of interest before the Society's Council approves the members to participate on the task force and periodically during the development of the guideline. All others participating in the guideline's development must also disclose any conflicts of interest in the matter under study, and most of these participants must be without any conflicts of interest. The CGS and the task force have reviewed all disclosures for this guideline and resolved or managed all identified conflicts of interest.

Conflicts of interest are defined as remuneration in any amount from commercial interests; grants; research support; consulting fees; salary; ownership interests [*e.g.*, stocks and stock options (excluding diversified mutual funds)]; honoraria and other payments for participation in speakers' bureaus, advisory boards, or boards of directors; and all other financial benefits. Completed forms are available through the Endocrine Society office.

The Endocrine Society provided the funding for this guideline; the task force received no funding or remuneration from commercial or other entities.

Commissioned Systematic Review

The task force commissioned two systematic reviews to support this guideline. The first one aimed to summarize the available evidence on the effect of sex steroid use in transgender individuals on lipids and cardiovascular outcomes. The review identified 29 eligible studies at moderate risk of bias. In transgender males (female to male), sex steroid therapy was associated with a statistically significant increase in serum triglycerides and low-density lipoprotein cholesterol levels. High-density lipoprotein cholesterol levels decreased significantly across all follow-up time periods. In transgender females (male to female), serum triglycerides were significantly higher without any changes in other parameters. Few myocardial infarction, stroke, venous thromboembolism (VTE), and death events were reported. These events were more frequent in transgender females. However, the quality of the evidence was low. The second review summarized the available evidence regarding the effect of sex steroids on bone health in transgender individuals and identified 13 studies. In transgender males, there was no statistically significant difference in the lumbar spine, femoral neck, or total hip BMD at 12 and 24 months compared with baseline values before initiating masculinizing hormone therapy. In transgender females, there was a statistically significant increase in lumbar spine BMD at 12 months and 24 months compared with baseline values before initiation of feminizing hormone therapy. There was minimal information on fracture rates. The quality of evidence was also low.

Introduction

Throughout recorded history (in the absence of an endocrine disorder) some men and women have experienced confusion and anguish resulting from rigid, forced conformity to sexual dimorphism. In modern history, there have been numerous ongoing biological, psychological, cultural, political, and sociological debates over various aspects of gender variance. The 20th century marked the emergence of a social awakening for men and women with the belief that they are "trapped" in the wrong body (3). Magnus Hirschfeld and Harry Benjamin, among others, pioneered the medical responses to those who sought relief from and a resolution to their profound discomfort. Although the term transsexual became widely known after Benjamin wrote "The Transsexual Phenomenon" (4), it was Hirschfeld who coined the term "transsexual" in 1923 to describe people who want to live a life that corresponds with their experienced gender vs their designated gender (5). Magnus Hirschfeld (6) and others (4, 7) have described other types of trans phenomena besides transsexualism. These early researchers proposed that the gender identity of these people was located somewhere along a unidimensional continuum. This continuum ranged from all male through "something in between" to all female. Yet such a classification does not take into account that people may have gender identities outside this continuum. For instance, some experience themselves as having both a male and female gender identity, whereas others completely renounce any gender classification (8, 9). There are also reports of individuals experiencing a continuous and rapid involuntary alternation between a male and female identity (10) or men who do not experience themselves as men but do not want to live as women (11, 12). In some countries, (*e.g.*, Nepal, Bangladesh, and Australia), these nonmale or nonfemale genders are officially recognized (13). Specific treatment protocols, however, have not yet been developed for these groups.

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Instead of the term transsexualism, the current classification system of the American Psychiatric Association uses the term gender dysphoria in its diagnosis of persons who are not satisfied with their designated gender (14). The current version of the World Health Organization's ICD-10 still uses the term transsexualism when diagnosing adolescents and adults. However, for the ICD-11, the World Health Organization has proposed using the term "gender incongruence" (15).

Treating persons with GD/gender incongruence (15) was previously limited to relatively ineffective elixirs or creams. However, more effective endocrinology-based treatments became possible with the availability of testosterone in 1935 and diethylstilbestrol in 1938. Reports of individuals with GD/gender incongruence who were treated with hormones and gender-affirming surgery appeared in the press during the second half of the 20th century. The Harry Benjamin International Gender Dysphoria Association was founded in September 1979 and is now called the World Professional Association for Transgender Health (WPATH). WPATH published its first Standards of Care in 1979. These standards have since been regularly updated, providing guidance for treating persons with GD/gender incongruence (16).

Prior to 1975, few peer-reviewed articles were published concerning endocrine treatment of transgender persons. Since then, more than two thousand articles about various aspects of transgender care have appeared.

It is the purpose of this guideline to make detailed recommendations and suggestions, based on existing medical literature and clinical experience, that will enable treating physicians to maximize benefit and minimize risk when caring for individuals diagnosed with GD/gender incongruence.

In the future, we need more rigorous evaluations of the effectiveness and safety of endocrine and surgical protocols. Specifically, endocrine treatment protocols for GD/gender incongruence should include the careful assessment of the following: (1) the effects of prolonged delay of puberty in adolescents on bone health, gonadal function, and the brain (including effects on cognitive, emotional, social, and sexual development); (2) the effects of treatment in adults on sex hormone levels; (3) the requirement for and the effects of progestins and other agents used to suppress endogenous sex steroids during treatment; and (4) the risks and benefits of gender-affirming hormone treatment in older transgender people.

To successfully establish and enact these protocols, a commitment of mental health and endocrine investigators is required to collaborate in long-term, large-scale studies across countries that use the same diagnostic and inclusion criteria, medications, assay methods, and response assessment tools (*e.g.*, the European Network for the Investigation of Gender Incongruence) (17, 18).

Terminology and its use vary and continue to evolve. Table 1 contains the definitions of terms as they are used throughout this guideline.

Biological Determinants of Gender Identity Development

One's self-awareness as male or female changes gradually during infant life and childhood. This process of cognitive and affective learning evolves with interactions with parents, peers, and environment. A fairly accurate timetable exists outlining the steps in this process (19). Normative psychological literature, however, does not address if and when gender identity becomes crystallized and what factors contribute to the development of a gender identity that is not congruent with the gender of rearing. Results of studies from a variety of biomedical disciplines—genetic, endocrine, and neuroanatomic—support the concept that gender identity and/or gender expression (20) likely reflect a complex interplay of biological, environmental, and cultural factors (21, 22).

With respect to endocrine considerations, studies have failed to find differences in circulating levels of sex steroids between transgender and nontransgender individuals (23). However, studies in individuals with a disorder/difference of sex development (DSD) have informed our understanding of the role that hormones may play in gender identity outcome, even though most persons with GD/gender incongruence do not have a DSD. For example, although most 46,XX adult individuals with virilizing congenital adrenal hyperplasia caused by mutations in *CYP21A2* reported a female gender identity, the prevalence of GD/gender incongruence was much greater in this group than in the general population without a DSD. This supports the concept that there is a role for prenatal/postnatal androgens in gender development (24–26), although some studies indicate that prenatal androgens are more likely to affect gender behavior and sexual orientation rather than gender identity *per se* (27, 28).

Researchers have made similar observations regarding the potential role of androgens in the development of gender identity in other individuals with DSD. For example, a review of two groups of 46,XY persons, each with androgen synthesis deficiencies and female raised, reported transgender male (female-to-male) gender role changes in 56% to 63% and 39% to 64% of patients, respectively (29). Also, in 46,XY female-raised individuals with cloacal

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doi: 10.1210/jc.2017-01658

Table 1. Definitions of Terms Used in This Guideline

Biological sex, biological male or female: These terms refer to physical aspects of maleness and femaleness. As these may not be in line with each other (*e.g.*, a person with XY chromosomes may have female-appearing genitalia), the terms biological sex and biological male or female are imprecise and should be avoided.
Cisgender: This means not transgender. An alternative way to describe individuals who are not transgender is "non-transgender people."
Gender-affirming (hormone) treatment: See "gender reassignment"
Gender dysphoria: This is the distress and unease experienced if gender identity and designated gender are not completely congruent (see Table 2). In 2013, the American Psychiatric Association released the fifth edition of the DSM-5, which replaced "gender identity disorder" with "gender dysphoria" and changed the criteria for diagnosis.
Gender expression: This refers to external manifestations of gender, expressed through one's name, pronouns, clothing, haircut, behavior, voice, or body characteristics. Typically, transgender people seek to make their gender expression align with their gender identity, rather than their designated gender.
Gender identity/experienced gender: This refers to one's internal, deeply held sense of gender. For transgender people, their gender identity does not match their sex designated at birth. Most people have a gender identity of man or woman (or boy or girl). For some people, their gender identity does not fit neatly into one of those two choices. Unlike gender expression (see below), gender identity is not visible to others.
Gender identity disorder: This is the term used for GD/gender incongruence in previous versions of DSM (see "gender dysphoria"). The ICD-10 still uses the term for diagnosing child diagnoses, but the upcoming ICD-11 has proposed using "gender incongruence of childhood."
Gender incongruence: This is an umbrella term used when the gender identity and/or gender expression differs from what is typically associated with the designated gender. Gender incongruence is also the proposed name of the gender identity–related diagnoses in ICD-11. Not all individuals with gender incongruence have gender dysphoria or seek treatment.
Gender variance: See "gender incongruence"
Gender reassignment: This refers to the treatment procedure for those who want to adapt their bodies to the experienced gender by means of hormones and/or surgery. This is also called gender-confirming or gender-affirming treatment.
Gender-reassignment surgery (gender-confirming/gender-affirming surgery): These terms refer only to the surgical part of gender-confirming/gender-affirming treatment.
Gender role: This refers to behaviors, attitudes, and personality traits that a society (in a given culture and historical period) designates as masculine or feminine and/or that society associates with or considers typical of the social role of men or women.
Sex designated at birth: This refers to sex assigned at birth, usually based on genital anatomy.
Sex: This refers to attributes that characterize biological maleness or femaleness. The best known attributes include the sex-determining genes, the sex chromosomes, the H-Y antigen, the gonads, sex hormones, internal and external genitalia, and secondary sex characteristics.
Sexual orientation: This term describes an individual's enduring physical and emotional attraction to another person. Gender identity and sexual orientation are not the same. Irrespective of their gender identity, transgender people may be attracted to women (gynephilic), attracted to men (androphilic), bisexual, asexual, or queer.
Transgender: This is an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with their sex designated at birth. Not all transgender individuals seek treatment.
Transgender male (also: trans man, female-to-male, transgender male): This refers to individuals assigned female at birth but who identify and live as men.
Transgender woman (also: trans woman, male-to female, transgender female): This refers to individuals assigned male at birth but who identify and live as women.
Transition: This refers to the process during which transgender persons change their physical, social, and/or legal characteristics consistent with the affirmed gender identity. Prepubertal children may choose to transition socially.
Transsexual: This is an older term that originated in the medical and psychological communities to refer to individuals who have permanently transitioned through medical interventions or desired to do so.

exstrophy and penile agenesis, the occurrence of transgender male changes was significantly more prevalent than in the general population (30, 31). However, the fact that a high percentage of individuals with the same conditions did not change gender suggests that cultural factors may play a role as well.

With respect to genetics and gender identity, several studies have suggested heritability of GD/gender incongruence (32, 33). In particular, a study by Heylens *et al.* (33) demonstrated a 39.1% concordance rate for gender identity disorder (based on the DSM-IV criteria) in 23 monozygotic twin pairs but no concordance in 21 same-sex dizygotic or seven opposite-sex twin pairs. Although numerous investigators have sought to identify specific genes associated with GD/gender incongruence, such studies have been inconsistent and without strong statistical significance (34–38).

Studies focusing on brain structure suggest that the brain phenotypes of people with GD/gender incongruence differ in various ways from control males and females, but that there is not a complete sex reversal in brain structures (39).

In summary, although there is much that is still unknown with respect to gender identity and its expression, compelling studies support the concept that biologic factors, in addition to environmental factors, contribute to this fundamental aspect of human development.

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Natural History of Children With GD/Gender Incongruence

With current knowledge, we cannot predict the psychosexual outcome for any specific child. Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called "desisters"). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence (20, 40). In adolescence, a significant number of these desisters identify as homosexual or bisexual. It may be that children who only showed some gender nonconforming characteristics have been included in the follow-up studies, because the DSM-IV text revision criteria for a diagnosis were rather broad. However, the persistence of GD/gender incongruence into adolescence is more likely if it had been extreme in childhood (41, 42). With the newer, stricter criteria of the DSM-5 (Table 2), persistence rates may well be different in future studies.

1.0 Evaluation of Youth and Adults

Gender-affirming treatment is a multidisciplinary effort. After evaluation, education, and diagnosis, treatment may include mental health care, hormone therapy, and/or surgical therapy. Together with an MHP, hormone-prescribing clinicians should examine the psychosocial impact of the potential changes on people's lives, including mental health, friends, family, jobs, and their role in society. Transgender individuals should be encouraged to experience living in the new gender role and assess whether this improves their quality of life. Although the focus of this guideline is gender-affirming hormone therapy, collaboration with appropriate professionals responsible for each aspect of treatment maximizes a successful outcome.

Diagnostic assessment and mental health care

GD/gender incongruence may be accompanied with psychological or psychiatric problems (43–51). It is therefore necessary that clinicians who prescribe hormones and are involved in diagnosis and psychosocial assessment meet the following criteria: (1) are competent in using the DSM and/or the ICD for diagnostic purposes, (2) are able to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) are trained in diagnosing psychiatric conditions, (4) undertake or refer for appropriate treatment, (5) are able to do a psychosocial assessment of the patient's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) regularly attend relevant professional meetings.

Because of the psychological vulnerability of many individuals with GD/gender incongruence, it is important that mental health care is available before, during, and sometimes also after transitioning. For children and adolescents, an MHP who has training/experience in child and adolescent gender development (as well as child and adolescent psychopathology) should make the diagnosis, because assessing GD/gender incongruence in children and adolescents is often extremely complex.

During assessment, the clinician obtains information from the individual seeking gender-affirming treatment. In the case

Table 2. DSM-5 Criteria for Gender Dysphoria in Adolescents and Adults

A. A marked incongruence between one's experienced/expressed gender and natal gender of at least 6 mo in duration, as manifested by at least two of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
   2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender
   4. A strong desire to be of the other gender (or some alternative gender different from one's designated gender)
   5. A strong desire to be treated as the other gender (or some alternative gender different from one's designated gender)
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's designated gender)

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
   1. The condition exists with a disorder of sex development.
   2. The condition is posttransitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (*e.g.*, penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).

Reference: American Psychiatric Association (14).

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doi: 10.1210/jc.2017-01658

of adolescents, the clinician also obtains information from the parents or guardians regarding various aspects of the child's general and psychosexual development and current functioning. On the basis of this information, the clinician:

- decides whether the individual fulfills criteria for treatment (see Tables 2 and 3) for GD/gender incongruence (DSM-5) or transsexualism (DSM-5 and/or ICD-10);
- informs the individual about the possibilities and limitations of various kinds of treatment (hormonal/surgical and nonhormonal), and if medical treatment is desired, provides correct information to prevent unrealistically high expectations;
- assesses whether medical interventions may result in unfavorable psychological and social outcomes.

In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues. Literature on postoperative regret suggests that besides poor quality of surgery, severe psychiatric comorbidity and lack of support may interfere with positive outcomes (52–56).

For adolescents, the diagnostic procedure usually includes a complete psychodiagnostic assessment (57) and an assessment of the decision-making capability of the youth. An evaluation to assess the family's ability to endure stress, give support, and deal with the complexities of the adolescent's situation should be part of the diagnostic phase (58).

Social transitioning

A change in gender expression and role (which may involve living part time or full time in another gender role that is consistent with one's gender identity) may test the person's resolve, the capacity to function in the affirmed gender, and the adequacy of social, economic, and psychological supports. It assists both the individual and the clinician in their judgments about how to proceed (16). During social transitioning, the person's feelings about the social transformation (including coping with the responses of others) is a major focus of the counseling. The optimal timing for social transitioning may differ between individuals. Sometimes people wait until they start gender-affirming hormone treatment to make social transitioning easier, but individuals increasingly start social transitioning long before they receive medically supervised, gender-affirming hormone treatment.

Criteria

Adolescents and adults seeking gender-affirming hormone treatment and surgery should satisfy certain criteria before proceeding (16). Criteria for gender-affirming hormone therapy for adults are in Table 4, and criteria for gender-affirming hormone therapy for adolescents are in Table 5. Follow-up studies in adults meeting these criteria indicate a high satisfaction rate with treatment (59). However, the quality of evidence is usually low. A few follow-up studies on adolescents who fulfilled these criteria also indicated good treatment results (60–63).

Recommendations for Those Involved in the Gender-Affirming Hormone Treatment of Individuals With GD/Gender Incongruence

1.1. We advise that only trained MHPs who meet the following criteria should diagnose GD/gender incongruence in adults: (1) competence in using the DSM and/or the ICD for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or ICD for diagnostic

Table 3. ICD-10 Criteria for Transsexualism

Transsexualism (F64.0) has three criteria:
1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatments.
2. The transsexual identity has been present persistently for at least 2 y.
3. The disorder is not a symptom of another mental disorder or a genetic, DSD, or chromosomal abnormality.

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Table 4. Criteria for Gender-Affirming Hormone Therapy for Adults

1. Persistent, well-documented gender dysphoria/gender incongruence
2. The capacity to make a fully informed decision and to consent for treatment
3. The age of majority in a given country (if younger, follow the criteria for adolescents)
4. Mental health concerns, if present, must be reasonably well controlled

Reproduced from World Professional Association for Transgender Health (16).

purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

Evidence

Individuals with gender identity issues may have psychological or psychiatric problems (43–48, 50, 51, 64, 65). It is therefore necessary that clinicians making the diagnosis are able to make a distinction between GD/gender incongruence and conditions that have similar features. Examples of conditions with similar features are body dysmorphic disorder, body identity integrity disorder (a condition in which individuals have a sense that their anatomical configuration as an able-bodied person is somehow wrong or inappropriate) (66), or certain forms of eunuchism (in which a person is preoccupied with or engages in castration and/or penectomy for

Table 5. Criteria for Gender-Affirming Hormone Therapy for Adolescents

Adolescents are eligible for GnRH agonist treatment if:

1. A qualified MHP has confirmed that:
- the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
- gender dysphoria worsened with the onset of puberty,
- any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,
- the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment,

2. And the adolescent:
- has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment
- agrees with the indication for GnRH agonist treatment,
- has confirmed that puberty has started in the adolescent (Tanner stage ≥G2/B2),
- has confirmed that there are no medical contraindications to GnRH agonist treatment.

Adolescents are eligible for subsequent sex hormone treatment if:

1. A qualified MHP has confirmed:
- the persistence of gender dysphoria,
- any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
- the adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,

2. And the adolescent:
- has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal induction:
- agrees with the indication for sex hormone treatment,
- has confirmed that there are no medical contraindications to sex hormone treatment.

Reproduced from World Professional Association for Transgender Health (16).

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doi: 10.1210/jc.2017-01658

reasons that are not gender identity related) (11). Clinicians should also be able to diagnose psychiatric conditions accurately and ensure that these conditions are treated appropriately, particularly when the conditions may complicate treatment, affect the outcome of gender-affirming treatment, or be affected by hormone use.

Values and preferences

The task force placed a very high value on avoiding harm from hormone treatment in individuals who have conditions other than GD/gender incongruence and who may not benefit from the physical changes associated with this treatment and placed a low value on any potential benefit these persons believe they may derive from hormone treatment. This justifies the good practice statement.

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 |⊕⊕◯◯)

Evidence

In most children diagnosed with GD/gender incongruence, it did not persist into adolescence. The percentages differed among studies, probably dependent on which version of the DSM clinicians used, the patient's age, the recruitment criteria, and perhaps cultural factors. However, the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain GD/gender incongruent in adolescence (20). If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty (40). Social transition is associated with the persistence of GD/gender incongruence as a child progresses into adolescence. It may be that the presence of GD/gender incongruence in prepubertal children is the earliest sign that a child is destined to be transgender as an adolescent/adult (20). However, social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence.

This recommendation, however, does not imply that children should be discouraged from showing gender-variant behaviors or should be punished for exhibiting such behaviors. In individual cases, an early complete social transition may result in a more favorable outcome, but there are currently no criteria to identify the GD/gender-incongruent children to whom this applies. At the present time, clinical experience suggests that persistence of GD/gender incongruence can only be reliably assessed after the first signs of puberty.

Values and preferences

The task force placed a high value on avoiding harm with gender-affirming hormone therapy in prepubertal children with GD/gender incongruence. This justifies the strong recommendation in the face of low-quality evidence.

1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 |⊕⊕⊕◯)

Remarks

Persons considering hormone use for gender affirmation need adequate information about this treatment in general and about fertility effects of hormone treatment in particular to make an informed and balanced decision (67, 68). Because young adolescents may not feel qualified to make decisions about fertility and may not fully understand the potential effects of hormonal interventions, consent and protocol education should include parents, the referring MHP(s), and other members of the adolescent's support group. To our knowledge, there are no formally evaluated decision aids available to assist in the discussion and decision regarding the future fertility of adolescents or adults beginning gender-affirming treatment.

Treating early pubertal youth with GnRH analogs will temporarily impair spermatogenesis and oocyte maturation. Given that an increasing number of transgender youth want to preserve fertility potential, delaying or temporarily discontinuing GnRH analogs to promote gamete maturation is an option. This option is often not preferred, because mature sperm production is associated with later stages of puberty and with the significant development of secondary sex characteristics.

For those designated male at birth with GD/gender incongruence and who are in early puberty, sperm production and the development of the reproductive tract are insufficient for the cryopreservation of sperm. However, prolonged pubertal suppression using GnRH analogs is reversible and clinicians should inform these individuals that sperm production can be initiated following prolonged gonadotropin suppression. This can be accomplished by spontaneous gonadotropin recovery after

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cessation of GnRH analogs or by gonadotropin treatment and will probably be associated with physical manifestations of testosterone production, as stated above. Note that there are no data in this population concerning the time required for sufficient spermatogenesis to collect enough sperm for later fertility. In males treated for precocious puberty, spermarche was reported 0.7 to 3 years after cessation of GnRH analogs (69). In adult men with gonadotropin deficiency, sperm are noted in seminal fluid by 6 to 12 months of gonadotropin treatment. However, sperm numbers when partners of these patients conceive are far below the "normal range" (70, 71).

In girls, no studies have reported long-term, adverse effects of pubertal suppression on ovarian function after treatment cessation (72, 73). Clinicians should inform adolescents that no data are available regarding either time to spontaneous ovulation after cessation of GnRH analogs or the response to ovulation induction following prolonged gonadotropin suppression.

In males with GD/gender incongruence, when medical treatment is started in a later phase of puberty or in adulthood, spermatogenesis is sufficient for cryopreservation and storage of sperm. *In vitro* spermatogenesis is currently under investigation. Restoration of spermatogenesis after prolonged estrogen treatment has not been studied.

In females with GD/gender incongruence, the effect of prolonged treatment with exogenous testosterone on ovarian function is uncertain. There have been reports of an increased incidence of polycystic ovaries in transgender males, both prior to and as a result of androgen treatment (74–77), although these reports were not confirmed by others (78). Pregnancy has been reported in transgender males who have had prolonged androgen treatment and have discontinued testosterone but have not had genital surgery (79, 80). A reproductive endocrine gynecologist can counsel patients before gender-affirming hormone treatment or surgery regarding potential fertility options (81). Techniques for cryopreservation of oocytes, embryos, and ovarian tissue continue to improve, and oocyte maturation of immature tissue is being studied (82).

2.0 Treatment of Adolescents

During the past decade, clinicians have progressively acknowledged the suffering of young adolescents with GD/gender incongruence. In some forms of GD/gender incongruence, psychological interventions may be useful and sufficient. However, for many adolescents with GD/gender incongruence, the pubertal physical changes are unbearable. As early medical intervention may prevent psychological harm, various clinics have decided to start treating young adolescents with GD/gender incongruence with puberty-suppressing medication (a GnRH analog). As compared with starting gender-affirming treatment long after the first phases of puberty, a benefit of pubertal suppression at early puberty may be a better psychological and physical outcome.

In girls, the first physical sign of puberty is the budding of the breasts followed by an increase in breast and fat tissue. Breast development is also associated with the pubertal growth spurt, and menarche occurs ~2 years later. In boys, the first physical change is testicular growth. A testicular volume ≥4 mL is seen as consistent with the initiation of physical puberty. At the beginning of puberty, estradiol and testosterone levels are still low and are best measured in the early morning with an ultrasensitive assay. From a testicular volume of 10 mL, daytime testosterone levels increase, leading to virilization (83). Note that pubic hair and/or axillary hair/odor may not reflect the onset of gonadarche; instead, it may reflect adrenarche alone.

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment (Table 5), and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 |⊕⊕◯◯)

2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty (Tanner stages G2/B2). (2 |⊕⊕◯◯)

Evidence

Pubertal suppression can expand the diagnostic phase by a long period, giving the subject more time to explore options and to live in the experienced gender before making a decision to proceed with gender-affirming sex hormone treatments and/or surgery, some of which is irreversible (84, 85). Pubertal suppression is fully reversible, enabling full pubertal development in the natal gender, after cessation of treatment, if appropriate. The experience of full endogenous puberty is an undesirable condition for the GD/gender-incongruent individual and may seriously interfere with healthy psychological functioning and well-being. Treating GD/gender-incongruent adolescents entering puberty with GnRH analogs has been shown to improve psychological functioning in several domains (86).

Another reason to start blocking pubertal hormones early in puberty is that the physical outcome is improved compared with initiating physical transition after puberty has been completed (60, 62). Looking like a man or woman when living as the opposite sex creates difficult

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doi: 10.1210/jc.2017-01658

barriers with enormous life-long disadvantages. We therefore advise starting suppression in early puberty to prevent the irreversible development of undesirable secondary sex characteristics. However, adolescents with GD/gender incongruence should experience the first changes of their endogenous spontaneous puberty, because their emotional reaction to these first physical changes has diagnostic value in establishing the persistence of GD/gender incongruence (85). Thus, Tanner stage 2 is the optimal time to start pubertal suppression. However, pubertal suppression treatment in early puberty will limit the growth of the penis and scrotum, which will have a potential effect on future surgical treatments (87).

Clinicians can also use pubertal suppression in adolescents in later pubertal stages to stop menses in transgender males and prevent facial hair growth in transgender females. However, in contrast to the effects in early pubertal adolescents, physical sex characteristics (such as more advanced breast development in transgender boys and lowering of the voice and outgrowth of the jaw and brow in transgender girls) are not reversible.

Values and preferences

These recommendations place a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm from early pubertal suppression.

Remarks

Table 6 lists the Tanner stages of breast and male genital development. Careful documentation of hallmarks of pubertal development will ensure precise timing when initiating pubertal suppression once puberty has started. Clinicians can use pubertal LH and sex steroid levels to confirm that puberty has progressed sufficiently before starting pubertal suppression (88). Reference ranges for sex steroids by Tanner stage may vary depending on the assay used. Ultrasensitive sex steroid and gonadotropin assays will help clinicians document early pubertal changes.

Irreversible and, for GD/gender-incongruent adolescents, undesirable sex characteristics in female puberty are breasts, female body habitus, and, in some cases, relative short stature. In male puberty, they are a prominent Adam's apple; low voice; male bone configuration, such as a large jaw, big feet and hands, and tall stature; and male hair pattern on the face and extremities.

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 l⊕⊕◯◯)

Evidence

Clinicians can suppress pubertal development and gonadal function most effectively via gonadotropin suppression using GnRH analogs. GnRH analogs are long-acting agonists that suppress gonadotropins by GnRH receptor desensitization after an initial increase of gonadotropins during ~10 days after the first and (to a lesser degree) the second injection (89). Antagonists immediately suppress pituitary gonadotropin secretion (90, 91). Long-acting GnRH analogs are the currently preferred treatment option. Clinicians may consider long-acting GnRH antagonists when evidence on their safety and efficacy in adolescents becomes available.

During GnRH analog treatment, slight development of secondary sex characteristics may regress, and in a later phase of pubertal development, it will stop. In girls, breast tissue will become atrophic, and menses will stop. In boys, virilization will stop, and testicular volume may decrease (92).

An advantage of using GnRH analogs is the reversibility of the intervention. If, after extensive exploration of his/her transition wish, the individual no longer desires transition, they can discontinue pubertal suppression. In subjects with

Table 6. Tanner Stages of Breast Development and Male External Genitalia

The description of Tanner stages for breast development:
1. Prepubertal
2. Breast and papilla elevated as small mound; areolar diameter increased
3. Breast and areola enlarged, no contour separation
4. Areola and papilla form secondary mound
5. Mature; nipple projects, areola part of general breast contour

For penis and testes:
1. Prepubertal, testicular volume <4 mL
2. Slight enlargement of penis; enlarged scrotum, pink, texture altered, testes 4–6 mL
3. Penis longer, testes larger (8–12 mL)
4. Penis and glans larger, including increase in breadth; testes larger (12–15 mL), scrotum dark
5. Penis adult size; testicular volume > 15 ml

Adapted from Lawrence (56).

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precocious puberty, spontaneous pubertal development has been shown to resume after patients discontinue taking GnRH analogs (93).

Recommendations 2.1 to 2.3 are supported by a prospective follow-up study from The Netherlands. This report assessed mental health outcomes in 55 transgender adolescents/young adults (22 transgender females and 33 transgender males) at three time points: (1) before the start of GnRH agonist (average age of 14.8 years at start of treatment), (2) at initiation of gender-affirming hormones (average age of 16.7 years at start of treatment), and (3) 1 year after "gender-reassignment surgery" (average age of 20.7 years) (63). Despite a decrease in depression and an improvement in general mental health functioning, GD/gender incongruence persisted through pubertal suppression, as previously reported (86). However, following sex hormone treatment and gender-reassignment surgery, GD/gender incongruence was resolved and psychological functioning steadily improved (63). Furthermore, well-being was similar to or better than that reported by age-matched young adults from the general population, and none of the study participants regretted treatment. This study represents the first long-term follow-up of individuals managed according to currently existing clinical practice guidelines for transgender youth, and it underscores the benefit of the multidisciplinary approach pioneered in The Netherlands; however, further studies are needed.

Side effects

The primary risks of pubertal suppression in GD/gender-incongruent adolescents may include adverse effects on bone mineralization (which can theoretically be reversed with sex hormone treatment), compromised fertility if the person subsequently is treated with sex hormones, and unknown effects on brain development. Few data are available on the effect of GnRH analogs on BMD in adolescents with GD/gender incongruence. Initial data in GD/gender-incongruent subjects demonstrated no change of absolute areal BMD during 2 years of GnRH analog therapy but a decrease in BMD *z* scores (85). A recent study also suggested suboptimal bone mineral accrual during GnRH analog treatment. The study reported a decrease in areal BMD *z* scores and of bone mineral apparent density *z* scores (which takes the size of the bone into account) in 19 transgender males treated with GnRH analogs from a mean age of 15.0 years (standard deviation = 2.0 years) for a median duration of 1.5 years (0.3 to 5.2 years) and in 15 transgender females treated from 14.9 (±1.9) years for 1.3 years (0.5 to 3.8 years), although not all changes were statistically significant (94). There was incomplete catch-up at age 22 years after sex hormone treatment from age 16.6 (±1.4) years for a median duration of 5.8 years (3.0 to 8.0 years) in transgender females and from age 16.4 (±2.3) years for 5.4 years (2.8 to 7.8 years) in transgender males. Little is known about more prolonged use of GnRH analogs. Researchers reported normal BMD *z* scores at age 35 years in one individual who used GnRH analogs from age 13.7 years until age 18.6 years before initiating sex hormone treatment (65).

Additional data are available from individuals with late puberty or GnRH analog treatment of other indications. Some studies reported that men with constitutionally delayed puberty have decreased BMD in adulthood (95). However, other studies reported that these men have normal BMD (96, 97). Treating adults with GnRH analogs results in a decrease of BMD (98). In children with central precocious puberty, treatment with GnRH analogs has been found to result in a decrease of BMD during treatment by some (99) but not others (100). Studies have reported normal BMD after discontinuing therapy (69, 72, 73, 101, 102). In adolescents treated with growth hormone who are small for gestational age and have normal pubertal timing, 2-year GnRH analog treatments did not adversely affect BMD (103). Calcium supplementation may be beneficial in optimizing bone health in GnRH analog–treated individuals (104). There are no studies of vitamin D supplementation in this context, but clinicians should offer supplements to vitamin D–deficient adolescents. Physical activity, especially during growth, is important for bone mass in healthy individuals (103) and is therefore likely to be beneficial for bone health in GnRH analog–treated subjects.

GnRH analogs did not induce a change in body mass index standard deviation score in GD/gender-incongruent adolescents (94) but caused an increase in fat mass and decrease in lean body mass percentage (92). Studies in girls treated for precocious puberty also reported a stable body mass index standard deviation score during treatment (72) and body mass index and body composition comparable to controls after treatment (73).

Arterial hypertension has been reported as an adverse effect in a few girls treated with GnRH analogs for precocious/early puberty (105, 106). Blood pressure monitoring before and during treatment is recommended.

Individuals may also experience hot flashes, fatigue, and mood alterations as a consequence of pubertal suppression. There is no consensus on treatment of these side effects in this context.

It is recommended that any use of pubertal blockers (and subsequent use of sex hormones, as detailed below) include a discussion about implications for fertility (see recommendation 1.3). Transgender adolescents may

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doi: 10.1210/jc.2017-01658

want to preserve fertility, which may be otherwise compromised if puberty is suppressed at an early stage and the individual completes phenotypic transition with the use of sex hormones.

Limited data are available regarding the effects of GnRH analogs on brain development. A single cross-sectional study demonstrated no compromise of executive function (107), but animal data suggest there may be an effect of GnRH analogs on cognitive function (108).

Values and preferences

Our recommendation of GnRH analogs places a higher value on the superior efficacy, safety, and reversibility of the pubertal hormone suppression achieved (as compared with the alternatives) and a relatively lower value on limiting the cost of therapy. Of the available alternatives, depot and oral progestin preparations are effective. Experience with this treatment dates back prior to the emergence of GnRH analogs for treating precocious puberty in papers from the 1960s and early 1970s (109–112). These compounds are usually safe, but some side effects have been reported (113–115). Only two recent studies involved transgender youth (116, 117). One of these studies described the use of oral lynestrenol monotherapy followed by the addition of testosterone treatment in transgender boys who were at Tanner stage B4 or further at the start of treatment (117). They found lynestrenol safe, but gonadotropins were not fully suppressed. The study reported metrorrhagia in approximately half of the individuals, mainly in the first 6 months. Acne, headache, hot flashes, and fatigue were other frequent side effects. Another progestin that has been studied in the United States is medroxyprogesterone. This agent is not as effective as GnRH analogs in lowering endogenous sex hormones either and may be associated with other side effects (116). Progestin preparations may be an acceptable treatment for persons without access to GnRH analogs or with a needle phobia. If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see adult section).

Remarks

Measurements of gonadotropin and sex steroid levels give precise information about gonadal axis suppression, although there is insufficient evidence for any specific short-term monitoring scheme in children treated with GnRH analogs (88). If the gonadal axis is not completely suppressed—as evidenced by (for example) menses, erections, or progressive hair growth—the interval of GnRH analog treatment can be shortened or the dose increased. During treatment, adolescents should be monitored for negative effects of delaying puberty, including a halted growth spurt and impaired bone mineral accretion. Table 7 illustrates a suggested clinical protocol.

Anthropometric measurements and X-rays of the left hand to monitor bone age are informative for evaluating growth. To assess BMD, clinicians can perform dual-energy X-ray absorptiometry scans.

2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule (see Table 8) after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years (Table 5). (1 |⊕⊕◯◯)

2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕◯◯◯)

2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment (Table 9). (2 |⊕⊕◯◯)

Table 7. Baseline and Follow-Up Protocol During Suppression of Puberty

Every 3–6 mo
Anthropometry: height, weight, sitting height, blood pressure, Tanner stages
Every 6–12 mo
Laboratory: LH, FSH, E2/T, 25OH vitamin D
Every 1–2 y
Bone density using DXA
Bone age on X-ray of the left hand (if clinically indicated)

Adapted from Hembree *et al.* (118).

Abbreviations: DXA, dual-energy X-ray absorptiometry; E2, estradiol; FSH, follicle stimulating hormone; LH, luteinizing hormone; T, testosterone;

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Table 8. Protocol Induction of Puberty

Induction of female puberty with oral 17β-estradiol, increasing the dose every 6 mo:
- 5 μg/kg/d
- 10 μg/kg/d
- 15 μg/kg/d
- 20 μg/kg/d
- Adult dose = 2–6 mg/d
- *In postpubertal transgender female adolescents, the dose of 17β-estradiol can be increased more rapidly:*
  - 1 mg/d for 6 mo
  - 2 mg/d

Induction of female puberty with transdermal 17β-estradiol, increasing the dose every 6 mo (new patch is placed every 3.5 d):
- 6.25–12.5 μg/24 h (cut 25-μg patch into quarters, then halves)
- 25 μg/24 h
- 37.5 μg/24 h
- Adult dose = 50–200 μg/24 h
- *For alternatives once at adult dose, see Table 11.*
- *Adjust maintenance dose to mimic physiological estradiol levels (see Table 15).*

Induction of male puberty with testosterone esters increasing the dose every 6 mo (IM or SC):
- 25 mg/m^2/2 wk (or alternatively, half this dose weekly, or double the dose every 4 wk)
- 50 mg/m^2/2 wk
- 75 mg/m^2/2 wk
- 100 mg/m^2/2 wk
- Adult dose = 100–200 mg every 2 wk
- *In postpubertal transgender male adolescents the dose of testosterone esters can be increased more rapidly:*
  - 75 mg/2 wk for 6 mo
  - 125 mg/2 wk
- *For alternatives once at adult dose, see Table 11.*
- *Adjust maintenance dose to mimic physiological testosterone levels (see Table 14).*

Adapted from Hembree *et al.* (118).

Abbreviations: IM, intramuscularly; SC, subcutaneously.

Evidence

Adolescents develop competence in decision making at their own pace. Ideally, the supervising medical professionals should individually assess this competence, although no objective tools to make such an assessment are currently available.

Many adolescents have achieved a reasonable level of competence by age 15 to 16 years (119), and in many countries 16-year-olds are legally competent with regard to medical decision making (120). However, others believe that although some capacities are generally achieved before age 16 years, other abilities (such as good risk assessment) do not develop until well after 18 years (121). They suggest that health care procedures should be divided along a matrix of relative risk, so that younger adolescents can be allowed to decide about low-risk procedures, such as most diagnostic tests and common therapies, but not about high-risk procedures, such as most surgical procedures (121).

Currently available data from transgender adolescents support treatment with sex hormones starting at age 16 years (63, 122). However, some patients may incur potential risks by waiting until age 16 years. These include the potential risk to bone health if puberty is suppressed

Table 9. Baseline and Follow-up Protocol During Induction of Puberty

Every 3–6 mo
- •Anthropometry: height, weight, sitting height, blood pressure, Tanner stages

Every 6–12 mo
- •In transgender males: hemoglobin/hematocrit, lipids, testosterone, 25OH vitamin D
- •In transgender females: prolactin, estradiol, 25OH vitamin D

Every 1–2 y
- •BMD using DXA
- •Bone age on X-ray of the left hand (if clinically indicated)

BMD should be monitored into adulthood (until the age of 25–30 y or until peak bone mass has been reached).
For recommendations on monitoring once pubertal induction has been completed, see Tables 14 and 15.

Adapted from Hembree *et al.* (118).

Abbreviation: DXA, dual-energy X-ray absorptiometry.

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doi: 10.1210/jc.2017-01658

for 6 to 7 years before initiating sex hormones (*e.g.*, if someone reached Tanner stage 2 at age 9-10 years old). Additionally, there may be concerns about inappropriate height and potential harm to mental health (emotional and social isolation) if initiation of secondary sex characteristics must wait until the person has reached 16 years of age. However, only minimal data supporting earlier use of gender-affirming hormones in transgender adolescents currently exist (63). Clearly, long-term studies are needed to determine the optimal age of sex hormone treatment in GD/gender-incongruent adolescents.

The MHP who has followed the adolescent during GnRH analog treatment plays an essential role in assessing whether the adolescent is eligible to start sex hormone therapy and capable of consenting to this treatment (Table 5). Support of the family/environment is essential. Prior to the start of sex hormones, clinicians should discuss the implications for fertility (see recommendation 1.5). Throughout pubertal induction, an MHP and a pediatric endocrinologist (or other clinician competent in the evaluation and induction of pubertal development) should monitor the adolescent. In addition to monitoring therapy, it is also important to pay attention to general adolescent health issues, including healthy life style choices, such as not smoking, contraception, and appropriate vaccinations (*e.g.*, human papillomavirus).

For the induction of puberty, clinicians can use a similar dose scheme for hypogonadal adolescents with GD/gender incongruence as they use in other individuals with hypogonadism, carefully monitoring for desired and undesired effects (Table 8). In transgender female adolescents, transdermal 17β-estradiol may be an alternative for oral 17β-estradiol. It is increasingly used for pubertal induction in hypogonadal females. However, the absence of low-dose estrogen patches may be a problem. As a result, individuals may need to cut patches to size themselves to achieve appropriate dosing (123). In transgender male adolescents, clinicians can give testosterone injections intramuscularly or subcutaneously (124, 125).

When puberty is initiated with a gradually increasing schedule of sex steroid doses, the initial levels will not be high enough to suppress endogenous sex steroid secretion. Gonadotropin secretion and endogenous production of testosterone may resume and interfere with the effectiveness of estrogen treatment, in transgender female adolescents (126, 127). Therefore, continuation of GnRH analog treatment is advised until gonadectomy. Given that GD/gender-incongruent adolescents may opt not to have gonadectomy, long-term studies are necessary to examine the potential risks of prolonged GnRH analog treatment. Alternatively, in transgender male adolescents, GnRH analog treatment can be discontinued once an adult dose of testosterone has been reached and the individual is well virilized. If uterine bleeding occurs, a progestin can be added. However, the combined use of a GnRH analog (for ovarian suppression) and testosterone may enable phenotypic transition with a lower dose of testosterone in comparison with testosterone alone. If there is a wish or need to discontinue GnRH analog treatment in transgender female adolescents, they may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see section 3.0 "Hormonal Therapy for Transgender Adults").

Values and preferences

The recommendation to initiate pubertal induction only when the individual has sufficient mental capacity (roughly age 16 years) to give informed consent for this partly irreversible treatment places a higher value on the ability of the adolescent to fully understand and oversee the partially irreversible consequences of sex hormone treatment and to give informed consent. It places a lower value on the possible negative effects of delayed puberty. We may not currently have the means to weigh adequately the potential benefits of waiting until around age 16 years to initiate sex hormones vs the potential risks/harm to BMD and the sense of social isolation from having the timing of puberty be so out of sync with peers (128).

Remarks

Before starting sex hormone treatment, effects on fertility and options for fertility preservation should be discussed. Adult height may be a concern in transgender adolescents. In a transgender female adolescent, clinicians may consider higher doses of estrogen or a more rapid tempo of dose escalation during pubertal induction. There are no established treatments yet to augment adult height in a transgender male adolescent with open epiphyses during pubertal induction. It is not uncommon for transgender adolescents to present for clinical services after having completed or nearly completed puberty. In such cases, induction of puberty with sex hormones can be done more rapidly (see Table 8). Additionally, an adult dose of testosterone in transgender male adolescents may suffice to suppress the gonadal axis without the need to use a separate agent. At the appropriate time, the multidisciplinary team should adequately prepare the adolescent for transition to adult care.

3.0 Hormonal Therapy for Transgender Adults

The two major goals of hormonal therapy are (1) to reduce endogenous sex hormone levels, and thus reduce

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the secondary sex characteristics of the individual's designated gender, and (2) to replace endogenous sex hormone levels consistent with the individual's gender identity by using the principles of hormone replacement treatment of hypogonadal patients. The timing of these two goals and the age at which to begin treatment with the sex hormones of the chosen gender is codetermined in collaboration with both the person pursuing transition and the health care providers. The treatment team should include a medical provider knowledgeable in transgender hormone therapy, an MHP knowledgeable in GD/gender incongruence and the mental health concerns of transition, and a primary care provider able to provide care appropriate for transgender individuals. The physical changes induced by this sex hormone transition are usually accompanied by an improvement in mental well-being (129, 130).

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕◯)

3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment (Table 10). (1 |⊕⊕⊕◯)

3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕◯◯)

Evidence

It is the responsibility of the treating clinician to confirm that the person fulfills criteria for treatment. The treating clinician should become familiar with the terms and criteria presented in Tables 1–5 and take a thorough history from the patient in collaboration with the other members of the treatment team. The treating clinician must ensure that the desire for transition is appropriate; the consequences, risks, and benefits of treatment are well understood; and the desire for transition persists. They also need to discuss fertility preservation options (see recommendation 1.3) (67, 68).

Transgender males

Clinical studies have demonstrated the efficacy of several different androgen preparations to induce masculinization in transgender males (Appendix A) (113, 114, 131–134). Regimens to change secondary sex characteristics follow the general principle of hormone replacement treatment of male hypogonadism (135). Clinicians can use either parenteral or transdermal preparations to achieve testosterone values in the normal male range (this is dependent on the specific assay, but is typically 320 to 1000 ng/dL) (Table 11) (136). Sustained supraphysiologic levels of testosterone increase the risk of adverse reactions (see section 4.0 "Adverse Outcome Prevention and Long-Term Care") and should be avoided.

Similar to androgen therapy in hypogonadal men, testosterone treatment in transgender males results in increased muscle mass and decreased fat mass, increased facial hair and acne, male pattern baldness in those genetically predisposed, and increased sexual desire (137).

Table 10. Medical Risks Associated With Sex Hormone Therapy

Transgender female: estrogen
Very high risk of adverse outcomes:
•Thromboembolic disease
Moderate risk of adverse outcomes:
•Macroprolactinoma
•Breast cancer
•Coronary artery disease
•Cerebrovascular disease
•Cholelithiasis
•Hypertriglyceridemia
Transgender male: testosterone
Very high risk of adverse outcomes:
•Erythrocytosis (hematocrit > 50%)
Moderate risk of adverse outcomes:
•Severe liver dysfunction (transaminases > threefold upper limit of normal)
•Coronary artery disease
•Cerebrovascular disease
•Hypertension
•Breast or uterine cancer

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doi: 10.1210/jc.2017-01658

Table 11. Hormone Regimens in Transgender Persons

Transgender females[a]	
Estrogen	
Oral	
Estradiol	2.0–6.0 mg/d
Transdermal	
Estradiol transdermal patch (New patch placed every 3–5 d)	0.025–0.2 mg/d
Parenteral	
Estradiol valerate or cypionate	5–30 mg IM every 2 wk 2–10 mg IM every week
Anti-androgens	
Spironolactone	100–300 mg/d
Cyproterone acetate[b]	25–50 mg/d
GnRH agonist	3.75 mg SQ (SC) monthly 11.25 mg SQ (SC) 3-monthly
Transgender males	
Testosterone	
Parenteral testosterone	
Testosterone enanthate or cypionate	100–200 mg SQ (IM) every 2 wk or SQ (SC) 50% per week
Testosterone undecanoate[c]	1000 mg every 12 wk
Transdermal testosterone	
Testosterone gel 1.6%[d]	50–100 mg/d
Testosterone transdermal patch	2.5–7.5 mg/d

Abbreviations: IM, intramuscularly; SQ, sequentially; SC, subcutaneously.

[a]Estrogens used with or without antiandrogens or GnRH agonist.

[b]Not available in the United States.

[c]One thousand milligrams initially followed by an injection at 6 wk then at 12-wk intervals.

[d]Avoid cutaneous transfer to other individuals.

In transgender males, testosterone will result in clitoromegaly, temporary or permanent decreased fertility, deepening of the voice, cessation of menses (usually), and a significant increase in body hair, particularly on the face, chest, and abdomen. Cessation of menses may occur within a few months with testosterone treatment alone, although high doses of testosterone may be required. If uterine bleeding continues, clinicians may consider the addition of a progestational agent or endometrial ablation (138). Clinicians may also administer GnRH analogs or depot medroxyprogesterone to stop menses prior to testosterone treatment.

Transgender females

The hormone regimen for transgender females is more complex than the transgender male regimen (Appendix B). Treatment with physiologic doses of estrogen alone is insufficient to suppress testosterone levels into the normal range for females (139). Most published clinical studies report the need for adjunctive therapy to achieve testosterone levels in the female range (21, 113, 114, 132–134, 139, 140).

Multiple adjunctive medications are available, such as progestins with antiandrogen activity and GnRH agonists (141). Spironolactone works by directly blocking androgens during their interaction with the androgen receptor (114, 133, 142). It may also have estrogenic activity (143). Cyproterone acetate, a progestational compound with antiandrogenic properties (113, 132, 144), is widely used in Europe. 5α-Reductase inhibitors do not reduce testosterone levels and have adverse effects (145).

Dittrich *et al.* (141) reported that monthly doses of the GnRH agonist goserelin acetate in combination with estrogen were effective in reducing testosterone levels with a low incidence of adverse reactions in 60 transgender females. Leuprolide and transdermal estrogen were as effective as cyproterone and transdermal estrogen in a comparative retrospective study (146).

Patients can take estrogen as oral conjugated estrogens, oral 17β-estradiol, or transdermal 17β-estradiol. Among estrogen options, the increased risk of thromboembolic events associated with estrogens in general seems most concerning with ethinyl estradiol specifically (134, 140, 141), which is why we specifically suggest that it not be used in any transgender treatment plan. Data distinguishing among other estrogen options are less well established although there is some thought that oral routes of administration are more thrombogenic due to the "first pass effect" than are transdermal and parenteral routes, and that the risk of thromboembolic events is dose-dependent. Injectable estrogen and sublingual

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estrogen may benefit from avoiding the first pass effect, but they can result in more rapid peaks with greater overall periodicity and thus are more difficult to monitor (147, 148). However, there are no data demonstrating that increased periodicity is harmful otherwise.

Clinicians can use serum estradiol levels to monitor oral, transdermal, and intramuscular estradiol. Blood tests cannot monitor conjugated estrogens or synthetic estrogen use. Clinicians should measure serum estradiol and serum testosterone and maintain them at the level for premenopausal females (100 to 200 pg/mL and <50 ng/dL, respectively). The transdermal preparations and injectable estradiol cypionate or valerate preparations may confer an advantage in older transgender females who may be at higher risk for thromboembolic disease (149).

Values

Our recommendation to maintain levels of gender-affirming hormones in the normal adult range places a high value on the avoidance of the long-term complications of pharmacologic doses. Those patients receiving endocrine treatment who have relative contraindications to hormones should have an in-depth discussion with their physician to balance the risks and benefits of therapy.

Remarks

Clinicians should inform all endocrine-treated individuals of all risks and benefits of gender-affirming hormones prior to initiating therapy. Clinicians should strongly encourage tobacco use cessation in transgender females to avoid increased risk of VTE and cardiovascular complications. We strongly discourage the unsupervised use of hormone therapy (150).

Not all individuals with GD/gender incongruence seek treatment as described (*e.g.*, male-to-eunuchs and individuals seeking partial transition). Tailoring current protocols to the individual may be done within the context of accepted safety guidelines using a multidisciplinary approach including mental health. No evidence-based protocols are available for these groups (151). We need prospective studies to better understand treatment options for these persons.

3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 ⊕◯◯◯)

Evidence

Transgender males

Physical changes that are expected to occur during the first 1 to 6 months of testosterone therapy include cessation of menses, increased sexual desire, increased facial and body hair, increased oiliness of skin, increased muscle, and redistribution of fat mass. Changes that occur within the first year of testosterone therapy include deepening of the voice (152, 153), clitoromegaly, and male pattern hair loss (in some cases) (114, 144, 154, 155) (Table 12).

Transgender females

Physical changes that may occur in transgender females in the first 3 to 12 months of estrogen and antiandrogen therapy include decreased sexual desire, decreased spontaneous erections, decreased facial and body hair (usually mild), decreased oiliness of skin, increased breast tissue growth, and redistribution of fat mass (114, 139, 149, 154, 155, 161) (Table 13). Breast development is generally maximal at 2 years after initiating hormones (114, 139, 149, 155). Over a long period of time, the prostate gland and testicles will undergo atrophy.

Although the time course of breast development in transgender females has been studied (150), precise information about other changes induced by sex hormones is lacking (141). There is a great deal of variability among individuals, as evidenced during pubertal development. We all know that a major concern for transgender females is breast development. If we work with estrogens, the result will be often not what the transgender female expects.

Alternatively, there are transgender females who report an anecdotal improved breast development, mood, or sexual desire with the use of progestogens. However, there have been no well-designed studies of the role of progestogens in feminizing hormone regimens, so the question is still open.

Our knowledge concerning the natural history and effects of different cross-sex hormone therapies on breast

Table 12. Masculinizing Effects in Transgender Males

Effect	Onset	Maximum
Skin oiliness/acne	1–6 mo	1–2 y
Facial/body hair growth	6–12 mo	4–5 y
Scalp hair loss	6–12 mo	—[a]
Increased muscle mass/strength	6–12 mo	2–5 y
Fat redistribution	1–6 mo	2–5 y
Cessation of menses	1–6 mo	—[b]
Clitoral enlargement	1–6 mo	1–2 y
Vaginal atrophy	1–6 mo	1–2 y
Deepening of voice	6–12 mo	1–2 y

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157), Wierckx *et al.* (158).

[a]Prevention and treatment as recommended for biological men.

[b]Menorrhagia requires diagnosis and treatment by a gynecologist.

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doi: 10.1210/jc.2017-01658

Table 13. Feminizing Effects in Transgender Females

Effect	Onset	Maximum
Redistribution of body fat	3–6 mo	2–3 y
Decrease in muscle mass and strength	3–6 mo	1–2 y
Softening of skin/decreased oiliness	3–6 mo	Unknown
Decreased sexual desire	1–3 mo	3–6 mo
Decreased spontaneous erections	1–3 mo	3–6 mo
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 mo	2–3 y
Decreased testicular volume	3–6 mo	2–3 y
Decreased sperm production	Unknown	>3 y
Decreased terminal hair growth	6–12 mo	>3 y[a]
Scalp hair	Variable	—[b]
Voice changes	None	—[c]

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157).

[a]Complete removal of male sexual hair requires electrolysis or laser treatment or both.

[b]Familial scalp hair loss may occur if estrogens are stopped.

[c]Treatment by speech pathologists for voice training is most effective.

development in transgender females is extremely sparse and based on the low quality of evidence. Current evidence does not indicate that progestogens enhance breast development in transgender females, nor does evidence prove the absence of such an effect. This prevents us from drawing any firm conclusion at this moment and demonstrates the need for further research to clarify these important clinical questions (162).

Values and preferences

Transgender persons have very high expectations regarding the physical changes of hormone treatment and are aware that body changes can be enhanced by surgical procedures (*e.g.*, breast, face, and body habitus). Clear expectations for the extent and timing of sex hormone–induced changes may prevent the potential harm and expense of unnecessary procedures.

4.0 Adverse Outcome Prevention and Long-Term Care

Hormone therapy for transgender males and females confers many of the same risks associated with sex hormone replacement therapy in nontransgender persons. The risks arise from and are worsened by inadvertent or intentional use of supraphysiologic doses of sex hormones, as well as use of inadequate doses of sex hormones to maintain normal physiology (131, 139).

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 |⊕⊕◯◯)

Evidence

Pretreatment screening and appropriate regular medical monitoring are recommended for both transgender males and females during the endocrine transition and periodically thereafter (26, 155). Clinicians should monitor weight and blood pressure, conduct physical exams, and assess routine health questions, such as tobacco use, symptoms of depression, and risk of adverse events such as deep vein thrombosis/pulmonary embolism and other adverse effects of sex steroids.

Transgender males

Table 14 contains a standard monitoring plan for transgender males on testosterone therapy (154, 159). Key issues include maintaining testosterone levels in the physiologic normal male range and avoiding adverse events resulting from excess testosterone therapy, particularly erythrocytosis, sleep apnea, hypertension, excessive weight gain, salt retention, lipid changes, and excessive or cystic acne (135).

Because oral 17-alkylated testosterone is not recommended, serious hepatic toxicity is not anticipated with parenteral or transdermal testosterone use (163, 164). Past concerns regarding liver toxicity with testosterone have been alleviated with subsequent reports that indicate the risk of serious liver disease is minimal (144, 165, 166).

Transgender females

Table 15 contains a standard monitoring plan for transgender females on estrogens, gonadotropin suppression, or antiandrogens (160). Key issues include avoiding supraphysiologic doses or blood levels of estrogen that may lead to increased risk for thromboembolic disease, liver dysfunction, and hypertension. Clinicians should monitor serum estradiol levels using laboratories participating in external quality control, as measurements of estradiol in blood can be very challenging (167).

VTE may be a serious complication. A study reported a 20-fold increase in venous thromboembolic disease in a large cohort of Dutch transgender subjects (161). This increase may have been associated with the use of the synthetic estrogen, ethinyl estradiol (149). The incidence decreased when clinicians stopped administering ethinyl estradiol (161). Thus, the use of synthetic estrogens and conjugated estrogens is undesirable because of the inability to regulate doses by measuring serum levels and the risk of thromboembolic disease. In a German gender clinic, deep vein thrombosis occurred in 1 of 60 of transgender females treated with a GnRH analog and oral

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Table 14. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Male

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of virilization and for development of adverse reactions.
2. Measure serum testosterone every 3 mo until levels are in the normal physiologic male range:[a]
   a. For testosterone enanthate/cypionate injections, the testosterone level should be measured midway between injections. The target level is 400–700 ng/dL to 400 ng/dL. Alternatively, measure peak and trough levels to ensure levels remain in the normal male range.
   b. For parenteral testosterone undecanoate, testosterone should be measured just before the following injection. If the level is <400 ng/dL, adjust dosing interval.
   c. For transdermal testosterone, the testosterone level can be measured no sooner than after 1 wk of daily application (at least 2 h after application).
3. Measure hematocrit or hemoglobin at baseline and every 3 mo for the first year and then one to two times a year. Monitor weight, blood pressure, and lipids at regular intervals.
4. Screening for osteoporosis should be conducted in those who stop testosterone treatment, are not compliant with hormone therapy, or who develop risks for bone loss.
5. If cervical tissue is present, monitoring as recommended by the American College of Obstetricians and Gynecologists.
6. Ovariectomy can be considered after completion of hormone transition.
7. Conduct sub- and periareolar annual breast examinations if mastectomy performed. If mastectomy is not performed, then consider mammograms as recommended by the American Cancer Society.

[a]Adapted from Lapauw *et al.* (154) and Ott *et al.* (159).

estradiol (141). The patient who developed a deep vein thrombosis was found to have a homozygous C677 T mutation in the methylenetetrahydrofolate reductase gene. In an Austrian gender clinic, administering gender-affirming hormones to 162 transgender females and 89 transgender males was not associated with VTE, despite an 8.0% and 5.6% incidence of thrombophilia (159). A more recent multinational study reported only 10 cases of VTE from a cohort of 1073 subjects (168). Thrombophilia screening of transgender persons initiating hormone treatment should be restricted to those with a personal or family history of VTE (159). Monitoring D-dimer levels during treatment is not recommended (169).

4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 l⊕⊕◯◯)

Evidence

Estrogen therapy can increase the growth of pituitary lactrotroph cells. There have been several reports of prolactinomas occurring after long-term, high-dose estrogen therapy (170–173). Up to 20% of transgender females treated with estrogens may have elevations in prolactin levels associated with enlargement of the pituitary gland (156). In most cases, the serum prolactin levels will return to the normal range with a reduction or discontinuation of the estrogen therapy or discontinuation of cyproterone acetate (157, 174, 175).

The onset and time course of hyperprolactinemia during estrogen treatment are not known. Clinicians should measure prolactin levels at baseline and then at least annually during the transition period and every 2 years thereafter. Given that only a few case studies reported prolactinomas, and prolactinomas were not reported in large cohorts of estrogen-treated persons, the risk is likely to be very low. Because the major presenting findings of microprolactinomas (hypogonadism and sometimes gynecomastia) are not apparent in transgender females, clinicians may perform radiologic examinations of the pituitary in those patients whose prolactin levels persistently increase despite stable or reduced estrogen levels. Some transgender individuals receive psychotropic medications that can increase prolactin levels (174).

Table 15. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Female

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of feminization and for development of adverse reactions.
2. Measure serum testosterone and estradiol every 3 mo.
   a. Serum testosterone levels should be <50 ng/dL.
   b. Serum estradiol should not exceed the peak physiologic range: 100–200 pg/mL.
3. For individuals on spironolactone, serum electrolytes, particularly potassium, should be monitored every 3 mo in the first year and annually thereafter.
4. Routine cancer screening is recommended, as in nontransgender individuals (all tissues present).
5. Consider BMD testing at baseline (160). In individuals at low risk, screening for osteoporosis should be conducted at age 60 years or in those who are not compliant with hormone therapy.

This table presents strong recommendations and does not include lower level recommendations.

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doi: 10.1210/jc.2017-01658

4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕◯◯)

Evidence

Transgender males

Administering testosterone to transgender males results in a more atherogenic lipid profile with lowered high-density lipoprotein cholesterol and higher triglyceride and low-density lipoprotein cholesterol values (176–179). Studies of the effect of testosterone on insulin sensitivity have mixed results (178, 180). A randomized, open-label uncontrolled safety study of transgender males treated with testosterone undecanoate demonstrated no insulin resistance after 1 year (181, 182). Numerous studies have demonstrated the effects of sex hormone treatment on the cardiovascular system (160, 179, 183, 184). Long-term studies from The Netherlands found no increased risk for cardiovascular mortality (161). Likewise, a meta-analysis of 19 randomized trials in nontransgender males on testosterone replacement showed no increased incidence of cardiovascular events (185). A systematic review of the literature found that data were insufficient (due to very low–quality evidence) to allow a meaningful assessment of patient-important outcomes, such as death, stroke, myocardial infarction, or VTE in transgender males (176). Future research is needed to ascertain the potential harm of hormonal therapies (176). Clinicians should manage cardiovascular risk factors as they emerge according to established guidelines (186).

Transgender females

A prospective study of transgender females found favorable changes in lipid parameters with increased high-density lipoprotein and decreased low-density lipoprotein concentrations (178). However, increased weight, blood pressure, and markers of insulin resistance attenuated these favorable lipid changes. In a meta-analysis, only serum triglycerides were higher at ≥24 months without changes in other parameters (187). The largest cohort of transgender females (mean age 41 years, followed for a mean of 10 years) showed no increase in cardiovascular mortality despite a 32% rate of tobacco use (161).

Thus, there is limited evidence to determine whether estrogen is protective or detrimental on lipid and glucose metabolism in transgender females (176). With aging, there is usually an increase of body weight. Therefore, as with nontransgender individuals, clinicians should monitor and manage glucose and lipid metabolism and blood pressure regularly according to established guidelines (186).

4.4. We recommend that clinicians obtain BMD measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕◯◯)

Evidence

Transgender males

Baseline bone mineral measurements in transgender males are generally in the expected range for their pretreatment gender (188). However, adequate dosing of testosterone is important to maintain bone mass in transgender males (189, 190). In one study (190), serum LH levels were inversely related to BMD, suggesting that low levels of sex hormones were associated with bone loss. Thus, LH levels in the normal range may serve as an indicator of the adequacy of sex steroid administration to preserve bone mass. The protective effect of testosterone may be mediated by peripheral conversion to estradiol, both systemically and locally in the bone.

Transgender females

A baseline study of BMD reported T scores less than −2.5 in 16% of transgender females (191). In aging males, studies suggest that serum estradiol more positively correlates with BMD than does testosterone (192, 193) and is more important for peak bone mass (194). Estrogen preserves BMD in transgender females who continue on estrogen and antiandrogen therapies (188, 190, 191, 195, 196).

Fracture data in transgender males and females are not available. Transgender persons who have undergone gonadectomy may choose not to continue consistent sex steroid treatment after hormonal and surgical sex reassignment, thereby becoming at risk for bone loss. There have been no studies to determine whether clinicians should use the sex assigned at birth or affirmed gender for assessing osteoporosis (*e.g.*, when using the FRAX tool). Although some researchers use the sex assigned at birth (with the assumption that bone mass has usually peaked for transgender people who initiate hormones in early adulthood), this should be assessed on a case-by-case basis until there are more data available. This assumption will be further complicated by the increasing prevalence of transgender people who undergo hormonal transition at a pubertal age or soon after puberty. Sex for comparison within risk assessment tools may be based on the age at which hormones were initiated and the length of exposure to hormones. In some cases, it may be

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reasonable to assess risk using both the male and female calculators and using an intermediate value. Because all subjects underwent normal pubertal development, with known effects on bone size, reference values for birth sex were used for all participants (154).

4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for those designated female at birth. (2 |⊕⊕◯◯)

4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 |⊕◯◯◯)

Evidence

Studies have reported a few cases of breast cancer in transgender females (197–200). A Dutch study of 1800 transgender females followed for a mean of 15 years (range of 1 30 years) found one case of breast cancer. The Women's Health Initiative study reported that females taking conjugated equine estrogen without progesterone for 7 years did not have an increased risk of breast cancer as compared with females taking placebo (137).

In transgender males, a large retrospective study conducted at the U.S. Veterans Affairs medical health system identified seven breast cancers (194). The authors reported that this was not above the expected rate of breast cancers in cisgender females in this cohort. Furthermore, they did report one breast cancer that developed in a transgender male patient after mastectomy, supporting the fact that breast cancer can occur even after mastectomy. Indeed, there have been case reports of breast cancer developing in subareolar tissue in transgender males, which occurred after mastectomy (201, 202).

Women with primary hypogonadism (Turner syndrome) treated with estrogen replacement exhibited a significantly decreased incidence of breast cancer as compared with national standardized incidence ratios (203, 204). These studies suggest that estrogen therapy does not increase the risk of breast cancer in the short term (<20 to 30 years). We need long-term studies to determine the actual risk, as well as the role of screening mammograms. Regular examinations and gynecologic advice should determine monitoring for breast cancer.

Prostate cancer is very rare before the age of 40, especially with androgen deprivation therapy (205). Childhood or pubertal castration results in regression of the prostate and adult castration reverses benign prostate hypertrophy (206). Although van Kesteren *et al.* (207) reported that estrogen therapy does not induce hypertrophy or premalignant changes in the prostates of transgender females, studies have reported cases of benign prostatic hyperplasia in transgender females treated with estrogens for 20 to 25 years (208, 209). Studies have also reported a few cases of prostate carcinoma in transgender females (210–214).

Transgender females may feel uncomfortable scheduling regular prostate examinations. Gynecologists are not trained to screen for prostate cancer or to monitor prostate growth. Thus, it may be reasonable for transgender females who transitioned after age 20 years to have annual screening digital rectal examinations after age 50 years and prostate-specific antigen tests consistent with U.S. Preventive Services Task Force Guidelines (215).

4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

Evidence

Although aromatization of testosterone to estradiol in transgender males has been suggested as a risk factor for endometrial cancer (216), no cases have been reported. When transgender males undergo hysterectomy, the uterus is small and there is endometrial atrophy (217, 218). Studies have reported cases of ovarian cancer (219, 220). Although there is limited evidence for increased risk of reproductive tract cancers in transgender males, health care providers should determine the medical necessity of a laparoscopic total hysterectomy as part of a gender-affirming surgery to prevent reproductive tract cancer (221).

Values

Given the discomfort that transgender males experience accessing gynecologic care, our recommendation for the medical necessity of total hysterectomy and oophorectomy places a high value on eliminating the risks of female reproductive tract disease and cancer and a lower value on avoiding the risks of these surgical procedures (related to the surgery and to the potential undesirable health consequences of oophorectomy) and their associated costs.

Remarks

The sexual orientation and type of sexual practices will determine the need and types of gynecologic care required following transition. Additionally, in certain countries, the approval required to change the sex in a birth certificate for transgender males may be dependent on having a complete hysterectomy. Clinicians should help patients research nonmedical administrative criteria and

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doi: 10.1210/jc.2017-01658

provide counseling. If individuals decide not to undergo hysterectomy, screening for cervical cancer is the same as all other females.

5.0 Surgery for Sex Reassignment and Gender Confirmation

For many transgender adults, genital gender-affirming surgery may be the necessary step toward achieving their ultimate goal of living successfully in their desired gender role. The type of surgery falls into two main categories: (1) those that directly affect fertility and (2) those that do not. Those that change fertility (previously called sex reassignment surgery) include genital surgery to remove the penis and gonads in the male and removal of the uterus and gonads in the female. The surgeries that effect fertility are often governed by the legal system of the state or country in which they are performed. Other gender-conforming surgeries that do not directly affect fertility are not so tightly governed.

Gender-affirming surgical techniques have improved markedly during the past 10 years. Reconstructive genital surgery that preserves neurologic sensation is now the standard. The satisfaction rate with surgical reassignment of sex is now very high (187). Additionally, the mental health of the individual seems to be improved by participating in a treatment program that defines a pathway of gender-affirming treatment that includes hormones and surgery (130, 144) (Table 16).

Surgery that affects fertility is irreversible. The World Professional Association for Transgender Health Standards of Care (222) emphasizes that the "threshold of 18 should not be seen as an indication in itself for active intervention." If the social transition has not been satisfactory, if the person is not satisfied with or is ambivalent about the effects of sex hormone treatment, or if the person is ambivalent about surgery then the individual should not be referred for surgery (223, 224).

Gender-affirming genital surgeries for transgender females that affect fertility include gonadectomy, penectomy, and creation of a neovagina (225, 226). Surgeons often invert the skin of the penis to form the wall of the vagina, and several literatures reviews have reported on outcomes (227). Sometimes there is inadequate tissue to form a full neovagina, so clinicians have revisited using intestine and found it to be successful (87, 228, 229). Some newer vaginoplasty techniques may involve autologuous oral epithelial cells (230, 231).

The scrotum becomes the labia majora. Surgeons use reconstructive surgery to fashion the clitoris and its hood, preserving the neurovascular bundle at the tip of the penis as the neurosensory supply to the clitoris. Some surgeons are also creating a sensate pedicled-spot adding a G spot to the neovagina to increase sensation (232). Most recently, plastic surgeons have developed techniques to fashion labia minora. To further complete the feminization, uterine transplants have been proposed and even attempted (233).

Neovaginal prolapse, rectovaginal fistula, delayed healing, vaginal stenosis, and other complications do sometimes occur (234, 235). Clinicians should strongly remind the transgender person to use their dilators to maintain the depth and width of the vagina throughout the postoperative period. Genital sexual responsivity and other aspects of sexual function are usually preserved following genital gender-affirming surgery (236, 237).

Ancillary surgeries for more feminine or masculine appearance are not within the scope of this guideline. Voice therapy by a speech language pathologist is available to transform speech patterns to the affirmed gender (148). Spontaneous voice deepening occurs during testosterone treatment of transgender males (152, 238). No studies have compared the effectiveness of speech therapy, laryngeal surgery, or combined treatment.

Breast surgery is a good example of gender-confirming surgery that does not affect fertility. In all females, breast size exhibits a very broad spectrum. For transgender females to make the best informed decision, clinicians should delay breast augmentation surgery until the patient has completed at least 2 years of estrogen therapy, because the breasts continue to grow during that time (141, 155).

Another major procedure is the removal of facial and masculine-appearing body hair using either electrolysis or

Table 16. Criteria for Gender-Affirming Surgery, Which Affects Fertility

1. Persistent, well-documented gender dysphoria
2. Legal age of majority in the given country
3. Having continuously and responsibly used gender-affirming hormones for 12 mo (if there is no medical contraindication to receiving such therapy)
4. Successful continuous full-time living in the new gender role for 12 mo
5. If significant medical or mental health concerns are present, they must be well controlled
6. Demonstrable knowledge of all practical aspects of surgery (*e.g.*, cost, required lengths of hospitalizations, likely complications, postsurgical rehabilitation)

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laser treatments. Other feminizing surgeries, such as that to feminize the face, are now becoming more popular (239–241).

In transgender males, clinicians usually delay gender-affirming genital surgeries until after a few years of androgen therapy. Those surgeries that affect fertility in this group include oophorectomy, vaginectomy, and complete hysterectomy. Surgeons can safely perform them vaginally with laparoscopy. These are sometimes done in conjunction with the creation of a neopenis. The cosmetic appearance of a neopenis is now very good, but the surgery is multistage and very expensive (242, 243). Radial forearm flap seems to be the most satisfactory procedure (228, 244). Other flaps also exist (245). Surgeons can make neopenile erections possible by reinervation of the flap and subsequent contraction of the muscle, leading to stiffening of the neopenis (246, 247), but results are inconsistent (248). Surgeons can also stiffen the penis by imbedding some mechanical device (*e.g.*, a rod or some inflatable apparatus) (249, 250). Because of these limitations, the creation of a neopenis has often been less than satisfactory. Recently, penis transplants are being proposed (233).

In fact, most transgender males do not have any external genital surgery because of the lack of access, high cost, and significant potential complications. Some choose a metaoidioplasty that brings forward the clitoris, thereby allowing them to void in a standing position without wetting themselves (251, 252). Surgeons can create the scrotum from the labia majora with good cosmetic effect and can implant testicular prostheses (253).

The most important masculinizing surgery for the transgender male is mastectomy, and it does not affect fertility. Breast size only partially regresses with androgen therapy (155). In adults, discussions about mastectomy usually take place after androgen therapy has started. Because some transgender male adolescents present after significant breast development has occurred, they may also consider mastectomy 2 years after they begin androgen therapy and before age 18 years. Clinicians should individualize treatment based on the physical and mental health status of the individual. There are now newer approaches to mastectomy with better outcomes (254, 255). These often involve chest contouring (256). Mastectomy is often necessary for living comfortably in the new gender (256).

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 ⊕⊕◯◯)

5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)

5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)

5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 ⊕◯◯◯)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 ⊕⊕◯◯).

5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 ⊕◯◯◯)

Evidence

Owing to the lack of controlled studies, incomplete follow-up, and lack of valid assessment measures, evaluating various surgical approaches and techniques is difficult. However, one systematic review including a large numbers of studies reported satisfactory cosmetic and functional results for vaginoplasty/neovagina construction (257). For transgender males, the outcomes are less certain. However, the problems are now better understood (258). Several postoperative studies report significant long-term psychological and psychiatric pathology (259–261). One study showed satisfaction with breasts, genitals, and femininity increased significantly and showed the importance of surgical treatment as a key therapeutic option for transgender females (262). Another analysis demonstrated that, despite the young average age at death following surgery and the relatively larger number of individuals with somatic morbidity, the study does not allow for determination of

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doi: 10.1210/jc.2017-01658

causal relationships between, for example, specific types of hormonal or surgical treatment received and somatic morbidity and mortality (263). Reversal surgery in regretful male-to-female transsexuals after sexual reassignment surgery represents a complex, multistage procedure with satisfactory outcomes. Further insight into the characteristics of persons who regret their decision postoperatively would facilitate better future selection of applicants eligible for sexual reassignment surgery. We need more studies with appropriate controls that examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine the long-term benefits of surgical treatment.

When a transgender individual decides to have gender-affirming surgery, both the hormone prescribing clinician and the MHP must certify that the patient satisfies criteria for gender-affirming surgery (Table 16).

There is some concern that estrogen therapy may cause an increased risk for venous thrombosis during or following surgery (176). For this reason, the surgeon and the hormone-prescribing clinician should collaborate in making a decision about the use of hormones before and following surgery. One study suggests that preoperative factors (such as compliance) are less important for patient satisfaction than are the physical postoperative results (56). However, other studies and clinical experience dictate that individuals who do not follow medical instructions and do not work with their physicians toward a common goal do not achieve treatment goals (264) and experience higher rates of postoperative infections and other complications (265, 266). It is also important that the person requesting surgery feels comfortable with the anatomical changes that have occurred during hormone therapy. Dissatisfaction with social and physical outcomes during the hormone transition may be a contraindication to surgery (223).

An endocrinologist or experienced medical provider should monitor transgender individuals after surgery. Those who undergo gonadectomy will require hormone replacement therapy, surveillance, or both to prevent adverse effects of chronic hormone deficiency.

Financial Disclosures of the Task Force*

Wylie C. Hembree (chair)—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Peggy T. Cohen-Kettenis**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Louis Gooren**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Sabine E. Hannema**—financial or business/organizational interests: none declared, significant financial interest or leadership position: Ferring Pharmaceuticals Inc. (lecture/conference), Pfizer (lecture). **Walter J. Meyer**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **M. Hassan Murad****—financial or business/organizational interests: Mayo Clinic, Evidence-based Practice Center, significant financial interest or leadership position: none declared. **Stephen M. Rosenthal**—financial or business/organizational interests: AbbVie (consultant), National Institutes of Health (grantee), significant financial interest or leadership position: Pediatric Endocrine Society (immediate past president). **Joshua D. Safer, FACP**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Vin Tangpricha**—financial or business/organizational interests: Cystic Fibrosis Foundation (grantee), National Institutes of Health (grantee), significant financial interest or leadership position, Elsevier *Journal of Clinical and Translational Endocrinology* (editor). **Guy G. T'Sjoen**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared.* Financial, business, and organizational disclosures of the task force cover the year prior to publication. Disclosures prior to this time period are archived.**Evidence-based reviews for this guideline were prepared under contract with the Endocrine Society.

Acknowledgments

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Disclosure Summary: See Financial Disclosures.

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EXHIBIT D-48

ENDOCRINE SOCIETY
Hormone Science to Health

August 13, 2019

Mr. Roger Severino
Director, Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Re: Nondiscrimination in Health and Health Education Programs and Activities (Section 1557 NPRM), RIN 0945-AA11

Dear Mr. Severino:

On behalf of the Endocrine Society, we appreciate the opportunity to provide comments on the proposed revisions to the non-discrimination provisions set forth in Section 1557 of the Affordable Care Act (ACA). Founded in 1916, the Endocrine Society represents approximately 18,000 physicians and scientists engaged in the treatment and research of endocrine disorders, such as diabetes, hypertension, infertility, obesity, osteoporosis, and thyroid disease. In 2013, the American Psychiatric Association removed "Gender Identity Disorder" to underscore the concept that a transgender identity, in and of itself, was no longer considered to be pathological. Many of our members care for transgender individuals, providing expert care across the range of transgender medical interventions including hormone therapy and surgeries. As established in our position statement on transgender health[1], we strongly support access to the full spectrum of medical care for transgender individuals and urge the Office for Civil Rights (OCR) to withdraw this proposed rule.

The proposed rule is focused on, among other things, the 2016 implementing regulation for Section 1557 of the ACA that defined "on the basis of sex" to include discrimination based on pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity. The rule proposes to eliminate specific nondiscrimination protections based on sex and gender identity. **We oppose the proposed rule.** If finalized, this rule will threaten women and transgender individuals' access to care and health insurance, create confusion among providers and patients about their rights and obligations, and promote discrimination against vulnerable populations that already struggle to access health care.

[1] Endocrine Society. Transgender Health. September 2017 *https://www.endocrine.org/advocacy/priorities-and-positions/transgender-health*

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Impact on access to care

Even with existing protections for transgender individuals that are meant to shield them from discrimination in the health care system, access to appropriately trained healthcare professionals can be challenging. There is a lack of formal education on gender dysphoria/gender incongruence among clinicians trained in the United States, making it difficult to find physicians with expertise in the transition process. Furthermore, they face barriers in accessing standard preventive services for their sex assigned at birth (i.e., prostate cancer screening for a transgender woman) from physicians who have had minimal experience caring for transgender individuals.

Removing these nondiscrimination protections will make it easier for providers to deny care to transgender individuals for any health care service, not just those related to their gender transition, and will discourage transgender individuals from seeking care or reporting when they have been a victim of discrimination. Furthermore, covered entities will no longer be required to treat a patient consistent with their gender identity and the rule will allow differential coverage or cost-sharing for services that are associated with their gender assigned at birth (denying medical treatment for ovarian cancer in a transgender male).

Studies have indicated that 70% of transgender individuals have experienced maltreatment by medical providers, including harassment and violence.[2] Transgender individuals who have been denied care show an increased likelihood of committing suicide and self-harm.[3] Making it harder to access health care services could further impact the health disparities and mental health issues that are experienced by transgender individuals. It is critical that transgender individuals can access appropriate treatment and care to ensure their health and well-being without the fear of discrimination or harassment.

Impact on insurance coverage and benefit design

The proposed rule interprets a covered entity much more narrowly than the 2016 implementing rule. Under current regulation, Section 1557 applies to all health programs and activities that receive federal financial assistance through the Department of Health and Human Services (HHS). As a result, all health plans offered by an insurer that participates in the Marketplace are subject to section 1557. This proposed rule will apply Section 1557 to only the specific program or activity that is principally engaged in providing health care and receives federal funding. This means that an insurance provider that is not principally engaged in providing health care will only have to apply Section 1557 regulations to its Marketplace plans (which receive federal funding). Furthermore, the proposed rule also eliminates the entire regulation that prohibits discrimination in insurance issuance, coverage, cost-sharing, marketing and benefit design.

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[2] Davidge-Pitts, C., et al. Transgender Health in Endocrinology: Current Status of Endocrinology Fellowship Program and Practicing Clinicians. *J Clin Endocrinol Metab*. (2017) 102(4):1286-1290.

[3] *ibid.*

Treatment for gender dysphoria/gender incongruence is considered elective by insurance companies, and many plans fail to provide coverage for physician-prescribed treatment. The 2016 implementing regulation changed that by prohibiting health insurance companies from discriminating through marketing practices or benefit design. As a result, insurers may not categorically exclude health care services related to gender transition or subject a policyholder to additional benefit limitations because they are transgender. A study looked at the response of insurers in the state individual markets and found that many insurers now include affirmative coverage language for transition-related services as a result of the 2016 Section 1557 implementing rule. By eliminating protections based on gender identity and limiting the scope of covered entities, this proposed rule will once again allow health insurers to use discriminatory benefit design, potentially resulting in more insurers reverting back to plans that do not provide coverage for transition-related care that is based on evidence-based standards of care.

Eliminating these protections from health insurance issuance, coverage, cost-sharing, marketing and benefit design will also allow plans to selectively cover services for a man and not a woman, place all or most medications for treatment of a specific disease on the plan's highest cost formulary tier, or applying age limits to treatment that has been proven to be effective at all ages. While this proposed rule will not impact essential health benefits, it will once again allow insurance providers to discriminate against someone solely because of their age, sexual orientation, gender and/or gender identity.

Expanded religious exemptions

The proposed rule applies Title IX's religious exemption to Section 1557's prohibition on sex discrimination. If implemented, this could allow religiously-affiliated hospitals and other health care entities to discriminate against patients based on sex, disproportionately harming transgender people and people seeking reproductive health services. This could impact a broad range of health care services, including birth control, sterilization, certain fertility treatments, abortion, gender-affirming care, and end of life care.

In our comments on the Statutory Conscience Rights in Health Care proposed rule (March 2018), we expressed concern that the expanded religious exemption would impact the right of every person to access comprehensive care that is affordable and easily accessible. As mentioned above, transgender individuals already face challenges finding physicians who have the experience to care for transgender individuals. Furthermore, there are residents of many rural and underserved communities that may have access to only one health care provider. According to a 2018 study of transgender individuals, 31 percent said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 30 percent said it would be

very difficult or not possible to find the same type of service at a different clinic.[4] We are concerned that this proposed rule would make it even more difficult to access transition-related care, obtain contraception or other reproductive planning, or treat a medical condition, and may result in the individual forgoing necessary health care, ultimately at a higher cost to both the individual and the healthcare system.

Nondiscrimination protections like the ones in Section 1557 do not prevent health care providers from using their medical judgement in the care of transgender individuals or women, they simply guarantee that these patients can access the same care provided to other patients, no matter who they are. The protections are fundamental for these vulnerable populations to be able to access the care that they need.

Thank you for considering our comments. We strongly believe that transgender individuals and women should have affordable access to the full continuum of care without the fear of discrimination and urge you not to finalize this rule. If we can be of further assistance, please contact Stephanie Kutler, Director, Advocacy & Policy, at skutler@endocrine.org.

Sincerely,

E. Dale Abel, MB.BS., D.Phil. (M.D., Ph.D.)
President, Endocrine Society

[4] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018) https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

EXHIBIT D-49

August 9, 2019

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Section 1557 NPRM, RIN 0945-AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically

Re: Comment on Proposed Rule Regarding Section 1557, Health Care Rights Law

The American Civil Liberties Union of South Carolina (ACLU of SC) submits these comments on the proposed rule published at 84 Fed. Reg. 27,846 (June 14, 2019), RIN 0945-AA11, with the title "Nondiscrimination in Health and Health Education Programs or Activities" (the "Proposed Rule").

The ACLU of SC was established over 50 years ago as the Palmetto State's premier civil liberties and civil rights organization. Our membership totals 8,000 South Carolinians, many of whom have experienced marginalization due to gender identity, sexual orientation, limited English proficiency, and reproductive healthcare history. A state affiliate of the national ACLU, our mission is to defend the rights defined in the U.S. Constitution for all Americans. We do so by working in the courts and legislatures, and in partnership with organizations and volunteers across the country.

The rule currently in place implementing Section 1557, titled "Nondiscrimination in Health Programs and Activities" (the "Current Rule"), was developed after years of review and consideration of comments from a variety of stakeholders. The Current Rule meets a critical need and fulfills Congress's intent to provide "equal access to health services and health insurance that all individuals should have, regardless of their race, color, national origin, age, or disability." 81 Fed. Reg. 31,459. Discrimination in the health care context leads to lasting harms to people's health and wellbeing, and the Department made detailed factual findings to that effect in support of the Current Rule: People subject to discrimination postpone or fail to obtain health services and are denied necessary care; such discrimination exacerbates health disparities in underserved communities.

The Proposed Rule, however, is yet another attempt by the Trump Administration and the Department of Health and Human Services (the "Department" or "HHS") to undermine access to health care for the most vulnerable individuals and communities, while emboldening discriminatory and dangerous denials of care. The Proposed Rule's explicit reductions in the scope of antidiscrimination protections, as well as the implicit invitation for health care providers to undermine access to care, completely disregard the potential harms to individuals trying to access health care and coverage. This approach is contrary to the statutory language of Section 1557, and is a reversal of the reasoned policy decisions of the Current Rule. Further, it will fail

to accomplish its stated goal to *decrease* confusion, instead *increasing* the burdens and costs of compliance.

For these reasons, as well as the ones that follow, the ACLU of SC recommends that the Department decline to finalize the Proposed Rule in its entirety.

I. THE PROPOSED RULE SHOULD NOT ROLL BACK AFFIRMATIVE ANTIDISCRIMINATION PROTECTIONS.

In a 2018 survey with 1,436 LGBTQ+ respondents from South Carolina, more than half reported delaying medical care. Among respondents whose identity is not cisgender, only 45% reported their doctors using their correct pronouns.

One focus group respondent whose wife is transgender shared the following story:

> "So, my wife was medically discharged from the military for Leukemia. She had to work with medical professionals because by the time they caught it, she had to go through chemo and everything. It wasn't the oncology that was the problem. It was that when we didn't realize when she was going through chemo, she couldn't eat salad because of low immunity. We went to an all you can eat soup and salad after chemo, and we went home, and she had a 105-degree fever. She started hallucinating so we went to the ER. It was the ER that was the problem. They didn't want to work with her because she was a trans woman. They were misgendering her. None of the nurses wanted to help her. After many nurses coming in and treating her with disrespect, they sent in the one lesbian nurse on staff to work with her, and she was the only nurse who would tend to my wife. My wife was at the point where she told them that if they didn't stop misgendering her, she would pull the iv out and leave. She would rather die than be treated with disrespect."

Another participant who is transgender added:

> "I went out of state for my top surgery. Finding a local doctor that is going to give you post-operative care unless you arrange that ahead of time - you're going to have to go to the ER and good luck. When you're paying all that money to do those surgeries, it's like - just insane. Gender confirmation is not simple, but top surgery should be simple. I went to Charlotte [NC] when I had problems. I was septic."

In 2018, the Human Rights Campaign classified South Carolina as having zero healthcare providers that could be considered a "Leader in LGBTQ Healthcare Equality," based on indicators of providers' quality of non-discrimination and staff training, patient services and support, employee benefits and policies, patient and community engagement, and responsible citizenship. The proposed rule will expand healthcare providers' ability to discriminate against individuals based on gender identity in a state that already fails to proactively serve individuals who are transgender and non-binary.

Additionally, South Carolina has a long history of racial discrimination in healthcare, particularly against women of color. It is for this reason that the maternal mortality rate for

women of color in South Carolina is 3.4 times higher than that of their white counterparts. By emboldening healthcare providers' right to refuse services to individuals based on their reproductive health history and/or specific healthcare needs, the proposed rule will exacerbate negative outcomes for South Carolina's women of color whose experience with the healthcare system is already disparate and, at times, life-threatening.

A. HHS Should Maintain the Existing Definition of Discrimination on the Basis of Sex and Protections Against Such Discrimination.

In promulgating the Current Rule, the Department recognized the importance of affirmative regulatory protections—specifically for all enumerated forms of sex discrimination. The Current Rule defines discrimination based on sex to include discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity. 45 CFR 92.4. The Proposed Rule eliminates this key provision that clarifies what discrimination on the basis of sex encompasses and removes explanatory examples of prohibited activity. The Proposed Rule also amends regulations—and incorporates an abortion exemption—that are unrelated to Section 1557. These changes are without justification and will directly harm patients seeking care.

1. The proposed amendments abandon LGBT individuals and people seeking reproductive health care, who depend on HHS to protect their statutory rights.

Section 1557 and the Current Rule are intended to protect people from the pervasive problem of sex-based discrimination in the health care context. Lesbian, gay, bisexual, and transgender ("LGBT") patients, as well as people who seek or have obtained reproductive health services, face discrimination based on sex in accessing health care. This discrimination can range from providers using harassing or abusive language to completely refusing necessary medical care. Sex-based exclusions from health care coverage can also make essential medical care unaffordable. For example, some transgender and non-binary individuals are subject to discriminatory categorical exclusions for health care related to gender transition that put necessary health care out of financial reach. By eliminating the definition of discrimination on the basis of sex, as well as stripping protections against discrimination based on gender identity and sexual orientation from other unrelated HHS regulations, the Proposed Rule will invite such discrimination against LGBT individuals and people seeking reproductive health care.

The Department fails to even consider the impact that the Proposed Rule would have on individuals who are protected under the Current Rule. A low estimate of the scope of impact in South Carolina is the estimated 21,000 individuals who are transgender. A recent study at the College of Charleston found that nearly 20% of respondents identify as LGBTQ+. When combined with other data which indicate that the percentage of individuals who identify as LGBTQ+ increases with each generation, there is reason to believe that the current scope of impact will grow significantly over time. The Department must prioritize the impact that inviting discrimination against patients will have on public health, particularly the harms to transgender and non-binary individuals, as well as people who need or have obtained pregnancy-related health services, all of whom would no longer have explicit regulatory protections against sex discrimination if the Proposed Rule is finalized.

2. The proposed amendments do not provide clarity, but only create more confusion.

The Department contends that the Proposed Rule is needed to reduce confusion and to clarify the scope of Section 1557. But should the Department delete the definitional provisions, it would actually *cause* confusion and embolden health care and insurance providers to discriminate. The Department's proposal does nothing to clarify what constitutes prohibited sex discrimination under Section 1557, as eliminating the definition does not mean that discrimination on the presently enumerated bases is suddenly permitted. Instead, eliminating the definition invites discrimination and undermines uniformity among providers—to the detriment of covered entities and patients alike.

Because discrimination based on sex would still be prohibited, discrimination based on gender identity would remain unlawful under Section 1557 as well. Courts have consistently held that Title IX's prohibition on sex discrimination protects individuals from discrimination based on gender nonconformity. *See EEOC v. R.G. &. G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 572 (6th Cir. 2018), *cert. granted in part*, 139 S. Ct. 1599 (2019); *Whitaker ex rel. Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1046–54 (7th Cir. 2017); *Glenn v. Brumby*, 663 F.3d 1312, 1316 (11th Cir. 2011); *Schwenk v. Hartford*, 204 F.3d 1187, 1201 (9th Cir. 2000); *Rosa v. Park W. Bank & Tr. Co.*, 214 F.3d 213, 215–16 (1st Cir. 2000). District courts across the country have also recognized that discrimination against transgender individuals because their gender identity diverges from their sex assigned at birth violates the plain text of Section 1557. *See Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 953 (D. Minn. 2018); *Flack v. Wis. Dep't of Health Servs*., 328 F. Supp. 3d 931, 951 (W.D. Wis. 2018); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1098–1100 (S.D. Cal. 2017). Given the extensive legal precedent, the Department cannot simply assert by regulation that covered entities will not be liable for gender identity discrimination claims where such discrimination is prohibited by the statutory text.

Further, while the preamble to the Proposed Rule spends an inordinate amount of time attempting to justify the elimination of gender identity as an identified form of sex discrimination, it does not explain why the other definitional provisions are eliminated as well. Removing the definition of sex discrimination cannot change the underlying legal precedent that the current definition was based on and that still prohibits discrimination on the enumerated bases, including discrimination based on sex stereotyping, pregnancy discrimination, and pregnancy-related conditions. To the extent there is variance among federal courts as to what constitutes discrimination based on sex, the Current Rule provides crucial uniformity.

3. *HHS should not import an abortion exemption into its definition of sex discrimination.*

The Proposed Rule would unnecessarily incorporate the abortion exemption from Title IX into regulations implementing Section 1557. Incorporating the abortion exemption violates the text and purpose of Section 1557, which prohibits discrimination "on the *ground[s]* prohibited under" the referenced civil rights statutes, not the attendant exemptions contained in those statutes. 42 U.S.C. § 18116 (emphasis added). Congress has already spoken clearly as to

the restrictions it intended to place on abortion care and coverage, through both the ACA itself, *see* 42 U.S.C. § 18023(b)(1)(A), (b)(4), as well as the Weldon, Church, and Coats Amendments. Abortion care is health care related to pregnancy and targeting it for exclusion undermines and stigmatizes access to care that is a constitutionally protected right.

* * *

Taken as a whole, the Proposed Rule strips explicit regulatory protections for LGBT individuals and for people who require reproductive health care, indicating that the underlying purpose for the amendments is to target transgender and non-binary individuals, as well as other people who face sex-based discrimination in accessing health care and insurance coverage. That is neither consistent with the text of the statute, nor the appropriate mission of the Department. The Proposed Rule is also untimely, as the U.S. Supreme Court granted petitions for review in three cases addressing whether sex discrimination encompasses discrimination based on sexual orientation, gender identity, and discrimination against transgender individuals due to sex stereotyping under Title VII. *Altitude Exp., Inc. v. Zarda*, 139 S. Ct. 1599 (2019); *Bostock v. Clayton Cty., Ga.*, 139 S. Ct. 1599 (2019); *R.G. & G.R. Harris Funeral Homes, Inc. v. EEOC*, 139 S. Ct. 1599 (2019). Because Title IX generally adopts the standards for discrimination under Title VII, the Department will need to address the practical implications of any decision by the Court through a renewed comment process. Accordingly, the Department should abandon the Proposed Rule and instead leave in place the existing rule that discrimination based on gender identity is a form of sex discrimination, as is discrimination based on pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, and sex stereotyping.

B. HHS Should Not Weaken Protections for People with Disabilities.

Historically, people with disabilities in the United States have been unable to access the health care they need because of discrimination by the health insurance industry. Prior to the ACA, people with disabilities were commonly denied or terminated from health coverage, faced annual and lifetime benefit limits, and could not find affordable coverage. Access to adequate health care at affordable rates is central to the ability of disabled people to participate fully in society.

The Department proposes to eliminate Section 92.207 of the Current Rule in its entirety, which would undermine the right of people with disabilities to challenge discriminatory benefit design. Under the Current Rule, for example, plans that cover bariatric surgery in adults but exclude such coverage for adults with particular developmental disabilities, place most or all drugs that treat a specific condition on the highest cost tiers, or exclude bone marrow transplants regardless of medical necessity, constitute disability discrimination in violation of Section 1577. The Department claims that the provision is redundant or may be confusing in relation to the Department's preexisting regulations. But the Current Rule is needed precisely because existing laws were insufficient to dismantle barriers to adequate health insurance for people with disabilities. The deletion thus contravenes Section 1557's plain language.

The application of antidiscrimination principles to health insurers and to benefit design is essential to the needs and rights of disabled people. The Proposed Rule does not apply those principles and should not be adopted.

C. HHS should not weaken protections for individuals with Limited English Proficiency.

The Department should not eliminate the language access protections as described by the Proposed Rule. In South Carolina, there are between 100,000 and 200,000 people with limited English proficiency ("LEP"), and they should all have meaningful access to health care and coverage. Language assistance is necessary to ensure that LEP persons are guaranteed such access and is a critical protection to combat discrimination on the basis of national origin, which encompasses discrimination on the basis of language.

The Proposed Rule would eliminate significant protections for LEP persons by removing the requirement that covered entities provide notices of legal rights and in-language taglines on significant publications. The taglines are cost-effective ways to maintain access for LEP individuals without translating entire documents. The Department ignores the impact on LEP individuals should this requirement be eliminated, relying solely on reports from health plans, with no public outreach to determine the impact of the taglines or to explore alternatives. Likewise, the Department should not eliminate references to language access plans, which are a useful tool for covered entities to fully plan how to meet the needs of LEP patients and consumers. Such plans also support covered entities' own compliance efforts, benefiting both LEP individuals and covered entities alike.

LEP individuals face unique risks and barriers to knowing and asserting their rights in the health care context. The proposed elimination of protections to aid communication with LEP individuals—both while they are accessing services and so that they know their rights—should be abandoned.

II. THE DEPARTMENT SHOULD NOT LIMIT THE BROAD IMPACT OF SECTION 1557.

The Proposed Rule includes several provisions that would so limit Section 1557's application as to render its protections a nullity for the very people Congress sought to protect. The proposal inappropriately limits the statute's reach in several respects and, as such, the Department should decline to finalize the Proposed Rule, leaving in place the Current Rule.

A. HHS Should Not Import a Religious Exemption into Section 1557.

The Proposed Rule wrongly would allow religiously affiliated healthcare providers to discriminate based on sex and to refuse access to necessary medical care, by importing Title IX's expansive religious exemptions into Section 1557. Religiously affiliated healthcare providers make up a significant percentage of the healthcare facilities in the United States. One in six patients is now treated in a Catholic facility each year, and religious hospitals are also increasingly the *only* health care option in many regions. In South Carolina, there are large

religiously affiliated hospitals in each primary region of the state, with beds totaling in the thousands.

The proposed religious exemption violates the text and purpose of Section 1557, as well as the constitutional commitment to the separation of church and state. The statute prohibits discrimination "on the *ground[s]* prohibited under" the referenced civil rights statutes, 42 U.S.C. § 18116 (emphasis added), but does not incorporate the attendant exemptions contained in those statutes—many of which are wholly inapposite to the health care context. The Department should not reverse course by incorporating the exemption, having initially rejected invitations to do so. Further, the First Amendment forbids government action favoring religion to the point of forcing third parties to bear the costs of those beliefs. *See Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 708–10 (1985). The Proposed Rule's exemption flies in the face of the careful balance courts have struck between civil rights and religious liberty, running afoul of the Establishment Clause.

Permitting a blanket religious exemption to Section 1557's nondiscrimination mandate threatens access to critical care for countless patients, especially transgender patients and patients seeking reproductive health services. The Proposed Rule altogether fails to consider the harmful consequences of importing a broad religious exemption into the health care context.

B. HHS Should Not Narrow the Scope of Covered Entities.

The Proposed Rule would further undercut Section 1557 by limiting the entities covered by the provision. Limiting the application of Section 1557's protections would sanction discriminatory denials of coverage by entities that are presently covered by Section 1557, causing confusion and serious harm to those unable to access care. Additionally, the Proposed Rule displays no awareness of the potential harm to individuals denied coverage of and access to health care due to the proposed limitations on Section 1557's application.

Excluding health insurance from Section 1557's nondiscrimination mandate as distinct from "health program or activity" is contrary to the text of the statute and the broader antidiscrimination purpose of the law. The false distinction is exacerbated by the Proposed Rule's new limitation on the application of Section 1557 in cases where the entity is not "principally engaged in the provision of health care." In such cases, under the proposal, Section 1557 would apply only to the specific operations of an entity that receive federal financial assistance—whereas Section 1557 covers *all* operations of entities principally engaged in health care that receive federal financial assistance. This distinction, too, is contrary to the text of the statute, which prohibits discrimination under "any health program or activity, *any part of which* is receiving Federal financial assistance." 42 U.S.C. § 18116 (emphasis added).

C. HHS Should Maintain Existing Remedies Available for Section 1557 Claims.

The Current Rule adopts a uniform standard, applicable to all grounds covered by Section 1557, and incorporates enforcement mechanisms that exist under any of the civil rights laws referenced by Section 1557. This includes a private right of action for disparate-impact claims and the availability of compensatory damages for all claims under Section 1557. In removing

these provisions, the proposed rule creates a scheme in which people are denied certain legal remedies because of the type of discrimination they experience. Such a change also privileges purported business interests in relieving regulatory burdens over the interests of the public and of individuals seeking health care. However, by removing the certainty of the Current Rule, covered entities and protected individuals alike would be uncertain as to the law's requirements and protections, instead leaving them to look to four other separate civil rights laws and various agencies' implementing regulations for clues.

The Proposed Rule's silence regarding the availability of a private right of action is at worst contrary to the rights-expanding aims of the statute and, at best, purposeless. Parties asserting private rights of action pursuant to Section 1557 have significantly expanded access to health care and combatted discriminatory health care policies, and will continue to do so, regardless of regulatory language explicitly affirming that such a right exists.

The Department should also not eliminate the Current Rule's provision for disparate-impact claims, which promotes better compliance with Section 1557's nondiscrimination provisions. The disparate-impact mechanism encourages health care providers to identify disparities and to adopt solutions that make a crucial difference in eliminating those disparities for individuals and improving public health.

These enforcement mechanisms are particularly important for people of color. Addressing racial disparities in health care is a matter of life and death. Such disparities are found across a range of illnesses and health care services, even when accounting for socioeconomic factors. Disparities in health care also have historic roots. As in other sectors of society, segregated health care was once sanctioned by law, and government-sanctioned discrimination continues to have a systemic impact on access to quality health care. At the same time, research suggests that many racial and ethnic health disparities could be reduced or even eliminated if identified and addressed. A disparate-impact private right of action is a crucial enforcement mechanism to confront and redress discrimination.

The Department's proposal would instead make enforcement more difficult and would increase confusion as to the scope of Section 1557's protections. The Department should accordingly continue to affirm existing enforcement mechanisms, including the private right of action for disparate-impact claims.

D. The Department Should Not Eliminate Grievance Procedures and Notice Requirements.

The Proposed Rule would unnecessarily eliminate the specific grievance procedures established under Section 1557, which would leave covered entities and impacted individuals without cohesive, uniform procedures for investigating grievances. Further, the Department should not eliminate the explicit requirement that such procedures "incorporate appropriate due process standards," which provides that the procedures in place are sufficient to address claims of discrimination promptly and equitably. 45 CFR 92.7. Likewise, the Department should not eliminate the requirement that covered entities provide notice to the public that they do not discriminate, as the current procedure is crucial to ensure that individuals are aware of the

safeguards in place and of the steps they can take to effectuate the protections under Section 1557. 45 CFR 92.8. The costs associated with the notice requirement are well worth the benefit of ensuring that protected individuals receive adequate notice of their rights.

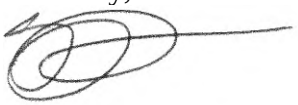
III. THE PROPOSED RULE VIOLATES SECTION 1554 OF THE ACA.

The Proposed Rule is additionally contrary to law because it violates another provision of the ACA: Section 1554. This provision limits the Department's rulemaking authority, prohibiting HHS from promulgating regulations that create any unreasonable barriers to the ability of individuals to obtain appropriate medical care, impede timely access to health care services, violate the ethical standards of health care professionals, or limit the availability of health care treatment for the full duration of a patient's medical needs—among other restrictions. 42 U.S.C. § 18114. For all the reasons outlined in this comment, the Proposed Rule represents a direct violation of Congress's command and should be entirely abandoned.

* * *

For all these reasons, the Department should withdraw the Proposed Rule.

Sincerely,



Susan K. Dunn
Legal Director
ACLU of South Carolina

EXHIBIT D-50

August 12, 2019

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Section 1557 NPRM, RIN 0945-AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically

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Re: Comment on Proposed Rule Regarding Section 1557, Health Care Rights Law

The ACLU of Nebraska submits these comments on the proposed rule published at 84 Fed. Reg. 27,846 (June 14, 2019), RIN 0945-AA11, with the title "Nondiscrimination in Health and Health Education Programs or Activities" (the "Proposed Rule").

Founded in 1966, The ACLU of Nebraska has seven full-time staff and a contract lobbyist, more than 5,000 donors across the state, more than 50 volunteer attorneys, and more than 20,000 online advocates. The ACLU of Nebraska has a long history of fighting for the rights of LGBTQ+ Nebraskans. For example, in 2017, the ACLU of Nebraska won *Stewart v. Heineman,* a unanimous, robust decision at the state supreme court ending the ban on gay and lesbian foster parents. In 2015, we settled a successful employment discrimination case for an employee fired after marrying his partner. Additionally, we have led successful legislative efforts over many years on issues such as ensuring hate crime enhancements for crimes against LGBTQ+ individuals, codifying anti-bullying protections, and stopping a license to discriminate attempt sought by child welfare agencies in 2016.We are presently representing intervenors in federal litigation to protect the rights of transgender Nebraskans under the Affordable Care Act and have successfully secured affirming medical care for incarcerated transgender Nebraskans.

The rule currently in place implementing Section 1557, titled "Nondiscrimination in Health Programs and Activities" (the "Current Rule"), was developed after years of review and consideration of comments from a variety of stakeholders. The Current Rule meets a critical need and fulfills Congress's intent to provide "equal access to health services and health insurance that all individuals should have, regardless of their race, color, national origin, age, or disability." 81 Fed. Reg. 31,459. Discrimination in the health care context leads to lasting harms to people's health and wellbeing, and the Department made

detailed factual findings to that effect in support of the Current Rule: People subject to discrimination postpone or fail to obtain health services and are denied necessary care; such discrimination exacerbates health disparities in underserved communities.

The Proposed Rule, however, is yet another attempt by the Trump Administration and the Department of Health and Human Services (the "Department" or "HHS") to undermine access to health care for the most vulnerable individuals and communities, while emboldening discriminatory and dangerous denials of care. The Proposed Rule's explicit reductions in the scope of antidiscrimination protections, as well as the implicit invitation for health care providers to undermine access to care, completely disregard the potential harms to individuals trying to access health care and coverage. This approach is contrary to the statutory language of Section 1557, and is a reversal of the reasoned policy decisions of the Current Rule. Further, it will fail to accomplish its stated goal to *decrease* confusion, instead *increasing* the burdens and costs of compliance.

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For these reasons, as well as the ones that follow, the ACLU of Nebraska recommends that the Department decline to finalize the Proposed Rule in its entirety.

I. THE PROPOSED RULE SHOULD NOT ROLL BACK AFFIRMATIVE ANTIDISCRIMINATION PROTECTIONS.

The ACLU of Nebraska has heard from people across the state who have experienced discrimination in accessing health care. For example, we recently heard about the experience of a young transgender man who was having difficulty accessing services from an endocrinologist based on his insurance company's policy to exclude gender-affirming services from coverage. We have also heard about the experiences of a transgender woman who was repeatedly subjected to harassment and name-calling when she was getting dialysis treatments.

A. HHS Should Maintain the Existing Definition of Discrimination on the Basis of Sex and Protections Against Such Discrimination.

In promulgating the Current Rule, the Department recognized the importance of affirmative regulatory protections—specifically for all enumerated forms of sex discrimination. The Current Rule defines discrimination based on sex to include discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity. 45 CFR 92.4. The Proposed Rule eliminates this key provision that clarifies what discrimination on the basis of sex encompasses, and removes explanatory examples of prohibited activity. The Proposed Rule also amends regulations—and incorporates an abortion

exemption—that are unrelated to Section 1557. These changes are without justification and will directly harm patients seeking care.

1. *The proposed amendments abandon LGBT individuals and people seeking reproductive health care, who depend on HHS to protect their statutory rights.*

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Section 1557 and the Current Rule are intended to protect people from the pervasive problem of sex-based discrimination in the health care context. Lesbian, gay, bisexual, and transgender ("LGBT") patients, as well as people who seek or have obtained reproductive health services, face discrimination based on sex in accessing health care. This discrimination can range from providers using harassing or abusive language to completely refusing necessary medical care. Sex-based exclusions from health care coverage can also make essential medical care unaffordable. For example, some transgender and non-binary individuals are subject to discriminatory categorical exclusions for health care related to gender transition that put necessary health care out of financial reach. By eliminating the definition of discrimination on the basis of sex, as well as stripping protections against discrimination based on gender identity and sexual orientation from other unrelated HHS regulations, the Proposed Rule will invite such discrimination against LGBT individuals and people seeking reproductive health care.

The Department fails to even consider the impact that the Proposed Rule would have on individuals who are protected under the Current Rule. It is estimated that approximately 55,192 Nebraskans identify as LGBT[1] with 5,400 Nebraskans identifying as transgender.[2] The Department must prioritize the impact that inviting discrimination against patients will have on public health, particularly the harms to transgender and non-binary individuals, as well as people who need or have obtained pregnancy-related health services, all of whom would no longer have explicit regulatory protections against sex discrimination if the Proposed Rule is finalized.

2. *The proposed amendments do not provide clarity, but only create more confusion.*

The Department contends that the Proposed Rule is needed to reduce confusion and to clarify the scope of Section 1557. But should the Department delete the definitional provisions, it would actually *cause* confusion and embolden

[1] *Nebraska's Equality Profile,* MOVEMENT ADVANCEMENT PROJECT, https://www.lgbtmap.org/equality_maps/profile_state/NE (last visited Aug. 9, 2019).
[2] Flores et. al, *How Many Adults Identify as Transgender in the United States?*, THE WILLIAMS INSTITUTE (June 2016), *available at*, https://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf.

health care and insurance providers to discriminate. The Department's proposal does nothing to clarify what constitutes prohibited sex discrimination under Section 1557, as eliminating the definition does not mean that discrimination on the presently enumerated bases is suddenly permitted. Instead, eliminating the definition invites discrimination and undermines uniformity among providers—to the detriment of covered entities and patients alike.

Because discrimination based on sex would still be prohibited, discrimination based gender identity would remain unlawful under Section 1557 as well. Courts have consistently held that Title IX's prohibition on sex discrimination protects individuals from discrimination based on gender nonconformity. *See EEOC v. R.G. &. G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 572 (6th Cir. 2018), *cert. granted in part*, 139 S. Ct. 1599 (2019); *Whitaker ex rel. Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1046–54 (7th Cir. 2017); *Glenn v. Brumby*, 663 F.3d 1312, 1316 (11th Cir. 2011); *Schwenk v. Hartford*, 204 F.3d 1187, 1201 (9th Cir. 2000); *Rosa v. Park W. Bank & Tr. Co.*, 214 F.3d 213, 215–16 (1st Cir. 2000). District courts across the country have also recognized that discrimination against transgender individuals because their gender identity diverges from their sex assigned at birth violates the plain text of Section 1557. *See Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 953 (D. Minn. 2018); *Flack v. Wis. Dep't of Health Servs*., 328 F. Supp. 3d 931, 951 (W.D. Wis. 2018); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1098–1100 (S.D. Cal. 2017). Given the extensive legal precedent, the Department cannot simply assert by regulation that covered entities will not be liable for gender identity discrimination claims where such discrimination is prohibited by the statutory text.

Further, while the preamble to the Proposed Rule spends an inordinate amount of time attempting to justify the elimination of gender identity as an identified form of sex discrimination, it does not explain why the other definitional provisions are eliminated as well. Removing the definition of sex discrimination cannot change the underlying legal precedent that the current definition was based on and that still prohibits discrimination on the enumerated bases, including discrimination based on sex stereotyping, pregnancy discrimination, and pregnancy-related conditions. For example, in Nebraska, The Fair Employment Practice Act (FEPA) supports the argument that discrimination based on sex encompasses discrimination based on pregnancy, childbirth, or related medical conditions. To the extent there is variance among Nebraska law and federal court decisions as to what constitutes discrimination based on sex, the Current Rule provides crucial uniformity.

3. *HHS should not import an abortion exemption into its definition of sex discrimination.*

The Proposed Rule would unnecessarily incorporate the abortion exemption from Title IX into regulations implementing Section 1557. Incorporating the abortion exemption violates the text and purpose of Section 1557, which prohibits discrimination "on the *ground[s]* prohibited under" the referenced civil rights statutes, not the attendant exemptions contained in those statutes. 42 U.S.C. § 18116 (emphasis added). Congress has already spoken clearly as to how it intended to regulate abortion care and coverage, through both the ACA itself, *see* 42 U.S.C. § 18023(b)(1)(A), (b)(4), as well as the Weldon, Church, and Coats Amendments. Abortion care is health care related to pregnancy, and targeting it for exclusion undermines and stigmatizes access to care that is a constitutionally protected right.

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* * *

Taken as a whole, the Proposed Rule strips explicit regulatory protections for LGBT individuals and for people who require reproductive health care, indicating that the underlying purpose for the amendments is to target transgender and non-binary individuals, as well as other people who face sex-based discrimination in accessing health care and insurance coverage. That is neither consistent with the text of the statute, nor the appropriate mission of the Department. The Proposed Rule is also untimely, as the U.S. Supreme Court granted petitions for review in three cases addressing whether sex discrimination encompasses discrimination based on sexual orientation, gender identity, and discrimination against transgender individuals due to sex stereotyping under Title VII. *Altitude Exp., Inc. v. Zarda*, 139 S. Ct. 1599 (2019); *Bostock v. Clayton Cty., Ga.*, 139 S. Ct. 1599 (2019); *R.G. & G.R. Harris Funeral Homes, Inc. v. EEOC*, 139 S. Ct. 1599 (2019). Because Title IX generally adopts the standards for discrimination under Title VII, the Department will need to address the practical implications of any decision by the Court through a renewed comment process. Accordingly, the Department should abandon the Proposed Rule and instead leave in place the existing rule that discrimination based on gender identity is a form of sex discrimination, as is discrimination based on pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, and sex stereotyping.

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The application of antidiscrimination principles to health insurers and to benefit design is essential to the needs and rights of disabled people. The Proposed Rule does not apply those principles and should not be adopted.

C. HHS should not weaken protections for individuals with Limited English Proficiency.

The Department should not eliminate the language access protections as described by the Proposed Rule. Between four and seven percent of Nebraskans are people with limited English proficiency ("LEP"), and they should all have meaningful access to health care and coverage.[3] Language assistance is necessary to ensure that LEP persons are guaranteed such access, and is a critical protection to combat discrimination on the basis of national origin, which encompasses discrimination on the basis of language.

The Proposed Rule would eliminate significant protections for LEP persons by removing the requirement that covered entities provide notices of legal rights and in-language taglines on significant publications. The taglines are cost-effective ways to maintain access for LEP individuals without translating entire documents. The Department ignores the impact on LEP individuals should this requirement be eliminated, relying solely on reports from health plans, with no public outreach to determine the impact of the taglines or to explore alternatives.

[3] *Percent of Persons 5 Years and Over Who Speak a Language Other Than English at Home and Speak English Less Than "Very Well"*, https://www.lep.gov/maps/2015/national/US_state_LEP_pct.ACS_5yr.2015.pdf. (last visited Aug.9, 2019).

Likewise, the Department should not eliminate references to language access plans, which are a useful tool for covered entities to fully plan how to meet the needs of LEP patients and consumers. Such plans also support covered entities' own compliance efforts, benefiting both LEP individuals and covered entities alike.

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A. HHS Should Not Import a Religious Exemption into Section 1557.

The Proposed Rule wrongly would allow religiously affiliated healthcare providers to discriminate based on sex and to refuse access to necessary medical care, by importing Title IX's expansive religious exemptions into Section 1557. Religiously affiliated healthcare providers make up a significant percentage of the healthcare facilities in the United States. One in six patients is now treated in a Catholic facility each year, and religious hospitals are also increasingly the *only* health care option in many regions. In Nebraska, between 30 and 39 percent of the acute care beds in the state are in Catholic-owned or Catholic-affiliated facilities.[4]

The proposed religious exemption violates the text and purpose of Section 1557, as well as the constitutional commitment to the separation of church and state. The statute prohibits discrimination "on the *ground[s]* prohibited under" the referenced civil rights statutes, 42 U.S.C. § 18116 (emphasis added), but does not incorporate the attendant exemptions contained in those statutes—many of which are wholly inapposite to the health care context. The Department should not reverse course by incorporating the exemption, having initially rejected invitations to do so. Further, the First Amendment forbids government action

[4] Uttley et. al, *Growth of Catholic Hospitals and Health Systems: 2016 Update of The Miscarriage of Medicine Report*, MERGERWATCH (2016), *available at* http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf?token=KO%2Bv8%2FG6n4LMJ7mdY%2BZldZJyp1s%3D.

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Permitting a blanket religious exemption to Section 1557's nondiscrimination mandate threatens access to critical care for countless patients, especially transgender patients and patients seeking reproductive health services. The Proposed Rule altogether fails to consider the harmful consequences of importing a broad religious exemption into the health care context. For example, at the ACLU of Nebraska, we have heard from an individual who was told that, due to her insurance company's Christian values, the insurance company would no longer cover the family when they discovered her partner was a woman.

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B. HHS Should Not Narrow the Scope of Covered Entities.

The Proposed Rule would further undercut Section 1557 by limiting the entities covered by the provision. Limiting the application of Section 1557's protections would sanction discriminatory denials of coverage by entities that are presently covered by Section 1557, causing confusion and serious harm to those unable to access care. Additionally, the Proposed Rule displays no awareness of the potential harm to individuals denied coverage of and access to health care due to the proposed limitations on Section 1557's application.

Excluding health insurance from Section 1557's nondiscrimination mandate as distinct from "health program or activity" is contrary to the text of the statute and the broader antidiscrimination purpose of the law. The false distinction is exacerbated by the Proposed Rule's new limitation on the application of Section 1557 in cases where the entity is not "principally engaged in the provision of health care." In such cases, under the proposal, Section 1557 would apply only to the specific operations of an entity that receive federal financial assistance—whereas Section 1557 covers *all* operations of entities principally engaged in health care that receive federal financial assistance. This distinction, too, is contrary to the text of the statute, which prohibits discrimination under "any health program or activity, *any part of which* is receiving Federal financial assistance." 42 U.S.C. § 18116 (emphasis added).

C. HHS Should Maintain Existing Remedies Available for Section 1557 Claims.

The Current Rule adopts a uniform standard, applicable to all grounds covered by Section 1557, and incorporates enforcement mechanisms that exist under any of the civil rights laws referenced by Section 1557. This includes a

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private right of action for disparate-impact claims and the availability of compensatory damages for all claims under Section 1557. In removing these provisions, the proposed rule creates a scheme in which people are denied certain legal remedies because of the type of discrimination they experience. Such a change also privileges purported business interests in relieving regulatory burdens over the interests of the public and of individuals seeking health care. However, by removing the certainty of the Current Rule, covered entities and protected individuals alike would be uncertain as to the law's requirements and protections, instead leaving them to look to four other separate civil rights laws and various agencies' implementing regulations for clues.

The Proposed Rule's silence regarding the availability of a private right of action is at worst contrary to the rights-expanding aims of the statute and, at best, purposeless. Parties asserting private rights of action pursuant to Section 1557 have significantly expanded access to health care and combatted discriminatory health care policies, and will continue to do so, regardless of regulatory language explicitly affirming that such a right exists.

The Department should also not eliminate the Current Rule's provision for disparate-impact claims, which promotes better compliance with Section 1557's nondiscrimination provisions. The disparate-impact mechanism encourages health care providers to identify disparities and to adopt solutions that make a crucial difference in eliminating those disparities for individuals and improving public health.

These enforcement mechanisms are particularly important for people of color. Addressing racial disparities in health care is a matter of life and death. Such disparities are found across a range of illnesses and health care services, even when accounting for socioeconomic factors. Disparities in health care also have historic roots. As in other sectors of society, segregated health care was once sanctioned by law, and government-sanctioned discrimination continues to have a systemic impact on access to quality health care. At the same time, research suggests that many racial and ethnic health disparities could be reduced or even eliminated if identified and addressed. A disparate-impact private right of action is a crucial enforcement mechanism to confront and redress discrimination.

The Department's proposal would instead make enforcement more difficult, and would increase confusion as to the scope of Section 1557's protections. The Department should accordingly continue to affirm existing enforcement mechanisms, including the private right of action for disparate-impact claims.

D. The Department Should Not Eliminate Grievance Procedures and Notice Requirements.

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The Proposed Rule would unnecessarily eliminate the specific grievance procedures established under Section 1557, which would leave covered entities and impacted individuals without cohesive, uniform procedures for investigating grievances. Further, the Department should not eliminate the explicit requirement that such procedures "incorporate appropriate due process standards," which provides that the procedures in place are sufficient to address claims of discrimination promptly and equitably. 45 CFR 92.7. Likewise, the Department should not eliminate the requirement that covered entities provide notice to the public that they do not discriminate, as the current procedure is crucial to ensure that individuals are aware of the safeguards in place and of the steps they can take to effectuate the protections under Section 1557. 45 CFR 92.8. The costs associated with the notice requirement are well worth the benefit of ensuring that protected individuals receive adequate notice of their rights.

III. THE PROPOSED RULE VIOLATES SECTION 1554 OF THE ACA.

The Proposed Rule is additionally contrary to law because it violates another provision of the ACA: Section 1554. This provision limits the Department's rulemaking authority, prohibiting HHS from promulgating regulations that create any unreasonable barriers to the ability of individuals to obtain appropriate medical care, impede timely access to health care services, violate the ethical standards of health care professionals, or limit the availability of health care treatment for the full duration of a patient's medical needs—among other restrictions. 42 U.S.C. § 18114. For all the reasons outlined in this comment, the Proposed Rule represents a direct violation of Congress's command and should be entirely abandoned.

* * *

For all these reasons, the Department should withdraw the Proposed Rule.

Sincerely,

Scout Richters

Scout Richters
Legal & Policy Counsel

EXHIBIT D-51

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August 13, 2019

By Electronic Submission

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Section 1557 NPRM, RIN 0945–AA1
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Mr. Roger Severino
Director
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave. S.W.
Washington, DC 20201

Re: Nondiscrimination in Health and Health Education Programs or Activities (Section 1557 NPRM), RIN 0945–AA11

Dear Secretary Azar and Mr. Severino:

The Transgender Legal Defense & Education Fund (TLDEF) is a 501(c)(3) nonprofit whose mission is to end discrimination and achieve equality for transgender and non-binary people, particularly those in our most vulnerable communities. We provide legal representation to transgender individuals who have been subject to discrimination, focusing on the key issues of employment, education, public accommodations, and healthcare. We also provide public education on transgender rights.

TLDEF appreciates the opportunity to comment on the Notice of Proposed Rulemaking Regarding Nondiscrimination in Health Programs and Activities under Section 1557 of the Patient Protection and Affordable Care Act (ACA). Section 1557 contributes to the health equity of the transgender community, promotes equal access to healthcare for all, and increases affordability and accessibility of coverage and care for all individuals.

TLDEF opposes the proposed rule and the rolling back of explicit and necessary protections for transgender individuals.[1] The proposed rule will be detrimental to transgender people by threatening to mislead individuals and institutions into thinking that discrimination against transgender individuals seeking to access medically necessary health care is permissible even though it is still prohibited by statute. It is also inconsistent with existing jurisprudence, other anti-discrimination legislation and general healthcare and insurance trends. This will cause unnecessary confusion and have a chilling effect on transgender people seeking to access healthcare.

TLDEF also opposes the proposed changes to roll back other, long-standing rules that prohibit discrimination on the basis of gender identity and sexual orientation.[2] These changes are outside of the Office for Civil Rights' (OCR) jurisdiction and are unrelated to Section 1557 of the ACA. It is not appropriate for these rulemakings to be combined, and it is arbitrary and capricious for HHS to characterize them as "conforming amendments" without offering any legal, policy or cost-benefit analysis about them and their impacts on various CMS programs. In particular, HHS offers no analysis of the impact these regulations have had during the years—in some cases over a decade—that they have been in effect or the impact of changing them now.

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[1] These are currently codified at 45 C.F.R. pt. 92.

[2] 45 CFR 155.120(c)(1)(ii) and 155.220(j)(2), 45 CFR 147.104(e), 45 CFR 156.200(e) and 156.1230(b)(3), 42 CFR 460.98(b)(3) and 460.112(a), 42 CFR 438.3(d)(4), 438.206(c)(2), and 440.262.

1. The proposed rule threatens transgender patients' access to healthcare.

1.1. Transgender people face pervasive discrimination in healthcare settings.

Transgender people have been subject to pervasive discrimination, particularly with regard to accessing healthcare. While this discrimination has begun to lessen, transgender people still experience much prejudice and violence. In addition to the direct harm to transgender individuals who are denied care or receive substandard care, this also has a chilling effect: 23% of transgender individuals in 2015 reported that they did not see a doctor when they needed to because of fear of being mistreated.[3] Transgender people are also more likely to live with psychological distress, with 40% having attempted suicide in their lifetime, nine times higher than the general population.[4]

In a survey by the Center for American Progress, of transgender people who had visited a doctor or healthcare providers' office in the past year, 29 percent said a doctor or other healthcare provider refused to see them because of their actual or perceived gender identity, 12 percent said a doctor or other healthcare provider refused to give them healthcare related to gender transition; 23 percent said a doctor or other healthcare provider intentionally misgendered them or used the wrong name; 21 percent said a doctor or other healthcare provider used harsh or abusive language when treating them; and 29 percent said that they experienced unwanted physical contact from a doctor or other healthcare provider (such as fondling, sexual assault, or rape).[5]

Many members of the LGBTQ community have a "high degree of

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[3] 2015 U.S. Transgender Survey Report, at 10, available at https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[4] *Id.* at 5.

[5] Center for American Progress, *Discrimination Prevents LGBTQ People from Accessing Healthcare* (January 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care.

anticipation and belief that they w[ill] face discriminatory care" which ultimately causes many people to not seek the essential care that they need.[6] For many transgender and gender-nonconforming people the fear of potential negative treatment from health care professionals is even more exacerbated.

1.1. Eliminating 42 C.F.R. § 92.207(b)(3), the explicit ban denying sex-specific care to transgender individuals, would hinder the enforcement of Section 1557.

Regulations explicitly prohibiting denials of sex-specific care are important to ensuring that transgender individuals receive equal access to basic preventative care including gynecological visits and cancer screenings. Prior to the 2016 regulations, denials of sex-specific care were rampant. For example, in 2012, a transgender woman who was denied coverage for a mammogram because her insurance company had recorded her sex as male required TLDEF's assistance to get this critical preventative procedure.[7] Similarly, OCR investigated the discriminatory exclusion of transgender women from a CDC-funded mammogram program, resulting in the CDC issuing new guidance clarifying that transgender women can participate in the program.[8] Without clear protections for sex-specific care, transgender people risk having to fight for preventative care even though it is covered under Section 1557's nondiscrimination requirements.

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[6] Lambda Legal, W*hen Health Care Isn't Caring, Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV,* at 6 (2010), http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf.

[7] Susan Donaldson James, *Transgender Woman Wins Insurance Coverage for Mammogram*, ABC NEWS, May 1, 2012, https://abcnews.go.com/Health/transgender-woman-wins-health-coverage-mammogram/story?id=16246219.

[8] U.S. Dep't of Health and Human Services, *OCR Enforcement under Section 1557 of the Affordable Care Act Sex Discrimination Cases*, (Sept. 23, 2015), https://web.archive.org/web/20150923030557/http:/www.hhs.gov/ocr/civilrights/understanding/section1557/casesum.html.

1.2. Eliminating 42 C.F.R. § 92.207(b)(4), the explicit ban on categorical exclusions for transgender-related healthcare, would hinder the enforcement of Section 1557.

TLDEF routinely receives requests for assistance with accessing healthcare. We are currently pursuing litigation against the state employee health plan of North Carolina because it contains an explicit exclusion for transgender-related health care.[9] As detailed in the complaint, the state health plan removed an exclusion for coverage for gender-affirming healthcare in 2017 in response to the 2016 Section 1557 regulations, but aided by the confusion created by *Franciscan Alliance, Inc. v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016), reinstated it in 2018. One plaintiff had surgery preauthorized in 2017 that was scheduled for 2018 and thus was no longer covered. Another plaintiff had treatment that was begun in 2017, and in 2019 had to purchase an individual plan on the Marketplace in order to continue to receive care. That this lawsuit's claims rely on Section 1557 and not to the regulations points to the reality that a categorical exclusion for transgender-related health care is prohibited under the statute. Eliminating 45 C.F.R. § 92.207(b)(4), which makes that prohibition explicit, may cause covered entities to continue to be mislead into engaging in unlawful practices for which they will face liability. Repealing the regulations will only lead to further confusion and litigation that hinders the enforcement of Section 1557.

1.3. Eliminating 42 C.F.R. § 92.207(b)(5), the explicit ban on discriminatory denials of insurance coverage for transgender-related healthcare, would hinder the enforcement of Section 1557.

Transgender people face many denials of insurance coverage caused not by categorical exclusions for all transgender-related healthcare, but by the care being deemed not medically necessary. For example, TLDEF currently represents transgender women who have been denied chest reassignment surgery by a major insurance company pursuant to its nationwide clinical policy that states that chest

[9] *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C. filed March 11, 2019).

reassignment surgery for transgender women—but not transgender men—is categorically considered to be not medically necessary and therefore excluded. Such a policy is clearly unlawful under 45 C.F.R. § 92.207(b)(5), which prohibits denying or limiting coverage "for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual." Targeted exclusions for other procedures such as facial gender reassignment surgery or surgery for people who are under age 18 are still commonly maintained by covered entities. TLDEF receives numerous requests for assistance to challenge such denials in public and private insurance, including Medicaid. Retention and enforcement of § 92.207(b)(5) is essential to prohibit these discriminatory denials of healthcare on the grounds of sex.

1.4. Eliminating 42 C.F.R. § 92.206, which requires equal program access on the basis of sex, would hinder the enforcement of Section 1557.

Section 92.206 ensures that transgender people can be placed in sex-specific hospital rooms, inpatient mental health facilities, and substance use treatment programs according to their affirmed sex. Not having access to sex-appropriate facilities has dire consequences for transgender people.

1.4.1. Access to substance use facilities.

Transgender individuals are at a higher risk of substance abuse than the general population.[10] Transgender individuals face high levels of

[10] Sari L. Reisner et al., *Substance Use to Cope with Stigma in Healthcare Among U.S. Female-to-Male Trans Masculine Adults*, 2 LGBT HEALTH 324 (2015); Lisa Miller & Anthony Grollman, *The Social Costs of Gender Nonconformity for Transgender Adults: Implications for Discrimination and Health*, 30 SOC. FORUM 809, 825 (2015); Larry Nuttbrock et al., *Gender Abuse, Depressive Symptoms, and Substance Use Among Transgender Women: A 3-Year Prospective Study*, 104 Am. J. of Public Health, 2199 (2014); Tiffany R. Glynn and Jacob J. van den Berg, *A Systematic Review of Interventions to Reduce Problematic Substance Use Among Transgender Individuals: A Call to Action*, 2.1 Transgender Health, 45 (2017); Eric G. Benotsch et al., *Non-Medical Use of Prescription Drugs, Polysubstance Use, and Mental Health in Transgender Adults,* 132 Drug and Alcohol Dependence 391 (2013); Paul Kobrak and Bali White, *Transgender Women and HIV Prevention in New York City: A Needs Assessment* (2011); National Research Council, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* 218 (2011).

prejudice, discrimination, violence, and other forms of stigma.[11] This results in physical effects including increased cortisol levels, anxiety, depression, suicidality, and using substances to cope.[12] Additionally, when transgender people do not have access to transgender-related health care, it is common for people to use substances to self-medicate and attempt to alleviate the symptoms of gender dysphoria.[13] Appropriate treatment for gender dysphoria is known to resolve substance use problems.[14]

Despite high rates of substance use, transgender individuals often encounter difficulties in accessing substance use treatment including discrimination, provider hostility and insensitivity, being barred from participating in sex-specific programs and facilities, and lack of acceptance in sex-appropriate recovery groups. In addition, transgender people who use substances are much more likely to experience challenges completing an education, obtaining stable housing and obtaining employment. Many find that their substance abuse disqualifies them from participating in programs specifically intended to assist them with these challenges.[15]

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[11] Jaclyn M. White Hughto et al., *Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions*, 147 Social Science and Medicine, 222-231 (2015).

[12] *Id.*; Sari L. Reisner et al., *Gender Minority Social Stress in Adolescence: Disparities in Adolescent Bullying and Substance Use by Gender Identity*, 52 J. of Sex Research 243 (2015).

[13] *E.g.*, Robin M. Mathy, *Transgender Identity and Suicidality in a Nonclinical Sample*, 14 J. of Psychology & Human Sexuality, 47, 61 (2003) ("[T]he significant relation between suicide attempts (but not suicidal ideation) and substance use difficulties suggests some transgender individuals may attempt to cope by 'self-medicating.'"); Beth R. Hoffman, *The Interaction of Drug Use, Sex Work, and HIV Among Transgender Women*, 49 Substance Use & Misuse, 1049 (2014) (noting transgender women experienced high rates of depression and anxiety and "engaged in substance use to cope with mental health problems and stress").

[14] *See* Jamil Rehman et al., *The Reported Sex and Surgery Satisfactions of 28 Postoperative Male-to-Female Transsexual Patients*, 28 Archives of Sexual Behavior 71, 83 (1999).

[15] Nina Kammerer et al., *Transgender Health and Social Service Needs in the Context of HIV Risk*, *in* Transgender and HIV: Risks, Prevention and Care (Walter Bockting & Sheila Kirk ed. 2001); K. Clements et al., *HIV Prevention and*

For example, Sabrina Wilson was a 32-year-old homeless transgender woman who was arrested for a drug offense and given the opportunity to participate in a drug treatment program as an alternative to incarceration. The residential program she was assigned to required her to room with men, to use the men's bathroom, and to dress and wear her hair in ways associated with men. The program also denied her participation in women's support groups and she had to attend all-male counseling sessions. These actions constructively forced her out of the facility, which resulted in her being sentenced to 2 1/2 years in jail. When she was released, she successfully filed discrimination charges against the facility under New York law.[16]

In response to on-going reports of lack of access to substance use treatment programs such as that experienced by Ms. Wilson, in 2016, TLDEF undertook a survey of 53 substance use treatment programs in New York and found that 47% engaged in some form of anti-transgender discrimination and 34% would refuse to allow a transgender person to be housed according to their true sex. We took our findings to the NYC Commission on Human Rights, which brought successful enforcement actions under the NYC Human

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Health Service Needs of the Transgender Community in San Francisco, 3 INT'L J. OF TRANSGENDERISM (1999); J. Sperber et al., *Access to Health Care for Transgendered Persons: Results of a Needs Assessment in Boston*, 8 INT'L J. OF TRANSGENDERISM 74 (2005); T. Nemoto et al., *Health and Social Services for Male-To-Female Transgender Persons of Color in San Francisco*, 8 INT'L J. OF TRANSGENDERISM 5 (2005); Samuel Lurie, *Identifying Training Needs of Health-Care Providers Related to Treatment and Care of Transgendered Patients: A Qualitative Needs Assessment Conducted in New England*, 8 INT'L J. OF TRANSGENDERISM 93 (2004); E.L. Lombardi & G. van Servellen, *Building Culturally Sensitive Substance Use Prevention and Treatment Programs for Transgendered Populations*, 19 J. OF SUBSTANCE ABUSE TREATMENT 291 (2002); U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (2012), https://store.samhsa.gov/system/files/sma12-4104.pdf; A.D. Marcel, *Determining barriers to treatment for transsexuals and transgenders in substance abuse programs.* Transgender Education Network, Boston (1998).

[16] *Wilson v. Phoenix House*, 978 N.Y.S.2d 748 (N.Y. Sup. Ct. Kings County 2013).

Rights Law.[17]

If OCR repeals or continues to refuse to defend or enforce this provision, in jurisdictions without such local laws and administrative agencies to rely on, transgender individuals will continue to be forced to hire a lawyer to enforce their rights under Section 1557 instead of being able to file a complaint with OCR. This will decrease enforcement actions. Section 1557 prohibits such discriminatory treatment on the grounds of sex, and substance use facilities need to be made plainly aware of their obligations to prevent unlawful discrimination and the need for litigation after the harm has already occurred.

1.4.1. Access to hospitals and doctor's offices.

Section 92.206 is also important for placement in hospital rooms. OCR previously enforced these provisions to ensure that transgender people could access care in hospitals.[18] In an enforcement action against a hospital in Brooklyn, OCR entered into an agreement to resolve a discrimination complaint alleging that the hospital housed a transgender woman in a double-occupancy patient room with a male occupant.

But TLDEF continues to receive reports of transgender individuals facing inappropriate treatment and harassment in hospitals and doctor's offices, and there is a need for an administrative complaint process for these claims to be heard by OCR. For example, in 2018, a transgender man who suffers from severe anxiety and depression had

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[17] NYC Commission on Human Rights, *NYC Commission on Human Rights Charges Four Substance Abuse Centers with Discriminatory Intake Policies for Transgender Patients* (July 13, 2017), https://www1.nyc.gov/assets/cchr/downloads/pdf/press-releases/Press%20Release%20-%20Substance%20Abuse%20Centers%20FINAL.pdf.

[18] Voluntary Resolution Agreement Between the U.S. Department of Health and Human Services Office for Civil Rights and the Brooklyn Hospital Center, Transaction Number: 12-147291 (2015), https://www.hhs.gov/sites/default/files/ocr/civilrights/activities/agreements/TBHC/vra.pdf; U.S. Dep't of Health and Human Services Office for Civil Rights, The Brooklyn Hospital Center Implements Non-Discriminatory Practices to Ensure Equal Care for Transgender Patients (July 14, 2015), https://www.hhs.gov/sites/default/files/ocr/civilrights/activities/agreements/TBHC/statement.pdf.

an appointment with a gynecologist in Brooklyn and was to schedule a hysterectomy. The staff member who was told to schedule it laughed in his face as if it were a joke. The doctor did not immediately address this situation, and the patient was severely distressed because of it. The patient was also scheduled for another procedure with the doctor but cancelled it due to his fear and discomfort with seeing the doctor or any other doctor again. Because of situations like these, the regulation ensuring "equal access to its health programs or activities without discrimination on the basis of sex"—and its enforcement by OCR—is vital to ensuring that transgender people can do something as basic as being treated with dignity and respect while being treated or hospitalized for serious health needs.

2. Repealing the 2016 Section 1557 rule is arbitrary and capricious, an abuse of discretion, or otherwise not in accordance with the law.

The 2016 implementing rule is sound, has been crucial for transgender patients to be able to access the care that they need, and promotes equal access to medically necessary health services. The 2016 Section 1557 implementing final rule was the product of a lengthy process of deliberation and public input. The rule was developed over the course of six years of study and following two comment periods, with over 25,000 comments from stakeholders, which were overwhelmingly supportive of inclusion of protections against discrimination based on sex stereotyping and gender identity. HHS engaged stakeholders through listening sessions, participation in conferences, and other outreach prior to taking regulatory action.

2.1. Eliminating 42 C.F.R. § 92.4, the definition section, is not in accordance with widespread court interpretation of discrimination on the basis of "sex" to include transgender status.

Proposing to eliminate nondiscrimination protections for transgender people contradicts longstanding court precedent. Section 92.4 defines "on the basis of sex" and "gender identity" to make it clear to covered entities that discrimination based on transgender status is unlawful. "Sex" in civil rights law has

universally been interpreted to include discrimination based on sex stereotypes and transgender status in multiple areas including employment (Title VII), education (Title IX), Equal Protection, and Section 1557 itself.

It is well-settled law that anti-transgender discrimination is prohibited sex discrimination under Title IX.[19] Cases to the contrary are readily distinguished.[20] Discriminating in insurance on the basis that the care sought is intended to change sex characteristics is inherently sex discrimination.[21]

A robust body of case law similarly holds that discriminatory

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[19] *See, e.g., Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1046-47 (7th Cir. 2017) (distinguishing *Ulane v. Eastern Airlines, Inc.*, 742 F.2d 1081 (7th Cir. 1984) and holding that Title IX prohibits treating transgender students differently from non-transgender students), *petition for cert. dismissed*, No.17-301, 138 S. Ct. 1260 (Mar. 5, 2018); *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217, 221 (6th Cir. 2016) (denying motion to stay preliminary injunction that prevented school district from excluding transgender girl from the girls' restroom); *Adams by Kasper v. Sch. Bd. of St. Johns Cty.*, 318 F. Supp. 3d 1293, 1298 (M.D. Fla. 2018), appeal docketed, No. 18-13592 (11th Cir. Aug. 24, 2018); *Grimm v. Gloucester County School Board*, No. 4:15-cv-54, 2019 WL 3774118 (E.D. Va. Aug. 9, 2019); *M.A.B. v. Bd. of Educ. of Talbot Cty.*, 286 F.Supp.3d 704 (D. Md. 2018); *A.H. v. Minersville Area Sch. Dist.*, 290 F.Supp.3d 321 (M.D. Pa. Nov. 22, 2017); *Bd. of Educ. of the Highland Local Sch. Dist. v. U.S. Dep't. of Educ.*, 208 F. Supp. 3d 850, 856-58 (S.D. Ohio 2016), *stay pending appeal denied sub nom.*, *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217 (6th Cir. 2016). *See also Doe by & through Doe v. Boyertown Area Sch. Dist.*, 897 F.3d 518, 533 (3d Cir. 2018), *cert. denied sub nom. Doe v. Boyertown Area Sch. Dist.*, 139 S. Ct. 2636 (2019) (agreeing that allowing boys and girls who are transgender to use sex-specific restrooms and locker rooms did not raise privacy concerns and "barring transgender students from restrooms that align with their gender identity would itself pose a potential Title IX violation."); *Students & Parents for Privacy v. U.S. Dep't of Educ.*, No. 16-cv-4945, 2016 WL 6134121, at *28-29 (N.D. Ill. Oct. 18, 2016) (report and recommendation) (same), *adopted by* 2017 WL 6629520 (N.D. Ill. Dec. 29, 2017).

[20] *Johnston v. Univ. of Pittsburgh*, 97 F.Supp.3d 657 (W.D. Pa. Mar. 31, 2015) (relying on outdated precedent to hold that Title IX does not prohibit discrimination based on gender identity or transgender status per se); *Texas v. United States*, 201 F.Supp.3d 810 (N.D. Tex. Aug. 21, 2016) (finding in a preliminary injunction that Title IX permitted bathrooms to be separated based on sex in light of specific regulations under Title IX).

[21] *See Franciscan Alliance, Inc. v. Burwell*, 227 F.Supp.3d 660, 688 (N.D. Tex. Dec. 31, 2016) ("[T]he text, structure, and purpose reveal that the definition of sex in Title IX's prohibition of sex discrimination unambiguously prevented discrimination on the basis of the biological differences between males and females.").

treatment of transgender individuals must needs be sex discrimination under Title VII. In 2012, the Equal Employment Opportunity Commission (EEOC) held that "intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination based on sex and such discrimination therefore violates Title VII."[22] As the Sixth Circuit put it, "[b]ecause an employer cannot discriminate against an employee for being transgender without considering that employee's biological sex, discrimination on the basis of transgender status necessarily entails discrimination on the basis of sex."[23] The Supreme Court has recognized sex stereotyping as a component of prohibited sex discrimination.[24] Federal courts, including the First, Sixth, Seventh, Eighth, Ninth, Eleventh and D.C. Circuits explicitly or implicitly agree that discrimination against transgender people is actionable sex discrimination.[25] The Third and Tenth Circuits have

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[22] *Macy v. Dep't. of Justice*, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, at *12 (Apr. 20, 2012). *See also Tamara Lusardi v. John McHugh, Sec'y, Dep't of the Army*, No. 0120133395, 2015 WL 1607756, at *9 (E.E.O.C. Apr. 1, 2015) (finding that "denying transgender individuals access to a restroom consistent with gender identity discriminates on the basis of sex in violation of Title VII.").

[23] *Equal Employment Opportunity Comm'n v. R.G. &. G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 574 (6th Cir. 2018), *cert. granted in part sub nom. R.G. & G.R. Harris Funeral Homes, Inc. v. E.E.O.C.*, No. 18-107, 2019 WL 1756679 (U.S. Apr. 22, 2019).

[24] *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989).

[25] *See Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (recognizing claim for sex discrimination under Equal Credit Opportunity Act, analogizing to Title VII); *Equal Employment Opportunity Comm'n v. R.G. &. G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 574 (6th Cir. 2018), *cert. granted in part sub nom. R.G. & G.R. Harris Funeral Homes, Inc. v. E.E.O.C.*, No. 18-107, 2019 WL 1756679 (U.S. Apr. 22, 2019) (holding "that discrimination on the basis of transgender and transitioning status violates Title VII); *Smith v. City of Salem*, 378 F.3d 566, 574-75 (6th Cir. 2004) ("Price Waterhouse…does not make Title VII protection against sex stereotyping conditional or provide any reason to exclude Title VII coverage for non sex-stereotypical behavior simply because the person is transsexual."); *Hively v. Ivy Tech Cmty. Coll. of Indiana*, 853 F.3d 339, 341 (7th Cir. 2017) (en banc) (upholding a Title VII sexual orientation discrimination claim and implicitly rejecting *Ulane v. Eastern Airlines, Inc.*, 742 F.2d 1081 (7th Cir. 1984)); *Hunter v. United Parcel Serv.*, 697 F.3d 697, 702 (8th Cir. 2012) (evaluating a transgender man's Title VII claim "based on his non-conformity to gender stereotypes or his being perceived as transgendered"); *Schwenk v. Hartford*, 204 F.3d 1187, 1202 (9th Cir. 2000) (relying on Title VII cases to conclude that violence against a transgender woman was violence because of gender under the Gender

assumed that a sex stereotyping claim is available to transgender plaintiffs.[26] Furthermore, dozens of district courts—both within and outside of the circuits that have explicitly recognized sex discrimination claims by transgender people—have found that anti-transgender discrimination is unlawful sex discrimination.[27]

Motivated Violence Act); *Chavez v. Credit Nation Auto Sales*, 641 F. App'x 883, 883 (11th Cir. 2016) ("Sex discrimination includes discrimination against a transgender person for gender nonconformity.") (citing *Glenn v. Brumby*, 663 F.3d 1312, 1316–17 (11th Cir. 2011)); *Evans v. Ga. Reg'l Hosp.*, 850 F.3d 1248, 1265-66 (11th Cir. 2017) (Pryor, J., concurring) (noting that "discrimination against a transsexual because she fails to conform to the employer's view that a birth-assigned male should have male anatomy" constitutes sex discrimination), *cert. denied*, 138 S. Ct. 557 (2017); *Schroer v. Billington*, 577 F. Supp. 2d 293, 306-08 (D.D.C. 2008) (noting that "the Library's refusal to hire Schroer after being advised that she planned to change her anatomical sex by undergoing sex reassignment surgery was literally discrimination 'because of ... sex.'").

[26] *See Stacy v. LSI Corp.*, 544 F. App'x 93, 97-98 (3d Cir. 2013); *Etsitty v. Utah Transit Auth.*, 502 F.3d 1215, 1224 (10th Cir. 2007).

[27] *See, e.g.*, *Fabian v. Hosp. of Cent. Conn.*, 172 F. Supp. 3d 509, 527 (D. Conn. 2016) ("Employment discrimination on the basis of transgender identity is employment discrimination 'because of sex' and constitutes a violation of Title VII of the Civil Rights Act."); *E.E.O.C. v. Rent-a-Center East, Inc.*, 2017 WL 4021130 (C.D. Ill., Sept. 8, 2017) (holding transgender discrimination is actionable under Title VII, relying on 7th Circuit rulings under Title IX (gender identity as sex discrimination) and Title VII (sexual orientation discrimination as sex discrimination) to justify not following an old circuit precedent); *Roberts v. Clark Cnty. Sch. Dist.*, 215 F.Supp.3d 1001, 1014 (D. Nev. 2016) (finding the weight of authority in the 9th Circuit holds discrimination based on transgender status is sex discrimination); *U.S. v. S.E. Okla. State Univ.*, No. 5:15-CV-324, 2015 WL 4606079 at *2 (W.D. Okla. July 10, 2015) (rejecting motion to dismiss premised on *Etsitty v. Utah Transit Auth.*, 502 F.3d 1215 (10th Cir. 2007) and allowing claim based on harassment, health insurance exclusion, and termination based on gender transition to proceed as sex stereotyping discrimination under Title VII); *Finkle v. Howard Cty., Md.*, 12 F. Supp. 3d 780, 789 (D. Md. 2014) (denying motion to dismiss Title VII claim where plaintiff plausibly alleged that she was rejected both "because of her obvious transgendered status" and also her gender nonconformity); *Hughes v. William Beaumont Hosp.,* No. 13-cv-13806, 2014 WL 5511507 (E.D. Mich. Oct. 31, 2014) (transgender woman subjected to disparate treatment where decision maker testified that people would be uncomfortable with "a man acting as a woman"); *Lopez v. River Oaks Imaging & Diagnostic Grp., Inc.*, 542 F. Supp. 2d. 653 (S.D. Tex. 2008) (holding that a transgender woman stated a claim under Title VII where the employer rescinded a job offer because she was transgender); *Tronetti v. TLC HealthNet Lakeshore Hosp.*, No. 03-CV- 0375E(SC), 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003) (finding an actionable claim where employer advised a transgender woman to avoid wearing overtly feminine attire and ultimately fired her because she failed to act

Anti-transgender discrimination has also been widely regarded as an unconstitutional sex-based classification triggering intermediate scrutiny for Equal Protection claims in the context of schools,[28] identity documents,[29] prisons,[30] the military,[31] and

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like a man).

[28] *Whitaker supra* note 19, at 1051 (holding that heightened scrutiny used for sex-based classifications applied to school policy requiring transgender student to use bathroom of sex listed on his birth certificate because it "treat[ed] transgender students . . . who fail to conform to the sex-based stereotypes associated with their assigned sex at birth, differently"); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 288 (W.D. Pa. 2017) (holding that "all of the indicia for the application of the heightened intermediate scrutiny standard are present" for transgender individuals); *M.A.B. v. Bd. of Educ. of Talbot Cty.*, 286 F.Supp.3d 704, 718-19 (D. Md. 2018) (reviewing *Glenn* and *Whitaker* and determining that heightened scrutiny applied in transgender school bathroom case); *Adams by Kasper v. Sch. Bd. of St. Johns Cty.*, 318 F. Supp. 3d 1293, 1298 (M.D. Fla. 2018), *appeal docketed,* No. 18-13592 (11th Cir. Aug. 24, 2018) (same); *A.H. v. Minersville Area Sch. Dist.*, 290 F.Supp.3d 321, 331 (M.D. Pa. 2017) (holding intermediate scrutiny applied in transgender school bathroom case); *Bd. of Educ. of the Highland Local Sch. Dist. supra* note 19, at 872–74 (finding that "transgender status is a quasi-suspect class under the Equal Protection Clause").

[29] *F.V. v. Barron*, 286 F.Supp.3d 1131, 1145 (D. Idaho Mar. 5, 2018) (applying intermediate scrutiny because "transgender people bear all of the characteristics of a quasi-suspect class").

[30] *E.g., Doe v. Mass. Dep't of Correction,* No. 1:17-cv-12255-RGS, 2018 WL 2994403 at *9 (D. Mass. Jun. 14, 2018) ("[W]here a State creates a classification based on transgender status, the classification is tantamount to discrimination based on sex and is therefore subject to heightened judicial scrutiny."); *Adkins v. City of New York*, 143 F. Supp. 3d 134, 140 (S.D.N.Y. 2015) (concluding "that transgender people are a quasi-suspect class"); *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015) (applying intermediate scrutiny where an transgender inmate was denied access to surgery to treat gender dysphoria).

[31] *Stone v. Trump*, 280 F. Supp. 3d 747, 755 (D. Md. 2017), *appeal dismissed*, No. 17-2398, 2018 WL 2717050 (4th Cir. Feb. 2, 2018) (applying intermediate scrutiny to decision to exclude transgender individuals from the military); *Doe 1 v. Trump*, 275 F. Supp. 3d 167, 210 (D.D.C. 2017), *vacated sub nom. Doe 2 v. Shanahan*, 755 F. App'x 19 (D.C. Cir. 2019) (vacated following change in federal policy) (same); *Karnoski v. Trump*, No. C17-1297-MJP, 2017 WL 6311305, at *7 (W.D. Wash. Dec. 11, 2017), *appeal dismissed*, No. 17-36009, 2017 WL 8229552 (9th Cir. Dec. 30, 2017) (applying intermediate scrutiny to a policy of denying transgender-related healthcare to military service members and granting a preliminary injunction); *Karnoski v. Trump*, No. C17-1297-MJP, 2018 WL 1784464, at *1 (W.D. Wash. Apr. 13, 2018), *vacated on other grounds and remanded*, 926 F.3d 1180 (9th Cir. 2019) (applying strict scrutiny to transgender people as a protected class where defendants sought to deny transgender-related healthcare to military

employment.[32]

Finally, courts have and will continue to find that the Section 1557 itself—independent of any regulation—protects transgender individuals from discrimination in health care in general,[33] and that transgender insurance exclusions in particular trigger sex discrimination protections under Section 1557.[34] Repealing the explicit transgender protections does nothing to change the underlying protections of the statute or court precedent but does create confusion about the obligations of covered entities and fosters a misguided license to discriminate. This harms not only transgender people who will need counsel to access health care, but also the covered entities who rely on HHS regulations to guide their practices.

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service members).

[32] *Smith v. City of Salem, Ohio*, 378 F.3d 566, 577 (6th Cir. 2004) (holding that the facts alleged by transgender plaintiff to support claims of gender discrimination on the basis of sex stereotyping "easily constitute a claim of sex discrimination grounded in the Equal Protection Clause of the Constitution"); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011) (recognizing discrimination against transgender people as sex discrimination and applying intermediate scrutiny).

[33] *Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 at *2 (D. Minn. Mar. 16, 2015); *Prescott v. Rady Children's Hospital-San Diego*, 265 F.Supp.3d 1090, 1099 (S.D. Cal. Sept. 27, 2017) ("Because Title VII, and by extension Title IX, recognize that discrimination on the basis of transgender identity is discrimination on the basis of sex, the Court interprets the ACA to afford the same protections.").

[34] *Cruz v. Zucker,* 116 F.Supp.3d 334, 348 (S.D.N.Y. 2015) (entertaining a sex discrimination claim for transgender people under Medicaid); *Flack v. Wis. Dep't of Health Servs.*, 328 F.Supp.3d 931 (W.D. Wis. Jul. 25, 2018) (granting a preliminary injunction barring enforcement of Wisconsin Medicaid's transgender exclusion because such an exclusion denies surgery on the basis of sex in violation of Section 1557); *Flack v. Wisconsin Dep't of Health Servs.,* No. 18-CV-309-WMC, 2019 WL 1772403, at *12 (W.D. Wis. Apr. 23, 2019) (same); *Boyden v. Conlin*, 341 F.Supp.3d 979, 997 (W.D. Wisc. 2018) (applying Section 1557 to Wisconsin state employee health plan); *Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 954 (D. Minn. 2018) (holding that employer and third-party administrator may be held liable for administering a self-funded plan containing an exclusion for "gender reassignment" treatment).

2.2. Eliminating 42 C.F.R. § 92.4, the definition section, is not in accordance with widespread court interpretation of "sex" to include gender identity as a biological component of sex.

The scientific consensus, as recognized by numerous courts, recognizes that "sex" includes myriad physical characteristics that comprise and define one's sex, which can include hormone levels, genital appearance, reproductive organs, and secondary sex characteristics such as facial hair, fat distribution, muscle mass, breasts, and neurological structure and function.[35] One of these components is gender identity: the self-knowledge of one's sex.[36] Everyone—transgender or not—is born with an internal sense of their sex; transgender persons know themselves to be a sex different from that which they were labeled at birth.[37] Courts have thus recognized that a transgender person's sex is not defined by genitalia

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[35] *See, e.g.*, *Schroer v. Billington*, 424 F. Supp. 2d 203, 211-13 (D.D.C. 2006) (scientific observation confirms "sex is not a cut-and-dried matter of chromosomes" but rather consists of "different components of biological sexuality") (citation omitted); *In re Heilig*, 816 A.2d 68, 73 (Md. 2003) (gender is determined by seven factors, including "personal sexual identity"); *Maffei v. Kolaeton Indus., Inc.*, 164 Misc. 2d 547, 551-52 (N.Y. Sup. Ct. 1995) (explaining that at least seven variables . . . interact to determine the ultimate sex of an individual," including gender identity); *F.V. v. Barron*, 286 F. Supp. 3d 1131, 1136 (D. Idaho 2018) ("There is scientific consensus that biological sex is determined by numerous elements"). *See also* Dru M. Levasseur, *Gender Identity Defines Sex: Updating the Law to Reflect Modern Medical Science is Key to Transgender Rights*, 39 VT. L. REV. 943, 951-52 (2015).

[36] *See Doe by & through Doe v. Boyertown Area Sch. Dist.*, 897 F.3d 518, 522 (3d Cir. 2018), *cert. denied* 139 S. Ct. 2636 (2019) ("A person's gender identity is their subjective, deep-core sense of self as being a particular gender."); *accord, e.g., Parents for Privacy v. Dallas Sch. Dist. No. 2*, 326 F. Supp. 3d 1075, 1083 (D. Or. 2018) *app. pending*, No. 18-35708 (9th Cir. 2019).

[37] *See, e.g., Karnoski v. Trump*, 926 F.3d 1180, 1188 (9th Cir. 2019) ("Although most people have a gender identity that matches their sex assigned at birth, this is not the case for transgender people, who identify as transgender because their gender identity does not match their birth-assigned sex."); *Boyden supra* note 34, at 986 ("For purposes of medical diagnosis, as well as increasingly for purposes of common usage, 'gender identity' is the internal core sense of one's own sex, such as male or female. All human beings have a gender identity. . . . 'Transgender' means there is an incongruence between a person's sex at birth (also referred to as one's 'natal sex' in medical texts) or the gender assigned at birth and the individual's gender identity").

at birth, but by their gender identity.[38] Courts have also long recognized that an individual's gender identity is immutable[39] and psychotherapy cannot change a person's gender identity.[40] It is largely because of this medical and legal consensus that at the federal level, people can correct the sex on their passports, immigration documents, Social Security cards, and federal employee records based on a letter from a doctor without any requirement of

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[38] *See, e.g.*, *Schroer v. Billington*, 424 F. Supp. 2d 203, 212-213 (D.D.C. 2006) (recognizing "real variations in how the different components of biological sexuality—chromosomal, gonadal, hormonal, and neurological – interact with each other, and in turn, with social, psychological, and legal conceptions of gender"); *Whitaker supra* note 19, at 1053 (acknowledging that in some cases, "it is clear that the marker on the birth certificate would not adequately account for or reflect one's biological sex, which would have to be determined by considering more than what was listed on the paper").

[39] *See, e.g.*, *Bd. of Educ. of the Highland Local Sch. Dist. supra* note 19, at 874 (being transgender is "immutable"); *Adkins supra* note 30, at 139-140 (same); *Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 947 n.20, 953, 953 n.29 (W.D. Wis. 2018) ("Gender identity is innate and generally considered an immutable characteristic."); *Evancho supra* note 28, at 277 n.12 ("[E]xternal sex organs are one (but by no means the only or most accurate) indicia of a person's sex and gender. . . . [B]eing transgender is not a 'preference.' . . . [B]eing transgender has a medically-recognized biological basis . . . it is an innate and non-alterable status.").

[40] *See, e.g.*, *Richards v. U.S. Tennis Ass'n*, 400 N.Y.S. 2d 267, 271 (N.Y. Sup. Ct. 1977) ("Medical Science has not found any organic cause or cure (other than sex reassignment surgery and hormone therapy) for transsexualism, nor has psychotherapy been successful in altering the transsexual's identification with the other sex or his desire for surgical change."); *Doe v. State of Minn., Dep't of Pub. Welfare*, 257 N.W. 2d 816, 819 (Minn. 1977) ("Given the fact that the roots of transsexualism are generally implanted early in life, the consensus of medical literature is that psychoanalysis is not a successful mode of treatment for the adult transsexual."); *Doe v. McConn*, 489 F. Supp. 76, 77 (S.D. Tex. 1980) (making a factual finding that "[t]reatment of this condition in adults by psychotherapy alone has been futile" and that "[a]dministration of hormones of the opposite sex followed by sex-conversion operations has resulted in better emotional and social adjustment by the transsexual individual in the majority of cases." Because transsexualism is not a "choice," "it has been found that attempts to treat the true adult transsexual psychotherapeutically have consistently met with failure."); *Sommers v. Iowa Civil Rights Comm'n*, 337 N.W.2d 470, 473 (Iowa 1983) ("It is generally agreed that transsexualism is irreversible and can only be treated with surgery to remove some of the transsexual feelings of psychological distress; psychotherapy is ineffective."); *In re Heilig*, *supra* note 35, at 78 ("[C]ourts have recognized that psychotherapy is not a 'cure' for transsexualism. Because transsexualism is universally recognized as inherent, rather than chosen, psychotherapy will never succeed in 'curing' the patient.").

undergoing surgery first.[41] In short, it is widely recognized in law and medicine that one's sex cannot be determined solely by reference to physical sex characteristics. Gender identity is an inherent part of the way law and medicine define "sex," and making attempts to eliminate "gender identity" arbitrary and not in accordance with the statute.

2.3. Section 1557 has protected transgender people from discrimination.

Section 1557 has been instrumental in protecting transgender individuals. Since 2016, the implementing final rule has provided an administrative framework for addressing legitimate complaints for individuals who are denied healthcare or receive substandard healthcare as a result of their transgender status.[42] This framework has enabled victims to seek redress without the costs and time associated with litigation.[43]

The 2016 regulations have been an instrumental part of a broader trend in healthcare coverage for transgender people. Since the 2016 regulations were enacted, insurers and employers have continued to expand coverage to include transgender healthcare and have increasingly removed transgender exclusions. At least 20 states now have explicit coverage in their Medicaid plans for gender dysphoria treatments,[44] and many of those policy changes explicitly reference

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[41] *See FAQ About Identity Documents*, Lambda Legal, https://www.lambdalegal.org/know-your-rights/article/trans-identity-document-faq (last visited Aug. 13, 2019).

[42] The Center for American Progress, *The ACA'S LGBTQ Nondiscrimination Regulations Prove Crucial* (March 7, 2018), available at https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial.

[43] *Id.*

[44] *See* National Center for Transgender Equality, Healthcare Action Center (2018), https://transequality.org/health-care-action-center; Department of Health and Human Services, Office of MaineCare Services, 10-144 C.M.R., Chapter 101, MaineCare Benefits Manual, Section 90, Chapter II, Physician Services (Jun. 18, 2019) (eliminating transsexual surgery exclusion to comply with § 1557 and implementing regulations), https://www.mainepublic.org/sites/mpbn/files/201906/mainecare_benefits_manual__se

Section 1557 and the implementing regulations as the basis for removing exclusions. Similarly, nineteen states and the District of Columbia prohibit the exclusion of transgender-related care in private insurance policies, with many citing Section 1557 and the 2016 regulations.[45] But as less than half of the states have explicit Medicaid coverage or explicit transgender insurance protections, the regulations are still very necessary to prevent discrimination.

3. The proposed rule also makes healthcare access for transgender people more difficult in additional ways.

3.1. The proposed rule will impede healthcare access for people with HIV/AIDS and other serious or chronic conditions.

Transgender people are up to five times more likely than the general population to be living with HIV/AIDS.[46] Transgender women of color are particularly likely to be at risk, with nearly one in five black transgender women living with HIV.[47]

Section 1557 and the 2016 implementing regulations prohibit health insurance companies from discriminating through marketing practices and benefit design. These protections are especially important for people with HIV/AIDS or other serious/chronic conditions. The proposed rule seeks to exempt most health insurance plans from Section 1557's nondiscrimination protections and eliminate the regulation prohibiting discriminatory benefit design and marketing, which could result in health insurers excluding benefits or designing their prescription drug formularies in a way that limits access to medically necessary care for those living with HIV and other chronic conditions.

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ction_90__chapter_ii__physician_services_emerg_.pdf.

[45] *See* Transcend Legal, *State Health Insurance Laws & Guidance*, https://transcendlegal.org/state-health-insurance-laws-and-guidance (listing bulletins, regulations and statutes that prohibit exclusions).

[46] 2015 U.S. Transgender Survey Report, *supra* note 3, at 10.

[47] *Id.*

3.2. The proposed rule will make it much harder for people to understand their legal rights and will disproportionately harm people who are limited English proficient.

The proposed rule will make it more challenging for patients—including transgender people who are also limited English proficient—to understand their healthcare rights under federal law. Many individuals may not know about their rights, how to request language services, or how to file a complaint if they face discrimination. By eliminating tagline requirements and notice standards, the proposed rule will undermine access to healthcare, health insurance, and legal redress for vulnerable communities.

3.3. The proposed rule will make it much harder for transgender people who need access to reproductive care.

The proposed rule also threatens access to reproductive healthcare. LGBTQ people, including transgender, non-binary, and gender nonconforming people, need access to reproductive healthcare and coverage, including abortion, contraception, pregnancy care, and fertility services, free from discrimination.

The proposed rule attempts to unlawfully incorporate a broad religious exemption to 1557's protections against discrimination on the basis of sex. The Department's attempts to add a religious exemption are contrary to the express purpose of Section 1557 and violate the plain language of the statute. Adding a religious exemption opens the door for discrimination and emboldens healthcare providers to deny patients care, threatening the health and well-being of LGBTQ patients and patients seeking reproductive healthcare.

4. Conclusion

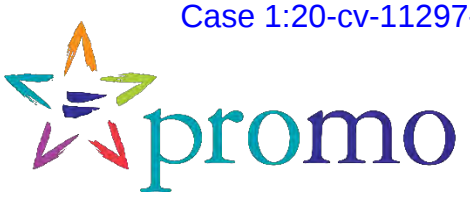
The proposed rule will harm transgender individuals by engendering confusion about the state of the law and promoting discrimination by providers and insurers. It also contradicts existing jurisprudence and medical consensus, causing inconsistency in access to healthcare and discriminatory denials of medically necessary care. We respectfully

request that the proposed rule be withdrawn in its entirety. If you have any questions, please contact David Brown, Legal Director (646) 862-9396, dbrown@transgenderlegal.org).

Sincerely,

Transgender Legal Defense & Education Fund

EXHIBIT D-52



2200 Gravois Ave · Suite 201 · St. Louis, MO · 63104

August 9, 2019

Secretary Alex Azar
Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F,
200 Independence Avenue SW,
Washington, DC 20201

Re: Section 1557 NPRM, RIN 0945-AA11, "Nondiscrimination in Health and Health Education Programs or Activities"

PROMO is Missouri's statewide organization dedicated to lesbian, gay, bisexual, transgender and queer (LGBTQ) equality. PROMO works to ensure that LGBTQ Missourians experience equality in employment, housing, and public accommodations. PROMO is one of Missouri's leading resources for education and policy to address LGBTQ inequality. Decreasing health disparities and ensuring LGBTQ people have access to competent health care is imperative to our work and LGBTQ people thriving in Missouri.

PROMO opposes the proposed rule. If finalized, this proposed rule would severely threaten LGBTQ patients' access to all forms of health care, create confusion among patients and providers about their rights and obligations, and promote discrimination. The proposed rule would encourage hospitals to deny care to LGBTQ people, and enable insurance companies to deny transgender people coverage for health care services that they cover for non-transgender people. The rule would also make it harder for other people experiencing discrimination in health care to know and exercise their rights, including people suffering from chronic health conditions like HIV. PROMO urges the Department of Health and Human Services (HHS) to withdraw the proposed rule.

The proposed rule will threaten LGBTQ patients' access to health care and coverage

All people who need medical care should be able to see their doctor without worrying about being mistreated, harassed, or denied service outright. The Affordable Care Act (ACA) helped address this issue by prohibiting health care providers and insurance companies from engaging in discrimination. The proposed rule will be especially harmful to the 235,000 Missourians who identify as LGBTQ, and more specifically the 25,050 Missourians who identify as transgender.

Under the insurance coverage expansion of the Affordable Care Act, in the first year of full implementation, uninsurance among LGBTQ people with incomes less than 400 percent of the federal poverty level dropped 8 percentage points, from one in three—34 percent—to one in four—26 percent—uninsured. This drop parallels the change seen in the general population in this same income range: According to the Commonwealth Fund, uninsurance among the general population with incomes less than 400 percent of the FPL decreased from 27 percent to 20 percent between 2013 and 2014. Despite the rise in insurance coverage, many thousands remain uninsured. According to the annual Gallup poll, the LGBTQ population is still significantly more likely than the general population to be

uninsured: Between the third quarter of 2013 and the second quarter of 2014, Gallup found an average uninsurance rate of 21.9 percent among LGBTQ people across all income ranges, compared to an average of 15.5 percent among their non-LGBTQ counterparts. By the second quarter of 2014, 17.6 percent of all LGBTQ people remained uninsured, compared to 13.2 percent of the general population. Like anyone else, LGBTQ individuals worry about health care costs, threats to their financial security from unaffordable medical bills, and obstacles to getting the care they need. On a population-wide level, LGBTQ communities experience numerous health disparities that insurance coverage can help address. Well-documented LGBTQ health disparities include:

- Higher rates of mental health concerns such as depression and suicide attempts
- Greater risk of HIV infection and AIDS mortality
- More frequent use of tobacco and other substances
- Higher rates of certain cancers, including breast cancer

Discrimination on the basis of sexual orientation or gender identity is a major reason why LGBTQ individuals are more likely than non-LGBTQ people to be uninsured. Despite advances in legal protections and social acceptance for LGBTQ people over the past several decades, there is still no federal law nor Missouri state law that specifically protects LGBTQ individuals from discrimination in employment, public accommodations, and other areas of everyday life. Experiences of employment discrimination, such as anti-LGBTQ bias in hiring, push many LGBTQ people into unemployment or low-wage jobs that do not offer benefits such as health insurance coverage.

One study by the National Center for Transgender Equality shows the majority (54 percent of LGBTQ Missouri, and 53 percent of the LGBTQ national population) of transgender people have faced harassment or disrespect in public accommodations. According to the 2015 U.S. Transgender Survey, 16 percent of respondents who have been employed reported losing a job in their lifetime because of their gender identity or expression, 15 percent of respondents reported being verbally harassed or (1 percent sexually assaulted) at work because of their gender identity or expression, and 27 percent of respondents reported other forms of mistreatment based on their gender identity or expression during that year, such as being forced to use a restroom that did not match their gender identity, or being told to present in the wrong gender in order to keep their job.

In the U.S. Transgender Survey, 24 percent of Missouri respondents experienced a problem in the past year with their insurance related to being transgender, such as denial of care. 28 percent of Missouri respondents who saw a health care provider reported having at least one negative experience related to being transgender, such as being refused treatment, verbal harassment, physical or sexual abuse, or having to teach the provider about transgender people in order to get appropriate care. The fear of mistreatment led to 24 percent of Missouri respondents not seeking care when they needed it, and unaffordability led to 40 percent of Missouri respondents in not seeking care. Additionally in Missouri, 12 percent of respondents also faced professional doctors and therapists trying to stop them from being transgender, a harmful and widely condemned medical practice also known as conversion therapy.

Finding another doctor is not an answer for all LGBTQ patients. The expansion of legislation, lawsuits, and administrative rule-making allowing for broad religious exemptions from providing services puts another impediment in the way of LGBTQ people receiving medical care. For those patients that do seek medical care and are turned away by providers, alternatives may not be easily accessible. This concern is exacerbated by a shortage of medical providers in key areas of treatment (such as mental health care) and geographic areas (such as rural communities).

LGBTQ Missourians have reported to PROMO that they are traveling up to 6 hours each way to receive medical care, because of a lack of LGBTQ competent care in their region. Even if a provider is found, insurance could historically refuse coverage, even when the provider has deemed it medically necessary. Here are excerpts of these from LGBTQ people in Missouri who have experienced this:

[In my residential facility], I am not allowed to be called by my preferred name. I get in trouble if I even call myself a boy. When I have clothing vouchers I am not allowed to get boy items. They say I cannot wear boy stuff because I am legally a girl. They tell me it's not their problem that I am uncomfortable wearing girl stuff and to get over it. I continue to get in trouble for acting like a boy on a daily basis. My [agency team] agrees that I should be allowed to have boy items, be called a boy, and go by my preferred name but the treatment facility refuses to comply.

I have recently been denied [surgery] for gender reassignment needed to contribute to any type of everyday living and mental health…Paid out of pocket for everything because insurance denied everything.

New data from a nationally representative CAP survey conducted in 2017 shows that 18 percent of LGBTQ people say it would be "very difficult" or "not possible" to find the same type of service at a different hospital, and 17 percent say it would be "very difficult" or "not possible" to find the same type of service at a different community health center or clinic. 41 percent of nonmetro respondents say the same about relocating to another hospital or health center. An estimated 2.9 to 3.8 million lesbian, gay, bisexual, and transgender (LGBTQ) people live in rural communities across the United States, and they are part of the fabric of rural American life.

The 2016 implementing rule is sound, has been crucial for LGBTQ patients to be able to access the care that they need, and promotes equal access to medically necessary health services.

The 2016 Section 1557 implementing final rule is the product of a lengthy process of deliberation and public input. The rule was developed over the course of six years of study and following two comment periods, with over 25,000 comments from stakeholders, which were overwhelmingly supportive of inclusion of protections against discrimination based on sex stereotyping and gender identity. HHS engaged stakeholders through listening sessions, participation in conferences, and other outreach prior to taking regulatory action.

By proposing to eliminate protections against discrimination based on transgender status and sex stereotyping, HHS is contradicting over 20 years of federal case law[1] and clear Supreme Court precedent.[2] The overwhelming majority of courts that have been presented with the question of whether

[1] *See, e.g., Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015); *Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. 2016); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090 (S.D. Cal. Sept. 27, 2017); *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018); *Boyden v. Conlin,* No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018); *Whitaker v. Kenosha Unified School District*, No. 16-3522 (7th Cir. 2017) (Title IX and Equal Protection Clause); *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal Protection Clause); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011) (Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004) (Title VII); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); Grimm v. Gloucester County School Board, No. 4:15-cv-54 (E.D. Va. May 22, 2018); M.A.B. v. Board of Education of Talbot County, 286 F. Supp. 3d 704 (D. Md. March 12, 2018).

[2] *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989)

federally sex discrimination laws such as Section 1557 specifically cover anti-transgender discrimination have firmly ruled that they do.

PROMO is also opposed to the proposed changes to roll back other, long-standing rules that prohibit discrimination on the basis of gender identity and sexual orientation.[3] These changes are outside of the Office for Civil Rights' jurisdiction and are unrelated to Section 1557 of the ACA. It is not appropriate for these rulemakings to be combined, and it is arbitrary and capricious for HHS to characterize them as "conforming amendments" without offering any legal, policy or cost-benefit analysis about them and their impacts on various CMS programs. In particular, HHS offers no analysis of the impact these regulations have had during the years—in some cases over a decade—that they have been in effect or the impact of changing them now.

Section 1557 of the Affordable Care Act and the 2016 implementing rule provided many LGBTQ people with meaningful health care options where they previously had few or none at all, have helped address the pervasive discrimination LGBTQ people often face in health care and coverage, and have made it possible for many transgender and non-transgender people alike to access essential care.

An Out2Enroll 2019 study of 37 states in the federal marketplace shows 94% of plans analyzed did not have blanket exclusions of transition-related care in 2019. This data is consistent with similar analyses from prior years (2017 and 2018). Many insurers in the individual market in Missouri, in fact, removed transgender exclusions in response to the 2016 implementing rule and many insurers now include affirmative coverage language in part due to the recognition of the fact that treatment for gender dysphoria is medically necessary and appropriate treatment. In Missouri, Ambetter, Cigna, and Medica explicitly cover some or all medically necessary transition-related care. Anthem includes partial coverage for transition-related care. As of 2019, *none* of the insurance providers in the Missouri marketplace have blanket exclusions.

Additionally, this proposed rule will cause confusion for providers and patients about people's rights under state and federal law. Missouri law currently does NOT protect LGBTQ Missourians, from firing a hardworking employee, denying them an apartment, or denying them critical services like hospice care simply because they are gay or transgender. The proposed rule will be particularly harmful for LGBTQ Missourians who will have to seek legal action to be able to exercise their rights. This rule will cause confusion among providers and patients about their rights, promote discrimination and dissuade people from seeking care when they need it.

The proposed rule will impede health care access for people with HIV/AIDS and other serious or chronic conditions.

Section 1557 and the 2016 implementing regulations prohibit health insurance companies from discriminating through marketing practices and benefit design. These protections are especially important for people with HIV/AIDS or other serious/chronic condition. The proposed rule seeks to exempt most health insurance plans from Section 1557's nondiscrimination protections and eliminate the regulation prohibiting discriminatory benefit design and marketing, which could result in health insurers excluding benefits or designing their prescription drug formularies in a way that limits access to medically necessary care for those living with HIV and other chronic conditions. Gay men in Missouri

[3] These are: 45 CFR 155.120(c)(1)(ii) and 155.220(j)(2), 45 CFR 147.104(e), 45 CFR 156.200(e) and 156.1230(b)(3), 42 CFR 460.98(b)(3) and 460.112(a), 42 CFR 438.3(d)(4), 438.206(c)(2), and 440.262.

are 19.5 times more likely to experience HIV than the general US population; African-American transgender women are 41.5 times more likely to experience HIV than the general population.[4]

The proposed rule will make it much harder for people to understand their legal rights and will disproportionately harm LGBTQ people who are limited English proficient (LEP), or who need access to reproductive care.

The proposed rule threatens access to reproductive health care. By attempting to eliminate protections against discrimination on the basis of termination of pregnancy, the proposed rule seeks to allow health care providers to discriminate against individuals who have had an abortion and could result in patients being denied critical care including miscarriage management. In addition, by narrowing the scope of covered entities, the proposed rule would allow more insurance plans to refuse to cover reproductive health services, such as pregnancy care or fertility coverage. LGBTQ people, including transgender, nonbinary, and gender nonconforming people, need access to reproductive health care and coverage, including abortion, contraception, pregnancy care, and fertility services, free from discrimination.

The proposed rule attempts to unlawfully incorporate a broad religious exemption to 1557's protections against discrimination on the basis of sex. The Department's attempts to add a religious exemption are contrary to the express purpose of Section 1557 and violate the plain language of the statute. Adding a religious exemption opens the door for discrimination and emboldens health care providers to deny patients care, threatening the health and well-being of LGBTQ patients and patients seeking reproductive health care.

PROMO opposes the proposed rule. If finalized, this proposed rule would severely threaten LGBTQ patients' access to all forms of health care. The 2016 implementing rule is sound, has been crucial for LGBTQ patients to be able to access the care that they need, and promotes equal access to medically necessary health services. PROMO urges the Department of Health and Human Services (HHS) to withdraw the proposed rule.

[4] "The PULSE/LGBT Community Health Assessment, Kansas City, Missouri," City of Kansas City, 2006.

EXHIBIT D-53

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Jon Laramore
Executive Director

August 12, 2019

Secretary Alex Azar
Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F,
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Washington, DC 20201

Re: Section 1557 NPRM, RIN 0945-AA11,
"Nondiscrimination in Health and Health Education Programs or Activities"

Secretary Azar:

Indiana Legal Services (ILS) submits the following comments in response to the proposed changes to HHS regulations implementing Section 1557 of the Patient Protection and Affordable Care Act of 2010 that eliminate the express prohibition of gender identity discrimination in health programs and activities regulated by the department. The proposed rule is dangerous for trans individuals, increases burdens on health care providers and public health systems, and will lead to negative health outcomes for transgender people.

The LGBT Law Project of Indiana Legal Services provides legal advice and representation to low-income members of the LGBT community throughout Indiana. We work to ensure that transgender Hoosiers have access to gender-affirming healthcare and services and are able to access all medically necessary care regardless of insurance provider or location. Indiana Legal Services submits the following comments on the agency's proposed rule to explain that the proposed rule will have a significant negative impact on transgender Hoosiers, and especially low-income transgender individuals. ILS also submits this comment as an employer who wants to ensure that our employees have equal opportunity in employment, regardless of gender identity or sexual orientation, which include health insurance benefits. Our comments are based on our clients' and employees' experiences as transgender residents of Indiana.

THE 2016 FINAL RULE HAS BEEN CRUCIAL FOR LGBT HOOSIERS TO ACCESS MEDICALLY NECESSARY HEALTH SERVICES.

Section 1557 of the Affordable Care Act and the 2016 Final Rule made it possible for many transgender Hoosiers to access essential medical care that has improved health outcomes and increased their quality of life. Section 1557 and the Final Rule provide LGBT Hoosiers with meaningful health care options where they previously had few or none and provides a vital tool to address the pervasive discrimination LGBT people face in health care and coverage. ILS is concerned that the proposed rule would significantly limit access to competent and necessary health care options for LGBT Hoosiers.

Indiana state law offers no protection to LGBT Hoosiers facing discrimination in health care. Not in services. Not in coverage. Not at the hospital. Not at a doctor's office. Not in the marketplace. This meant that before the Final Rule, both public and private insurance plans excluded coverage for transgender healthcare and LGBT Hoosiers outside the small number of cities and counties with anti-discrimination ordinances could be discriminated against when visiting the doctor or hospital, even when seeking care—like setting a broken bone or getting antibiotics—that has no relationship to being transgender. [1]

Before the Final Rule, both public and private insurances companies denied coverage for much of the medically necessary treatment recommended to assist people experiencing gender dysphoria, including treatment options to feminize or masculinize the body "through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people." [2] Insurance companies would deny coverage for hormones and often had blanket exclusions for surgical treatment. These exclusions left transgender Hoosiers unable to treat their gender dysphoria, a serious medical condition which causes "clinically significant

[1] Less than a third of Indiana residents live in a place that has a local or county ordinance prohibiting discrimination based on gender identity in public accommodations. Movement Advancement Project, *Indiana's Equality Profile*, *available at http://www.lgbtmap.org/equality_maps/profile_state/IN.*

[2] WPATH, *Standards of Care* 5 (7th ed. 2011). WPATH develops medical standards of care for treatment of gender dysphoria and is "recognized as authoritative standards of care by the American Medical Association, the American Psychiatric Association, and the American Psychological Association.". The World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, 2 (7th ed. 2011); *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1170 (N.D. Cal. 2015).

psychological distress, dysfunction, debilitating depression and, for some people without access to appropriate medical care and treatment, suicidality and death."[3]

After publication of the Final Rule, transgender Hoosiers had a tool to ensure that insurance companies cover their medically necessary health care. With the Final Rule's guidance that Section 1557 prohibits gender identity discrimination, transgender Hoosiers were able to compel insurance companies to cover hormones and surgical procedures, both inside and outside of the courtroom. Now, our clients can pick up their hormone prescription or schedule surgery without a lengthy court battle.

The Final Rule also provides protection for the great number of transgender Hoosiers who live in rural areas. Our clients who live in rural areas generally have limited health care options and are often the only, or one of a few, transgender persons in their area. This means that they often face ignorance and discrimination when trying to access routine medical care. For example, one of our transgender clients who went to a local medical clinic was consistently addressed with the wrong name and pronouns. This made the client skip sessions with her providers, which in turn caused her mental health to deteriorate, requiring additional services. Advocacy with the clinic and a reminder of the Final Rule's prohibition against gender identity discrimination resulted in the clinic correcting its practices and using the appropriate name and pronouns for our client, enabling our client to access necessary medical care. As discussed below, medical care free from discrimination is necessary for successful medical treatment.

THE PROPOSED RULE WILL IMPEDE HEALTH CARE ACCESS AND OUTCOMES FOR LGBT PEOPLE.

The current language of the proposed rule will severely impede transgender Hoosiers' access to all forms of health care by encouraging discrimination against transgender people. The proposed rule permits health insurance companies to reinsert discriminatory categorical exclusions for the treatment of gender dysphoria back into all commercial health insurance plans sold outside of health care exchanges established under Title I of the PPACA. Additionally, hospitals, health centers, and health care providers will be permitted to discriminate against transgender patients without limitation, from refusing to acknowledge a transgender individual's experienced sex to outright denials of treatment. These acts of discrimination have enormous financial and social costs which Section 1557 and the Final Rule sought to alleviate, and which the proposed rule inappropriately excludes from its Regulatory Impact Analysis.

[3] Resolution 122, Am. Med. Ass'n, *Removing Financial Barriers to Care for Transgender Patients* (2008).

There is no legitimate debate that transition-related treatments and procedures for the treatment of gender dysphoria are medically necessary.[4] Yet, by ignoring more than three decades of Federal Court decisions and interpreting "sex" under Title IX to exclude gender identity discrimination, HHS seeks to permit health care providers and health insurers to deny transgender patients these medically necessary treatments. Permitting discrimination in health care against transgender people has severe consequences, from negative health outcomes for patients, to increased financial burdens on individual patients, health care providers, and public health systems, as well as increased societal costs and harms.

Transgender and gender nonconforming adults in the United States experience greater health disparities in comparison to their cisgender peers, including poor health, difficulty concentrating, remembering, or making decision, and limitations in functioning.[5] Research indicates that discrimination toward transgender people contributes to even worse health outcomes.[6] Discriminatory health care denials for transition-related services are closely linked to negative health outcomes for transgender people.[7] Indeed, the generally accepted diagnostic standards for gender dysphoria indicate that when transgender people are denied transition-related treatment and procedures that are medically necessary, gender dysphoria symptoms are exacerbated, leading to negative health outcomes including increased depression, anxiety, substance abuse, self-harm and suicidality.[8] Gender based discrimination affecting access to services is a strong predictor of suicide risk among transgender persons.[9]

Denials of health insurance coverage result in transgender people either foregoing necessary medical treatment or incurring significant out-of-pocket expense, both of which also contribute to poor health outcomes. Foregoing medically necessary transition-related treatment is associated with poor mental health outcomes: individuals

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[4] *See e.g.* WPATH, *Standards of Care* 5 (7th ed. 2011); Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California San Francisco, Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People (2nd ed. 2016).
[5] Institute of Medicine (IOM). The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. Washington, D.C.: National Academies Press (US): 2011, *available at* https://www.ncbi.nlm.nih.gov/books/NBK64806/.
[6] Streed et al., *Association Between Gender Minority Status and Self-Reported Physical and Mental Health in the United States*. JAMA (2017).
[7] Gorton, RN, *Transgender Medicine. San Francisco: Lyon-Marin Health Services*, 2010.
[8] Diagnostic and Statistical Manual of Mental Disorders 451-459, American Psychiatric Association(5th ed. 2013).
[9] Kristin Clements-Nolle, et al., *Attempted Suicide among Transgender Persons: The Influence of Gender-Based Discrimination and Victimization*, 53 J Homosexuality 3, 53-69 (Oct. 2008).

with gender dysphoria who have undergone no gender confirmation treatment are twice as likely to experience moderate to severe depression and four times more likely to experience anxiety than their surgically-affirmed peers.[10] The out-of-pocket costs for transition-related treatment for the individual patient are quite high. Procedures can cost anywhere from $1,000 per year for hormone replacement therapy, up to $300,000 for genital surgeries.[11] These costs are significantly less for health insurance companies that have significant negotiating leverage with health care providers. Paying for transition-related health care out-of-pocket is a leading driver of transgender people participating in "underground" economy work, including sex work and drug trafficking.[12]

In addition to the negative impacts of discriminatory coverage exclusions, discrimination by health care providers contributes to transgender people frequently foregoing preventative care and necessary treatments for conditions not related to their gender dysphoria. Nearly one-quarter of transgender respondents to the 2015 U.S. Transgender Survey indicated that they postponed or avoided medical treatment when they were sick or injured because of fear of discrimination by health care providers.[13] Lack of timely access to prevention and treatment services results in poorer health outcomes and added costs by opening the door to life-threatening consequences such as advance-stage cancer diagnosis, HIV infection, and serious complications of conditions such as heart disease or diabetes.[14]

The negative health outcomes for transgender people denied medically necessary treatment results in enormous social costs, and increasing long-term health care costs for the patients. Patients who are denied care engaged in health harming behaviors at alarming rates, from substance abuse, self-harm and suicidality, to self-prescribed transition procedures like injection of construction grade silicone into the breasts and hips, and other interventions that have the potential to cause adverse effects.[15] These behaviors often lead to long-term harms, including contracting HIV or other chronic

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[10] Ashli Owen-Smith, et al., *Association Between Gender Confirmation Treatments and Perceived Gender Congruence, Body Image Satisfaction, and Mental Health in a Cohort of Transgender Individuals*, 15 J Sexual Med 4, 591-600 (Apr. 2018).

[11] Dave Muoio, *Managed Health Care Connect, "Transgender Patients: Calculating the Actual Cost*, (2017).

[12] Center for American Progress, *Paying an Unfair Price: The Financial Penalty for Being Transgender in America* (2015).

[13] 2015 U.S. Transgender Survey, p. 93.

[14] Center for American Progress, *Paying an Unfair Price: The Financial Penalty for Being Transgender in America* (2015) (*citing* Population Association of America, 2013 Annual Meeting, *Untitled Working Paper*, *available at* https://paa2013.princeton.edu/papers/132584.

[15] AMA, *Issue Brief: Health Insurance Coverage for Gender-Affirming Care of Transgender Patients* (2019).

health conditions. These health harming behaviors increase overall costs of health systems and insurers, who must pay for treatments to address these harms.

Yet studies demonstrate dramatic reductions in these health harming behaviors when medically necessary treatments are received by transgender patients. One meta-analysis found that suicidality rates dropped from 30% pre-treatment to 8% post-treatment for transgender patients.[16] Other studies demonstrate that depression and anxiety symptoms decreased and mental health and function improved after receiving gender-affirming care for a majority of transgender patients.[17] Additionally, receiving gender-affirming care is associated with decreased substance use and improved HIV medication adherence among the transgender population, reducing long-term negative health outcome and potential transmittal rates.[18] Care appropriately supervised by medical professionals also reduces rates of harmful self-prescribed transition treatments.[19]

HHS's proposed rule, removing explicit protections against discrimination on the basis of gender identity will result in a dramatic increase in negative health outcomes among transgender people, which will result in a significant financial burden for public health systems, private health insurers, and consumers. The proposed rule thwarts the purpose of Section 1557 rather than furthering its objectives.

THE FINAL RULE WAS THE PRIMARY FACTOR WHEN ILS SUCCESSFULLY NEGOTIATED REMOVING THE CATEGORICAL EXCLUSION OF TRANSGENDER HEALTH CARE COVERAGE FROM OUR EMPLOYEE HEALTH INSURANCE PLAN.

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[16] M. Hassan Murad, et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 Clinical Endocrinology 2, 214-331 (Feb. 2010).

[17] Yolonda Smith, et al., *Sex Reassignment: Outcomes and Predictors of treatment for Adult and Adolescent Transsexuals*, 35 Psychological Med. 1, 89-99 (Jan. 2005); Tiffany Ainsworth & Jeffrey Spiegel, *Quality of Life of Individuals With and Without Facial Feminization Surgery or Gender Reassignment Surgery*, 19 Quality Life Res. 7, 1019-24 (Sep. 2010).

[18] Jamil Rehman, et al., *The Reported Sex and Surgery Satisfactions of 28 Postoperative Male-to-Female Transsexual Patients*, 28 Archives Sexual Behav. 1, 71-89; Jae Sevelius, Adam Carrico & Mallory Johnson, *Antiretroviral Therapy Adherence Among Transgender Women Living with HIV*, 21 J. Ass'n Nurses AIDS Care 3, 256-64 (May 2010).

[19] Jessica Xavier, Admin. HIV and AIDS, D.C. Gov't, *The Washington Transgender Needs Assessment Survey* (2000); Wendy Bostwick & Gretchen Kenagy, *Health and Social Service Needs of Transgendered People in Chicago*, 8 Int'l J. Transgenderism 2-3, 57-66 (Oct. 2008); Cathy Reback, et al., *Los Angeles Transgender Health Study: Community Report* (2001).

In April 2015, prior to the publication of the Final Rule, Indiana Legal Services requested that our insurance provider remove the categorical exclusion of "services and supplies related to sex transformation" from the ILS-sponsored employee health insurance plan serviced by Anthem Blue Cross Blue Shield of Indiana. Anthem informed ILS that it would not remove the exclusion from the plan, but that ILS could purchase a rider providing coverage for the specific employee only, at a cost that was unfeasible for a non-profit civil legal services agency. As a result, the employee did not receive coverage for her transition-related care and incurred approximately $8,000 of out-of-pocket medical expenses. The employee was forced to work a second job to finance her medical care and also delayed medically necessary procedures recommended by her treatment team because she was unable to afford the out-of-pocket costs for those procedures.

In June 2016, following publication of the Final Rule, ILS again requested that Anthem remove the categorical exclusion. Anthem informed ILS that it would remove the exclusion from all of its commercial insurance plans pursuant to the Final Rule as of January 1, 2017. Despite the December 31, 2016 injunction, Anthem Indiana did not reinsert the categorical exclusion back into its Indiana commercial insurance policies. As a result of the regulatory change, at least two transgender ILS employees have received coverage for mental health therapy, hormone-replacement therapy, and genital reconstructive surgery for treatment of gender dysphoria. These employees would not have received this treatment but-for Anthem removing the categorical exclusion in response to publication of the Final Rule. The Final Rule gave employers the flexibility to design a cost-effective plan to meet the needs of its employees, whereas the proposed rule would hamper this flexibility.

THE PROPOSED RULE WOULD WORK AGAINST ITS STATED OBJECTIVES OF MINIMIZING CONFUSION, FURTHERING SUBSTANTIVE COMPLIANCE, AND CLARIFYING THE SCOPE OF SECTION 1557 IN KEEPING WITH PRE-EXISTING CIVIL RIGHTS STATUTORY AND REGULATORY SCHEMES.

The proposed rule purports to emphasize clarity but removes the primary mechanisms the Final Rule adopted to provide consistent guidance to covered entities, individuals, and decisionmakers. The proposed rule's elimination of 1) a definitions section; 2) specific nondiscrimination protections based on gender identity; 3) notice requirements; 4) compliance and grievance processes; and 5) enforcement provisions is contrary to the text, history, and spirit of Section 1557 and would only create confusion and additional litigation risks by creating conflict between the statutory text and agency regulation.

The vast majority of courts to consider whether federal sex discrimination laws—including Section 1557, Title IX, Title VII, and the Fair Housing Act—prohibit discrimination based on gender identity or transgender status have concluded that they do.[20] Regulatory guidance across agencies enforcing federal sex discrimination laws also make clear that discrimination based on gender identity is sex discrimination.[21] The Department's current regulation acknowledges that the question remains unsettled and adopts a regulatory definition consistent with Supreme Court precedent. *Price Waterhouse v. Hopkins*, 490 U.S. 228, 250-51 (1989); 81 Fed. Reg. at 31389. The Department's proposed elimination of this definition and express protections from discrimination based on gender identity will result in needless expense and confusion—covered entities will be required to expend time and resources to revise policies knowing that they may have to again revise them to comport with the Supreme Court's decisions. Maintaining the current regulations and preserving the status quo is a far more reasonable response to pending Supreme Court guidance.

The Department's proposed rule also ignores over three decades of federal court caselaw interpreting the statutory meaning of sex discrimination. Instead of tracking well-settled case law, the proposed rule relies almost exclusively on *Franciscan Alliance* for the proposition that the proposed rule will minimize litigation risks surrounding the

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[20] *EEOC v. R.G. &. G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560 (6th Cir. 2018); *Whitaker v. Kenosha Unified School District*, 858 F.3d 1034 (7th Cir. May 30, 2017); *Dodds v. U.S. Dept. of Education*, 845 F.3d 217 (6th Cir. Dec.16, 2016); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. Dec. 6, 2011); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. March 25, 2005); *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. Aug. 5, 2004) ; *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. June 8, 2000); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. Feb. 29, 2000); *Tovar v. Essentia Health*, cv-16-100-DWF-LIB (D. Minn. Sept. 20, 2018); *Boyden v. Conlin*, No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018); *EEOC v. A&E Tire*, 1:17-cv-02362 (D. Colo. Sept. 5, 2018); *Adams v. School Board of St. Johns County*, 318 F.Supp.3d 1293 (M.D. Fla. Jul. 26, 2018*); Flack v. Wisconsin Department of Health Services*, 18-cv-309, 2018 WL 3574875 (W.D. Wis. Jul. 25, 2018); *Doe v. Massachusetts Department of Correction, et al.*, No. CV 17-12255-RGS, 2018 WL 2994403 (D. Mass. June 14, 2018); *Grimm v. Gloucester County School Board*, No. 4:15-cv-54 (E.D. Va. May 22, 2018); *Parker v. Strawser Construction*, 307 F. Supp. 3d 744 (S.D. Ohio Apr. 25, 2018); *M.A.B. v. Board of Education of Talbot County*, 286 F. Supp. 3d 704 (D. Md. March 12, 2018); *F.V. v. Barron*, 286 F. Supp. 3d 1131 (D. Idaho March 5, 2018); *Karnoski v. Trump*, C17-1297-MJP, 2017 WL 5668071 (W.D. Wash. Dec 11, 2017); *A.H. ex rel. Handling v. Minersville Area School District*, No. 3:17-CV-391 2017 WL 5632662 (M.D. Pa. Nov. 22, 2017); *Stone v. Trump*, 280 F. Supp. 3d 747 (D. Md. Nov. 21, 2017); *Prescott v. Rady Children's Hospital-San Diego*, 265 F. Supp. 3d 1090 (S.D. Cal. Sept. 27, 2017).

[21] *E.E.O.C. v. Rent-a-Center East, Inc.*, 264 F. Supp. 3d 952 (C.D. Ill. Sept. 8, 2017); *Brown v. Dept. of Health and Hum. Servs.*, No. 8:16DCV569, 2017 WL 2414567 (D. Neb. June 2, 2017); *Smith v. Avanti*, 249 F. Supp. 3d 1149, 2017 WL 1284723; *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267 (W.D. Pa. Feb. 27, 2017); *Mickens v. Gen. Elec. Co.* , No. 16-603, 2016 WL 7015665 (W.D. Ky. Nov. 29, 2016); *Roberts v. Clark Cty. Sch. Dist.*, No. 2:15-cv-00388, 2016 WL 5843046 (D. Nev. Oct. 4, 2016); *Bd. of Ed. of Highland Local Sch. Dist. v. U.S. Dep't of Educ.*, 208 F. Supp. 3d 850 (S.D. Ohio Sept. 26, 2016); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. Jul. 5, 2016)).

scope of Section 1557's prohibition on sex discrimination.[22] *Franciscan Alliance* challenged the regulation itself and has no impact on Section 1557's statutory prohibition on sex discrimination.

The proposed rule fails to consider that, outside of *Franciscan Alliance*, every district court to consider the question has held that discrimination based on transgender status is sex discrimination and prohibited by Section 1557's statutory protections. The proposed rule would make the Department's regulations inconsistent with judicial treatment of the statute causing further confusion and litigation, which is inconsistent with the principle that federal agency guidance should increase uniform application of federal law. The proposed rule's emphasis on giving "flexibility" to states and localities to decide whether transgender individuals are protected from discrimination contradicts basic principles of supremacy and the proposed rule's emphasis on "consistency." The proposed rule would endorse an absurd policy position that an individual's entitlement to healthcare under a federal healthcare law depends on their state and local laws.

The proposed rule makes explicit that it views cost-saving as a more pressing concern than the lives of transgender individuals. The proposed rule eliminates notice and grievance processes in the interest of alleged cost saving to the detriment of transgender individuals. Removing the notice processes eliminates a primary means of communicating an individual's rights. Without knowledge of those rights, an individual has no ability to vindicate those rights. The proposed removal of the grievance procedures will mean more discrimination will go unaddressed. For many of our clients, a grievance is the only way to seek redress because the costs and expenses of initiating and maintaining a civil action are prohibitive. The Department recognizes that the majority of complaints it anticipates defending arise from claims of discrimination based on gender identity or sex stereotyping and explicitly attributes savings to removing nondiscrimination protections because that change would eliminate the majority of its caseload.

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[22] *Fabian v. Hosp. of Cent. Conn*., 172 F. Supp. 3d 509 (D. Conn. Mar. 18, 2016); Doe v. State of Ariz., No. CV-15-02399-PHX-DGC, 2016 WL 1089743 (D. Ariz. Mar. 21, 2016); *Dawson v. H&H Elec., Inc.,* No. 4:14CV00583 SWW, 2015 WL 5437101 (E.D. Ark. Sept. 15, 2015); *Norsworthy v. Beard,* 87 F. Supp. 3d 1164 (N.D. Ca. Oct. 5, 2015); *U.S. v. S.E. Okla. State Univ.*, No. CIV–15–324–C, 2015 WL 4606079 (W.D. Okla. July 10, 2015); *Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015); *Finkle v. Howard Cty*., 12 F. Supp. 3d 780 (D. Md. 2014); *Lopez v. River Oaks Imaging & Diagnostic Group, Inc.*, 542 F. Supp. 2d 653 (S.D. Tex. 2008); *Mitchell v. Axcan Scandipharm, Inc.,* No. Civ.A. 05-243, 2006 WL 456173 (W.D. Pa. 2006); *Tronetti v. Healthnet Lakeshore Hosp.,* No. 03–CV–0375E, 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. Sept. 19, 2008)

CONCLUSION

We reiterate that the likely outcome of this rule will be to harm Indiana Legal Services' vulnerable client population.

Sincerely,

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Indiana Legal Services

Katherine Wood
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Kathleen Cullum
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EXHIBIT D-54

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AMERICAN MEDICAL ASSOCIATION

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August 13, 2019

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200 Independence Avenue, SW
Washington, DC 20201

RE: Docket ID HHS-OCR-2019-0007, RIN 0945-AA11, Nondiscrimination in Health and Health Education Programs or Activities

Dear Secretary Azar:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express our opposition to the Notice of Proposed Rulemaking (NPRM) entitled, "Nondiscrimination in Health and Health Education Programs or Activities," published by the Office for Civil Rights (OCR) and the Centers for Medicare and Medicaid Services (CMS). Section 1557 of the Affordable Care Act (ACA) was intended to help protect people who experience significant barriers to accessing health care, including lesbian, gay, bisexual, transgender, and queer (LGBTQ) people, minorities, individuals whose primary language is not English, and those in need of reproductive health care and help provide those populations equal access to health care and health coverage. **This proposal, however, is contrary to the intent and the plain language of the law.** It will negatively affect patients by drastically limiting the scope of health plans to which the non-discrimination provisions apply, thereby eliminating coverage protections for certain individuals, such as transgender people, women, LGBTQ people, and individuals living with HIV. The NPRM also eliminates anti-discrimination protections based on gender identity and sex stereotypes, despite decades of case law recognizing such protections, including in the context of section 1557.

The NPRM comes on the heels of the Department of Health and Human Services' (HHS) final regulations on more than 20 federal statutory provisions related to the ability of individuals and health care institutions to refuse to provide services to which they have religious or moral objections, as well as significant revisions by HHS to the Title X program, both of which empower individuals and institutions to refuse to provide or participate in medical treatment, services, information, and referrals. Meanwhile, **this proposal marks the rare occasion in which a federal agency seeks to <u>remove</u> civil rights protections.** It legitimizes unequal treatment of patients by not only providers, health care organizations, and insurers, but also by the government itself—and it will harm patients. HHS states that the NPRM is necessary to "address legal concerns" raised by the *Franciscan Alliance v. Burwell* litigation and simplify regulatory confusion, but it in fact creates confusion and enables discrimination. It deems certain classes of people less worthy of care, compassion, access, and good health than others. Such policy should not be permitted by the U.S. government, let alone proposed by it.

Respect for the diversity of patients is a fundamental value of the medical profession. There is no basis for the denial to any human being of equal rights or privileges because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin, or age. **Based on longstanding policy, the AMA strongly opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such policies.** AMA policy also supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

The AMA believes in the critical importance of ensuring health equity—optimal health for all—recognizing the importance and urgency of ensuring that all people and communities reach their full health potential. Unfortunately, at the provider and institutional levels, there is a growing body of evidence demonstrating that implicit and explicit biases negatively impact the quality of health care equity and patient safety and drive these inequities. Indeed, "racism is considered a fundamental cause of adverse health outcomes for racial/ethnic minorities and racial/ethnic inequities in health."[1] Additionally, there is evidence that experiences of discrimination and racism have a "weathering"[2] physiological effect on the body (e.g., irregular heartbeat, anxiety, heartburn), which over time can be compounded and lead to long-term negative health outcomes.[3] The Joint Center for Political and Economic Studies estimates that health inequalities and premature deaths cost the U.S. economy $309.3 billion a year;[4] the proposed elimination of most of the anti-discrimination protections in the 2016 implementing regulations (Current Rule) will likely increase this figure.

As advocates for our patients, we strongly support patients' access to comprehensive health care services. Physicians are expected to provide care in emergencies, respect basic civil liberties, and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient. We expect the same for the rest of the health care system and for the federal government's health care activities and programs. **In sum, the AMA strongly opposes the proposed elimination or rollback of critical protections guaranteed by section 1557 of the ACA and the Current Rule and, accordingly, we urge HHS to withdraw this proposal.**

Scope of Application

Section 1557 of the ACA prohibits discrimination by "any health program or activity, any part of which is receiving federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under [Title I of the ACA]."[5] Accordingly, under the Current Rule, an insurer that offers a plan in the ACA Marketplace must ensure that all of its plans—not only those offered in the Marketplace—comply with section 1557. However, the proposed rule improperly attempts to narrow the application of section 1557's protections

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[1] David R.William et al., *Racism and Health: Evidence and Needed Research*, Annu. Rev. Public Health (Jan. 2, 2019), available at https://www.annualreviews.org/doi/pdf/10.1146/annurev-publhealth-040218-043750.
[2] Arline T. Geronimus, ScD, et al., *"Weathering" and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States*, Am J Public Health (May 2006), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470581/.
[3] Healthy People 2020, citing Pascoe EA, Smart RL, *Perceived discrimination and health: a meta-analytic review*, Psychol Bull. 2009;135(4):531–54, available at https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/discrimination#5.
[4] Thomas A. LaVeist, et al., *The Economic Burden Of Health Inequalities in the United States*, Joint Ctr. for Pol. and Econ. Stud., available at https://jointcenter.org/sites/default/files/Economic%20Burden%20of%20Health%20Inequalities%20Fact%20Sheet.pdf.
[5] 42 U.S.C. § 18116(a).

to only the portion of a health care program or activity that receives federal financial assistance. As such, insurers offering plans in the Marketplace will only need to ensure that Marketplace plans comply with section 1557—not all of their plans. **The statute is clear that it applies to health programs or activities, *any part of which* receives federal financial assistance.** If Congress had intended that only the product receiving such assistance was bound by the nondiscrimination provisions, it could have easily stated as much in very simple terms.

Additionally, the NPRM restricts the scope of application to health plans that are "principally engaged in the business of providing health care" as opposed to those primarily engaged in providing health insurance. As stated in the preamble, these criteria would thus exclude short term limited duration insurance (STLDI) plans from needing to comply with section 1557 as such plans are neither (1) principally engaged in the business of health care, nor (2) receiving federal financial assistance with respect to STLDI plans specifically. Notably, such plans are widely-regarded as discriminatory on the basis of sex, age, and disability. For example, a 2018 study found that no short term plans covered maternity care.[6] Other data demonstrates that short term health plans charge women higher premiums than men.[7] Free of a requirement to comply with non-discrimination laws, STLDI plans will be emboldened to deny coverage for any number of conditions and services, including those that affect only women (e.g., uterine cancer or abortion) or transgender populations (e.g., gender dysphoria or transition-related services).

HHS also appears to be narrowing the scope of the regulations to only HHS-administered health programs and activities that fall under Title I of the ACA. This is a drastic and improper shift that will have a wide-ranging impact, as health programs and activities such as those administered by the Health Resource Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), Substance Abuse and Mental Health Services Administration (SAMHSA), CMS, and the Indian Health Service (IHS) would no longer be covered by section 1557. We are unsure why HHS is proposing this change as section 1557's statutory text clearly states that it applies to "any program or activity that is administered by an Executive Agency."

Each of these proposals are contrary to what section 1557's statutory text states and are a clear attempt to reduce the number of health insurance plans, health programs, and health activities covered by the regulations. This policy is not only illogical and confusing, but also creates a standard that discrimination is acceptable for some beneficiaries but not others. **HHS should not finalize the proposed change in scope and should instead retain the Current Rule's application of section 1557, which accurately reflects the language and intent of the underlying statute.[8]**

Protections on the Basis of Sex

The NPRM eliminates the regulatory definition of sex-based discrimination. If finalized, this will impact protections not only for LGBTQ individuals, but also for women who are pregnant, have miscarried, who have had complications with childbirth, or who have terminated a pregnancy. Loss of protections for these classes of individuals will lead to barriers to care, lack of health insurance coverage, and higher

[6] Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Foundation (Apr. 23, 2018), available at https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/.
[7] Sarah Lueck, *Key Flaws of Short-Term Health Plans Pose Risks to Consumers*, Ctr. on Budget & Pol'y Priorities (Sept. 20, 2018), available at https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers.
[8] 45 CFR §92.2(a).

costs (either in premiums or cost-sharing rates) for those services that are covered. It also simply chips away at people's dignity.

The AMA strongly believes that discrimination on the basis of sex includes discrimination on the basis of gender identity and sexual orientation. The courts and federal agencies agree. Since 2012, OCR has interpreted section 1557 of the ACA's sex discrimination prohibition to extend to claims of discrimination based on gender identity or sex stereotypes and accepted such complaints for investigation. Numerous federal agencies, including the U.S. Department of Justice, U.S. Department of Labor, U.S. Department of Education, and the U.S. Department of Housing and Urban Development, have previously interpreted sex discrimination to include discrimination on the basis of gender identity. The NPRM disregards these interpretations—reversing OCR's own long-standing policy—and disregards the Supreme Court's holding in *Price Waterhouse v. Hopkins* (1989), which states that discrimination based on stereotypical notions of appropriate behavior, appearance, or mannerisms for each gender constitutes sex discrimination.[9] Lower courts, including in the context of section 1557, have also recognized that sex discrimination includes discrimination based on gender identity.[10]

Section 1557's protections against sex discrimination are necessary. Transgender, nonbinary, and gender nonconforming people already experience high rates of discrimination and harassment in health care. According to the 2015 U.S. Transgender Survey, 33 percent had at least one negative experience in a health care setting relating to their gender identity in the past year, and 23 percent did not seek health care when they needed it due to fear of being disrespected or mistreated as a transgender person.[11] These rates tend to be higher for non-white respondents and individuals with disabilities.[12] Following an early 2017 Freedom of Information Act (FOIA) request to HHS for complaints of discrimination under section 1557, the Center for American Progress (CAP) found that the most common complaints involved individuals being denied care or insurance coverage because of their gender identity or transgender status.[13] Examples include a transgender woman being denied a mammogram, a transgender man being refused a screening for a urinary tract infection, an insurer not covering reproductive health care because of an individual's gender identity, and an insurer not covering genetic testing for breast cancer for a transgender man despite the testing being recommended by the complainant's physician.[14] CAP notes that existing enforcement of section 1557 is "working well to resolve very real issues of discrimination, and that the fears raised by the *Franciscan Alliance* [*v. Burwell*] lawsuit are not well-founded."[15] Incidentally,

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[9] 490 U.S. 228 (1989).

[10] *See, e.g., Rumble v. Fairview Heath Servs.*, Civ. No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (Section 1557) (order denying motion to dismiss); *Barnes v. City of Cincinnati*, 401 F.3d 729, 737 (6th Cir.), cert. denied, 546 U.S. 1003 (2005)(Title VII); *Smith v. City of Salem, Ohio*, 378 F.3d 566, 575 (6th Cir. 2004) (Title VII); *Schroer v. Billington*, 577 F.Supp.2d 293, 304 (D.D.C. 2008) (Title VII).

[11] S.E. James, et al., Nat'l Ctr. for Transgender Equality, *Report Of The 2015 U.S. Transgender Survey* (2016), available at https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[12] S.E. James, et al., Nat'l Ctr. for Transgender Equality, *Report Of The 2015 U.S. Transgender Survey* (2016), available at https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[13] Sharita Gruberg and Frank J. Bewkes, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial*, Center for American Progress (March 7, 2018), available at https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/.

[14] Sharita Gruberg and Frank J. Bewkes, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial*, Center for American Progress (March 7, 2018), available at https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/.

[15] Sharita Gruberg and Frank J. Bewkes, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial*, Center for American Progress (March 7, 2018), available at https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/.

none of the complaints involved HHS ordering a health care professional to perform a service against his or her medical judgement.

Additionally, the AMA does not condone discrimination based on whether a woman has had an abortion. While the NPRM notes that Title IX prohibits discrimination based on pregnancy, including termination of pregnancy, it fails to clarify whether HHS will enforce those protections. HHS should clearly state, for example, that it is illegal for a pharmacist to refuse medication for someone who is miscarrying, or for an insurer to refuse coverage to a woman who has had an abortion. **Given HHS' recent regulations finalizing the ability of individuals and health care institutions to refuse to provide services to which they morally object, as well as the significant revisions to the Title X program, protections against discrimination on the basis of pregnancy (including termination thereof) are critical.** We anticipate that many women will experience barriers when they seek reproductive health services or attempt to obtain insurance coverage for reproductive health care.

Furthermore, the NPRM attempts to incorporate Title IX's religious exemption, which could permit health care entities controlled by a religious organization to discriminate if the entity claims that compliance with sex discrimination protections would conflict with its religious beliefs. If finalized, this could impact a broad range of health care services, including access to birth control, sterilization, certain fertility treatments, abortion, gender-affirming care, and end of life care. For example, religiously-affiliated pharmacies could refuse to prescribe contraception to someone because they are not married or refuse to provide infertility treatment to a same-sex or transgender couple.

Finally, HHS is proposing to eliminate prohibitions on discrimination based on gender identity and sexual orientation in 10 regulations outside of section 1557, including those concerning qualified health plan issuers, agents, and brokers that assist with Marketplace applications and enrollment; marketing or benefit design practices of health insurance issuers under the ACA; organizations operating Programs for All-inclusive Care of the Elderly (PACE) programs and participants receiving PACE services under Medicare; Medicaid beneficiary enrollment; and promotion and delivery of access and services. The regulations for these programs are not connected to section 1557 and many have been in effect for years; changing them now would not only create significant confusion, but also have wide-ranging consequences for millions of individuals. Furthermore, this NPRM is not the appropriate mechanism to revise such regulations. HHS should not finalize this proposal.

<u>Language Access</u>

The AMA supports access to quality care for all individuals and encourages physicians to make their offices accessible to patients with disabilities and limited English proficiency (LEP). Moreover, the AMA strongly believes that clear, direct communication and understanding is the bedrock of the patient-physician relationship and is very important in ensuring the provision of quality medical care to all patients. However, we believe that the financial burden of medical interpretive services and translation should not fall entirely on physician practices. Rather, as with interpreters or other auxiliary aids or services for individuals with hearing impairments, language interpretive services should be a covered benefit for all health plans, which are in a much better position to pass on the costs of these federally mandated services as a business expense.

Relatedly, AMA members have reported to the AMA that individuals with LEP often bring trusted adults with them to an appointment to facilitate communication. The Current Rule states that a physician may

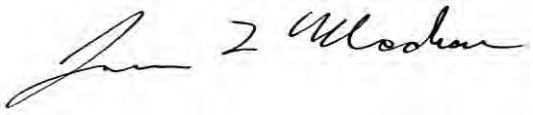
rely on an adult accompanying an individual with LEP to interpret or facilitate communication only if reliance on that adult for such assistance is "appropriate under the circumstances." This standard remains unclear to physicians, causing them to take on the additional burden and expense of interpreters out of an abundance of caution when it may not be always necessary to do so. For example, when a physician sees an adult male patient presenting with flu-like symptoms, who is accompanied by his adult brother, and the patient requests that his brother translate, a physician may find this request appropriate under the circumstances. Conversely, if a female patient presenting with a broken arm is accompanied by her husband, the physician may have concerns about domestic abuse. In this case, it may be inappropriate to rely on the husband to provide accurate interpretation services. The AMA urges HHS to clarify the circumstances in which a physician may rely on an adult accompanying a patient to interpret or facilitate communication. We would welcome the opportunity to assist the agency with guidance.

Conclusion

This NPRM is at odds with section 1557's clear mandate. Undoing the protections of the Current Rule will cause confusion about what the law requires and who is protected by it and, in doing so, will limit access to critically needed care and services for millions of individuals. The proposed rule disproportionately harms people seeking reproductive health care (including abortion), LGBTQ individuals, individuals with LEP (including immigrants), those living with disabilities, and people of color. For the reasons detailed above, **HHS should not finalize the proposed rule, but rather should redirect their efforts toward advancing health care access and equity for all. The AMA remains ready to assist with such efforts.**

Thank you again for the opportunity to submit comments on the proposed rule. Should you have any questions or wish to discuss these issues, please contact Laura Hoffman, Assistant Director of Federal Affairs, at laura.hoffman@ama-assn.org or 202-789-7414.

Sincerely,



James L. Madara, MD

EXHIBIT D-55

Actors Fund ☙ African Services Committee ☙ Children's Defense Fund-New York
Community Service Society of New York ☙ Consumers Union ☙ Empire Justice Center
Make the Road New York ☙ Medicare Rights Center ☙ Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition ☙ Project CHARGE
Public Policy and Education Fund of New York/Citizen Action of New York
Raising Women's Voices-New York ☙ Schuyler Center for Analysis and Advocacy ☙ Young Invincibles

August 13, 2019

VIA ELECTRONIC SUBMISSION

Secretary Alex Azar
U.S. Department of Health and Human Services
Herbert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

RE: Docket ID HHS-OCR-2019-0007, RIN 0945-AA11, Nondiscrimination in Health and Health Education Programs or Activities

Dear Secretary Azar:

Health Care For All New York (HCFANY) is a coalition of over 170 organizations that advocate for high-quality, affordable health care for everyone. The proposed revisions of Section 1557 of the Patient Protection and Affordable Care Act would create barriers to health care for many, including lesbian, gay, bisexual, transgender and queer people; people who need reproductive health care; and people whose primary language is not English. The Department of Health and Human Services (the Department)'s interpretation of Section 1557 is also inconsistent with the intent of the law. The revisions should be withdrawn.

There are already many barriers in place preventing Americans from accessing health care when they need it. The proposed revisions add another by sending the message that health care workers can turn people seeking medical treatment away because of their personal characteristics. Health care workers must treat all patients with respect and in accordance with the best medical knowledge. Those individuals who cannot do this unless their patients match specific personal characteristics are guilty of discrimination, and it should not be condoned by the United States government.

I. The current rule addresses discriminatory behavior by health care providers that produces disparities in health care experienced by women and LGBTQ people, and should not be changed.

The Department proposes to remove clear language prohibiting discrimination based on pregnancy and childbirth. The United States is experiencing a maternal mortality crisis. Pregnancy in the United States is dangerous, and is made more dangerous when providers are allowed to believe they can deny care such as abortions to women whose pregnancies endanger their lives, such as those with ectopic pregnancies.

The new rule would be especially harmful for people who are transgender, who have often been targeted for discrimination from providers who refuse to provide medically-necessary care related to gender transition. Health care workers who refuse to provide that care (and health insurers that refuse to cover it) are doing so in opposition to the best medical knowledge, which should never be allowed. Transgender people also frequently experience discrimination from providers when seeking care that is unrelated to their gender, for example when providers refuse to call them by the right name or waste appointment time by focusing on gender instead of the health issue at hand. Insurers sometimes reject claims for services like pap smears or mammograms for people identified as male or as non-binary even when their gender at birth might mean those services are important for early identification of serious health problems like cancer. Medical providers should be able to determine which services and tests are needed based on the physical needs of their patient, not the gender marker used on paperwork.

Providers should not feel empowered to treat transgender people differently than they treat anyone else. In order to make sure that never happens, the current rule is very clear about prohibiting discrimination based on gender identity. To ensure that providers follow the rules, transgender people need a way to fight back when they do experience discrimination. The current rule's inclusion of gender identity and avenues for people to take action when discriminated against for that reason was an important step towards ensuring quality health care for all, and it should stay.

II. Language access protections ensure that people whose primary language is not English are able to communicate with health care workers and receive safe care and should remain in place as written in the current final rule

The Department argues that language access requirements do not extend to written notifications and that high-quality video is unnecessary for verbal language interpretation (as opposed to sign language interpretation for patients who are deaf). Taglines on written documents explaining the availability of interpretive services are an inexpensive way to ensure

that all patients get health information that they can understand and act on. Video standards are important so that interpreters can see any demonstrations that need to be explained to the patient or images that the health care provider is referring to. Without a visual connection, the chance of misinterpretations increases – an unjustifiable risk when someone's health is at stake.

Clear communication is vital in medical settings. Patients cannot receive the treatment they need if they cannot communicate their needs to health care workers or understand the doctor's instructions. Even people with advanced English skills may need help in a medical setting with all its attendant stresses and unfamiliar vocabulary. HCFANY asks the Department to keep the current rule's high standards for language access. Given that United States Census data finds that there are over 25 million Americans who have limited English language skills – over 2.6 million in New York State - those standards are necessary to ensure adequate health outcomes.

The Department also asks if standards relating to interpretation and communication with people who have disabilities should be lowered. HCFANY does not believe that there should be any exemptions to the requirement that health care entities have auxiliary aids and provide auxiliary services so that their place of business is accessible to people with disabilities, regardless of the size of the provider's business. Allowing health care providers to turn people with disabilities away or provide sub-optimal care because they have not taken simple steps to ensure clear communication between doctor and patient places far too great a burden on people with disabilities.

III. The Department is limiting the scope of the rule beyond its authority to do so.

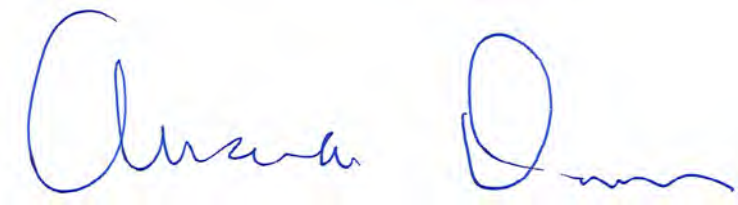
The Department argues that the Civil Rights Restoration Act (CRRA) does not cover the full operations of entities that provide health insurance rather than health care, outside of Marketplace plans. HCFANY disagrees. Health insurance is the medium through which most Americans access health care. Discrimination in health insurance provisions means discrimination in health care access. The current rule is correct in stating that "health program or activity" should include the provision of health insurance, and that those entities engaged in providing health insurance should be subject to the CRRA. The way that Americans access and pay for health care has evolved since the CRRA passed and the language in the current rule reflects that evolution. It is not an expansion of the CRRA's reach but a logical change reflecting current circumstances and the law's original intent.

Further, the Patient Protection and Affordable Care Act explicitly states that the law, including Section 1557, applies to "any health program or activity, any part of which is receiving

Federal financial assistance… including contracts of insurance."[1] The statute does not limit itself to benefits provided by HHS but applies to any Executive Agency. The federal government subsidizes health insurance beyond the support it provides to the Marketplaces through HHS. For example, the federal government provides billions of dollars every year to support the provision of employer-based health care. The Department's argument that it is too hard to regulate the health insurance provided to employees at great expense to the federal government is unconvincing.

Thank you for your attention.

Sincerely,



Amanda Dunker
Senior Health Policy Associate
Community Service Society of New York

[1] 42 U.S.C. § 18116(a).

EXHIBIT D-56

National Hispanic Leadership Agenda

MEMBER ORGANIZATIONS

Alianza Americas
American G.I. Forum
ASPIRA Association
Avance Inc.
Casa de Esperanza: National Latin@ Network
Congressional Hispanic Caucus Institute
Farmworker Justice
Green Latinos
Hispanic Association of Colleges & Universities
Hispanic Federation
Hispanic National Bar Association
Hispanics in Philanthropy
Inter-University Program for Latino Research
Labor Council for Latin American Advancement
LatinoJustice PRLDEF
League of United Latin American Citizens
MANA, A National Latina Organization
Mexican American Legal Defense and Educational Fund
Mi Familia Vota
NALEO Education Fund
National Association of Hispanic Federal Executives
National Association of Hispanic Publications
National Association of Latino Arts and Culture
National Association of Latino Independent Producers
National Conference of Puerto Rican Women, Inc.
National Day Laborer Organizing Network
National Hispana Leadership Institute
National Hispanic Caucus of State Legislators
National Hispanic Council on Aging
National Hispanic Environmental Council
National Hispanic Foundation for the Arts
National Hispanic Media Coalition
National Hispanic Medical Association
National Institute for Latino Policy
National Latina Institute for Reproductive Health
National Latina/o Psychological Association
Presente.org
SER Jobs for Progress National
Southwest Voter Registration Education Project
U.S.- Mexico Foundation
UnidosUS
United States Hispanic Chamber of Commerce
United States Hispanic Leadership Institute
United States-Mexico Chamber of Commerce
Voto Latino

VIA ELECTRONIC SUBMISSION

Secretary Alex Azar
U.S. Department of Health and Human Services
Herbert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

RE: Docket ID HHS-OCR-2019-0007, RIN 0945-AA11, Nondiscrimination in Health and Health Education Programs or Activities

Dear Secretary Azar:

On behalf of The National Hispanic Leadership Agenda (NHLA), a coalition of 45 leading national Latino nonpartisan civil rights and advocacy organizations, we submit this comment in response to the Department of Health and Human Services' ("HHS", "Department") and the Center for Medicare and Medicaid Services ("CMS") Notice of Proposed Rulemaking ("proposed rule," "NPRM") to express our concerns with the proposed rule entitled "Nondiscrimination in Health and Health Education Programs or Activities," published in the Federal Register on July 14, 2019.

NHLA was established in 1991 as a nonpartisan association of major Hispanic national organizations and distinguished Hispanic leaders from all over the nation. NHLA's mission calls for unity among Latinos around the country to provide the Hispanic community with greater visibility and a clearer, stronger influence in our country's affairs. NHLA brings together Hispanic leaders to establish policy priorities that address, and raise public awareness of, the major issues affecting the Latino community and the nation as a whole. NHLA is composed of 45 of the leading national and regional Hispanic civil rights and public policy organizations and other elected officials, and prominent Hispanic Americans. NHLA coalition members represent the diversity of the Latino community – Mexican Americans, Puerto Ricans, Cubans, and other Hispanic Americans. NHLA supports the positive changes the Affordable Care Act ("ACA") has brought to Hispanics living in the United States and maintaining access to quality and affordable health care.

NHLA strongly opposes the proposed elimination or rollback of critical protections guaranteed by Section 1557 of the Affordable Care Act ("Section 1557") and the 2016 Nondiscrimination in Health Programs or Activities final rule ("2016 final rule"). We demand that this NPRM be rescinded in its entirety.

Communities of color, including immigrant women and lesbian, gay, bisexual, transgender, and queer ("LGBTQ") Latinos, have historically experienced many systemic barriers such as high costs, lack of access to clinics in rural areas, and insufficient culturally and linguistically competent health care. As Latinos face increasing hostility and life threatening circumstances in this country and attacks on our civil rights, it is more important than ever to ensure that our communities have protections and access to the health care they need. These proposed changes to the implementing regulations of

Section 1557 are an attack on our civil rights, and if implemented, would only create more barriers to accessing care for the communities we serve.

Section 1557 protects individuals from discrimination on the basis of race, color, national origin, sex, (including gender identity, sexual orientation, and sex stereotypes; and pregnancy, childbirth, and related medical conditions), age, and disability in certain health programs or activities. Critically, Section 1557 specifically protects against intersectional discrimination, or discrimination based on multiple protected characteristics, by allowing people to file complaints of such discrimination in one place.

The 2016 final rule implementing Section 1557 explicitly prohibits discrimination on the basis of sex, which includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping and gender identity. The 2016 final rule also protects individuals with Limited English Proficiency ("LEP") and individuals with disabilities and/or chronic conditions from discrimination.

While Section 1557 is still the law, this proposed rule attempts to change the administrative implementation in a way that is contrary to the plain language of the law. The NPRM's proposed changes pose significant risks to those the law is intended to protect, including LGBTQ individuals, people who need reproductive health care including abortion, women of color, people living with disabilities and/or chronic conditions, and people whose primary language is not English – all people who already experience significant barriers to accessing health care. LGBTQ Latinos find themselves at the intersections of many identities including race, gender, sexual orientation, class, citizenship status, and many more. The proposed changes could create additional barriers and potentially lead to worse health outcomes, disproportionately impacting those living at the intersections of these identities. For example, an immigrant woman seeking reproductive health care could face harassment because she is a woman and has LEP. Similarly, a provider could discriminate against an Afro-Latina woman because of both her race and gender.

Section 1557 is the law of the land, but the proposed rule would almost entirely replace the 2016 final rule that made clear what forms of discrimination are prohibited by Section 1557. The proposed rule is not justified and seeks to impermissibly depart from the statutory text of Section 1557 and the 2016 final rule, which was finalized after robust public comment, including a request for information and one notice of proposed rulemaking. HHS considered more than 24,875 public comments submitted for the 2016 final rule.[1] By replacing most of the 2016 final rule with unclear regulations, the proposed rule, if finalized, would create confusion and could open the door to illegal discrimination.

In direct opposition to the text of Section 1557, the proposed rule improperly seeks to exempt many health insurance plans from the anti-discrimination provisions, as well as any health program or activity run by HHS that was not created by Title I of the ACA. It eliminates regulations pertaining to the fundamental requirement that all beneficiaries, enrollees, applicants, and members of the public receive notice of their rights under Section 1557 and removes important regulations that protect individuals with LEP. It improperly tries to incorporate Title IX's religious exemption, which could permit health

[1] 81 Fed. Reg. 31376.

care entities controlled by a religious organization to discriminate if the entity claims complying with the sex discrimination protections conflicts with its religious beliefs. The rule attempts to overrule decades of federal court precedent by trying to eliminate protections against discrimination on the basis of gender identity, and completely disregards Supreme Court precedent on discrimination based on sex stereotyping. Although the preamble to the proposed rule acknowledges that Section 1557 prohibits discrimination based on pregnancy, including termination of pregnancy, the Department refuses to state whether it would enforce those protections. Additionally, contrary to the plain language of the law, the proposed rule improperly seeks to incorporate an abortion carveout from Title IX to narrow the protection under Section 1557. This is an attack on all of our civil rights and will harm Latinos living in the United States.

In order to reflect the ACA's clear intent and its overriding purpose of eliminating discrimination in health care, the proposed rule should not be finalized.

I. The Proposed Rule Impermissibly Attempts to Dramatically Narrow the Scope of Section 1557

The 2016 final rule made clear that Section 1557 applies to all health programs and activities that receive federal financial assistance from the Department, all health programs and activities administered by the Department, and state-based marketplaces. The 2016 final rule defines health programs and activities to include all operations of an entity receiving federal financial assistance that is principally engaged in the provision or administration of health-related services or health-related insurance coverage.

The proposed rule attempts to reduce the number of health insurance plans that are covered by claiming that if the issuer of a health plan is "not principally engaged in the business of providing health care (as opposed to health insurance), only its Marketplace plans would be covered and any plans it offers outside the marketplace would not be subject to Section 1557."[2] Additionally, the proposed rule improperly attempts to narrow that application of Section 1557's protections to only the portion of a health care program or activity that received Federal financial assistance. These changes unlawfully narrow the scope of Section 1557's application. Rather, the statute is clear that the law's provisions apply broadly to "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)."[3]

This change is illegal. If it were nevertheless implemented, it would have significant consequences, particularly for consumers, including Latinos, who purchase short-term limited duration insurance ("STDLI"). If implemented, the proposed rule would generally not apply to STDLI plans because these insurers are no longer considered health care entities, and these specific plans do not receive federal financial assistance.

This rollback could mean that certain insurance plans, like STDLIs, would not be subject to the language access requirements of the Section 1557 regulations. LEP Latinos faces

[2] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.
[3] 42 U.S.C. § 18116(a)

several challenges to care, and if implemented, this would only exacerbate this inequity and associated health disparities. Finding a provider who provides culturally and linguistically appropriate care is already challenging for many in the Latino community. When these barriers are coupled with an insurance plan that would not meet the language access requirements of Section 1557, this only adds additional hurdles to accessing the care a person needs.

The proposed rule would also allow STDLIs to discriminate against women by refusing to cover reproductive health services, such as maternity, contraceptive care or fertility care and coverage, or deny coverage altogether for other conditions like cervical cancer. Latinas suffer from cervical cancer at a higher rate than their white counterparts[4] and critical coverage of preventive care helps to reduce rates of the highly preventable disease. Additionally, a 2018 study found that not a single short-term plan covered maternity care.[5] Short-term plans also discriminate based on gender identity by excluding coverage for transition-related services for gender affirming care, such as surgery and can charge higher premiums for women.

Women have long been the subject of discrimination in health care[6] and this is only worse for women of color. This includes discrimination in emergency rooms where men are more likely to treated quickly[7] and wait times for Hispanics are 13 percent longer than those for whites.[8] Despite the historic achievements of the ACA, women are still more likely to forego care because of cost.[9] In the last 12 months, nearly a quarter of Latinos have gone without health care services due to cost, as opposed to 13 percent of their white counterparts.[10] These barriers mean women, and specifically women of color, are more likely not to receive routine and preventive care than men. With the proposed changes to narrow the scope of who must comply with Section 1557, Latinas may face additional discrimination and continue to lack care.

II. The Proposed Rule Impermissibly Attempts to Narrow the Definition of Sex Discrimination

Sex discrimination in health care has a disproportionate impact on women of color, LGBTQ people, and individuals living at the intersections of multiple identities–resulting in them paying more for health care, receiving improper diagnoses at higher rates, being provided less effective treatments, and sometimes being denied care altogether. As the first broad prohibition against sex-based discrimination in health care, Section 1557 is

[4] U.S. Cancer Statistics Working Grp, *U.S. Cancer Statistics Data Visualizations Tool: Rate of New Cancers, Cervix, United States, 2016,* Ctrs. for Disease Control & Prevention (Jun. 2019), https://www.cdc.gov/cancer/cervical/statistics/race.htm.

[5] Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance,* Kaiser Family Foundation (Apr. 23, 2018), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/.

[6] Prior to the ACA, women were charged more for health care on the basis of sex and were continually denied health insurance coverage for services that only ciswomen, transgender, and gender non-conforming patients need. *See Turning to Fairness*, Nat'l Women's L. Ctr. 1, 3-4 (2012), https://nwlc.org/wp-content/uploads/2015/08/nwlc_2012_turningtofairness_report.pdf (noting that while the ACA changed the health care landscape for women in significant ways, women still face additional hurdles).

[7] "Waiting Time at the Emergency Department from a Gender Equity Perspective." (thesis, University of Gothenburg, Sweden, 2014). https://gupea.ub.gu.se/bitstream/2077/39196/1/gupea_2077_39196_1.pdf

[8] Silberner, Josefina. "Study: Longer Wait Times for Emergency Rooms." NPR. January 15, 2008.

[9] *See* Shartzer, et al., Health Reform Monitoring Survey, Urban Inst. Health Policy Ctr. (Jan. 2015), http://hrms.urban.org/briefs/Health-Care-Costs-Are-a-Barrier-to-Care-for-Many-Women.html.

[10] "Health and Health Care for Hispanics in the United States." Kaiser Family Foundation. May 19, 2019. https://www.kff.org/infographic/health-and-health-care-for-hispanics-in-the-united-states/

critical to ending gender-based discrimination in the health care industry. In addition to personal stories, there have been surveys, studies, and reports documenting discrimination in health care against these communities and their families.

a. **Sex discrimination based on gender identity**

LGBTQ Latinos face a number of health inequities due to discriminatory practices by providers, insurers, and other systemic barriers. LGBTQ Latinos already experience high rates of poverty and discrimination in employment that contribute to poor health outcomes.[11]

The 2016 final rule clarified that Section 1557's prohibition on sex discrimination includes a prohibition of discrimination on the basis of gender identity, including transgender and/or nonbinary status. The proposed rule illegally attempts to erase all reference to the ACA's protections against discrimination on the basis of gender identity.

A 2016 study conducted by the Williams Institute found that 21 percent of transgender identified adults also identify as Latino or Hispanic.[12] Within this community, transgender and gender non-conforming Latinos are already subject to a number of intersecting barriers to quality health care and increased health disparities.

The 2016 final rule clarified that health care providers cannot refuse to treat someone because of their gender identity. The proposed rule illegally purports to allow a health care provider to refuse to treat someone because of their gender identity. For example, a doctor could refuse to treat a transgender person for a cold or a broken bone, simply because of their gender identity.

The 2015 U.S. Transgender Survey showed that over a fourth of transgender individuals did not see a doctor when they needed to because of fear of being mistreated as a transgender person, and 37 percent, more than a third, did not see a doctor when needed because they could not afford it.[13] 32 percent, about one-third, of transgender individuals who saw a health care provider in the past year reported having at least one negative experience related to being transgender.[14] The reported negative experiences included being refused treatment, being verbally harassed, being physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care.[15] 29 percent of transgender individuals were refused to be seen by a health care provider on

[11] National Center for Transgender Equality, National Gay and Lesbian Taskforce and LULAC. (2012, September 11). Injustice at every turn: a look at Latino/a respondents in the National Transgender Discrimination Survey, 1-2. Retrieved at http://www.transequality.org/Resources/Injustice_Latino_englishversion.pdf (28 % of Latina/o transgender individuals live in poverty and 26 % of Latina/o transgender persons were terminated from their jobs because of bias and 47 % were not hired due to bias.)

[12] Flores, Andrew et al. "Race And Ethnicity Of Adults Who Identify As Transgender In The United States." Williams Institute. October 2016. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Race-and-Ethnicity-of-Transgender-Identified-Adults-in-the-US.pdf

[13] James, S. E. & Salcedo, B. (2017). 2015 U.S. Transgender Survey: Report on the Experiences of Latino/a Respondents. Washington, DC and Los Angeles, CA: National Center for Transgender Equality and TransLatin@ Coalition.

[14] James, S. E. & Salcedo, B. (2017). 2015 U.S. Transgender Survey: Report on the Experiences of Latino/a Respondents. Washington, DC and Los Angeles, CA: National Center for Transgender Equality and TransLatin@ Coalition.

[15] James, S. E. & Salcedo, B. (2017). 2015 U.S. Transgender Survey: Report on the Experiences of Latino/a Respondents. Washington, DC and Los Angeles, CA: National Center for Transgender Equality and TransLatin@ Coalition.

the basis of their perceived or actual gender identity and 29 percent experienced unwanted physical contact from a health care provider.[16]

There is also data showing how Latino transgender individuals are refused care or are mistreated by providers. According to a national survey of transgender people conducted by the National Gay and Lesbian Task Force and National Center for Transgender Equality, one in three Latino and Hispanic respondents reported unequal treatment by a doctor or hospital.[17] Undocumented transgender respondents were found to be particularly vulnerable to physical attack in doctors' offices, hospitals, and emergency rooms.[18] Additionally, transgender persons have been denied care even for medically necessary treatment, and this discrimination has sometimes resulted in death.[19] The fear of being treated differently or discriminated against has lasting consequences for individuals. For example, 36 percent of Latino transgender persons postponed care when they were sick or injured because they feared discrimination.[20]

The 2016 final rule clarified that insurance companies cannot categorically exclude or deny coverage for gender-affirming care. The proposed rule illegally attempts to again open the door to insurance companies categorically excluding coverage of gender-affirming care from their plans or denying individuals coverage of procedures used for gender affirmation. Prior to the 2016 final rule, many insurers did not cover gender-affirming care. However, as a result of Section 1557 and the 2016 final rule, many insurers removed categorical coverage exclusions that harmed transgender people and began to cover gender-affirming services,[21] increasing access to care. The proposed rule could give insurers the false impression that they could refuse to cover gender-affirming care.

The World Professional Association for Transgender Health guidelines provide that gender-affirming interventions, when sought by transgender individuals, are medically necessary and part of the standard of care.[22] The American College of Obstetricians and Gynecologists warns that failure to provide gender-affirming treatment can lead to serious

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[16] Shabab Ahmed Mirza & Caitlin Rooney, Discrimination Prevents LGBTQ People from Accessing Health Care, Ctr. for American Progress, (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-peopleaccessing-health-care/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-fordiscrimination&email_referrer=&email_subject=rx-for-discrimination.

[17] Grant JM et al. National Gay and Lesbian Taskforce; National Center for Transgender Equality. Injustice at every turn: A report of the National Transgender Discrimination Survey, 73-74, 2011, available at http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf.

[18] Grant JM et al. National Gay and Lesbian Taskforce; National Center for Transgender Equality. Injustice at every turn: A report of the National Transgender Discrimination Survey, 73-74, 2011, available at http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf.

[19] Ravishankar M. The story about Robert Eads. The Journal Of Global Health. January 18, 2013. http://www.ghjournal.org/jgh-online/the-story-about-robert-eads/.

[20] Harrison-Quintana, J, Peréz. D. and Grant, J. (2012). Injustice at Every Turn: A Look at Latino/a Respondents in the National Transgender Discrimination Survey, 3. National Center for Transgender Equality; National Gay and Lesbian Taskforce; League of United Latin American Citizens. Retrieved at http://www.thetaskforce.org/downloads/reports/reports/ntds_latino_english_2.pdf

[21] OUT2Enroll, *Summary of Findings: 2019 Marketplace Plan Compliance with Section 1557*, https://out2enroll.org/out2enroll/wp-content/uploads/2018/11/Report-on-Trans-Exclusions-in-2019-Marketplace-Plans.pdf (last visited Jul. 17, 2019).

[22] Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, World Prof. Association for Transgender Health (2011), https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20%202011%20WPATH%20(2)(1).pdf.

health consequences for transgender individuals.[23] This proposed rule could lead to more transgender individuals, including Latinos, to be denied gender-affirming care and the coverage they need to access this care.

The 2016 final rule made clear that issuers cannot deny health services or impose additional costs on services that are ordinarily or exclusively available to individuals of one sex or gender based on the fact that the individual's recorded sex in medical or insurance records differs from the one to which such health services are ordinarily or exclusively available. The proposed rule impermissibly tries to permit providers and insurers to refuse to provide and cover certain reproductive health care for transgender, nonbinary, and gender nonconforming people.

Additionally, Section 1557 and the 2016 final rule prohibit covered entities from denying, limiting, or imposing additional cost-sharing for services based on sex or gender. If implemented, the proposed rule would eliminate the regulations that specifically address cost-sharing, adding confusion about whether covered entities may impose additional financial burdens on transgender, nonbinary, and gender nonconforming individuals.

If this illegal rule is implemented, a health care provider might deny a transgender Latino man coverage of cervical cancer treatment because of his gender identity. The National Transgender Discrimination Survey found that only 8 percent of transmasculine respondents (assigned female at birth) had a hysterectomy to remove their uterus and, in most cases, the cervix.[24] This demonstrates that the vast majority of transmasculine individuals require cervical cancer screening, but only 27 percent reported that they had a Pap test in the past year.[25] This is especially damaging because queer Latinos are more likely to disproportionately experience cervical cancer because of racial, ethnic, sexual orientation, and gender identity health disparities.[26]

If implemented, under the proposed changes, health care providers could charge higher copayments only for services related to gender-affirming care. Gender-affirming care is already difficult or impossible to access due to cost.[27] The proposed rollback of Section 1557 could significantly harm transgender Latinos in the multitude of ways that individuals access health care services, as listed above.

b. Sex discrimination based on sex stereotyping

The 2016 final rule reiterated that sex stereotpying is a prohibited form of discrimination under the 1989 Supreme Court decision, *Price Waterhouse v. Hopkins.*[28] The proposed

[23] Committee Opinion 512: Health Care for Transgender Individuals, Am. Coll. Obstetricians & Gynecologists (Dec. 2011), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-HealthCare-for-Underserved-Women/Health-Care-for-Transgender-Individuals.
[24] James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality. Pages 101-102. Retrieved from http:// www.transequality.org/sites/default/ files/docs/usts/USTS%20Full%20Report%20-%20FINAL%20 1.6.17.pdf
[25] Rebekah Rollston, The Fenway Inst., Promoting Cervical Cancer Screening Among Female-to-Male Transmasculine Patients(2019), https://fenwayhealth.org/wp-content/uploads/TFIP-28_TransMenCervicalCancerScreeningBrief_web.pdf.
[26] National Latina Institute for Reproductive Health. Cervical Cancer & Latinxs: The Fight for Prevention and Health Equity. January 2018, available at http://www.latinainstitute.org/sites/default/files/NLIRH_CervicalCancer_FactSheet18_Eng_R1.pdf.
[27] S.E. James, et al., Nat'l Ctr. for Transgender Equality, Report Of The 2015 U.S. Transgender Survey 100 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.
[28] 490 U.S. 228 (1989).

rule attempts to erase established Supreme Court precedent recognizing that discrimination on the basis of sex includes discrimination on the basis of sex stereotypes. This could result in health providers thinking they could turn a patient away because the patient does not conform with traditional stereotypes about their sex. Federal courts have applied the reasoning of *Price Waterhouse* to both LGBTQ and non-LGBTQ people seeking relief for sex discrimination.

Discrimination based on sex stereotypes can affect anyone who does not conform to traditional, societal expectations of their sex. The proposed rule illegally purports to allow a health care provider to refuse to provide maternity or contraceptive care to an unmarried woman.

LGBTQ Latinos are deeply and personally affected by reproductive health and justice issues like abortion restrictions, access to contraception, and comprehensive sex education and it is critical that the members of the Latino community continue to have access to all of the health care services they need, when they need it. Approximately 21 percent of Latinos and Latinas identify as LGBT[29] and 29 percent of Latino and Latina same-sex couples are raising children.[30] The estimated 146,100 Latino and Latina individuals in same-sex partnerships tend to live in areas where there are higher proportions of Latinos and Latinas.[31] This means that a third of Latino and Latina same-sex couples live in New Mexico, California, and Texas.[32] These individuals and their families could be harmed by the proposed changes if the rule is permitted to go into effect.

c. Sex discrimination based on pregnancy, including termination of pregnancy

Sex discrimination takes many forms and has the potential to occur at every step in the health care system—from obtaining insurance coverage to receiving proper diagnosis and treatment to harassment by a provider. Such discrimination has serious adverse impacts on the lives of Latinos, causing them to pay more for health care and to risk receiving improper diagnoses and less effective treatments. The effects of sex discrimination for Latinos may be compounded by other forms of discrimination they face, including racial discrimination and discrimination based on language proficiency.

The 2016 final rule made clear that sex discrimination under Section 1557 includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related conditions. The proposed rule attempts to roll back these protections. Although HHS acknowledges in the preamble to this proposed rule that the prohibition against sex discrimination includes termination of pregnancy, it refuses to state whether the Department would enforce those protections and proposes to delete the 2016 final rule's clarification that the ban on sex discrimination includes all pregnancy related care. In doing so, the Department illegally attempts to eliminate the express protections that apply to someone who has had an abortion or has experienced a miscarriage or ectopic pregnancy and needs care for those conditions. While the scope of

[29] Gary J. Gates and Angeliki Kastanis. "LGBT Latino/a Individuals and Latino/a Same-Sex Couples." October 2013. Available at https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-latino-oct-2013/
[30] Gary J. Gates and Angeliki Kastanis. "LGBT Latino/a Individuals and Latino/a Same-Sex Couples." October 2013. Available at https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-latino-oct-2013/
[31] Gary J. Gates and Angeliki Kastanis. "LGBT Latino/a Individuals and Latino/a Same-Sex Couples." October 2013. Available at https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-latino-oct-2013/
[32] Gary J. Gates and Angeliki Kastanis. "LGBT Latino/a Individuals and Latino/a Same-Sex Couples." October 2013. Available at https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-latino-oct-2013/

protection under Section 1557 is clear, without explicit implementing regulations and enforcement, illegal discrimination is likely to flourish.

The proposed rule could result in patients illegally being denied critical care including miscarriage management. This could particularly harm transgender, nonbinary, and gender nonconforming people who already face unique barriers to accessing abortion, pregnancy care, and miscarriage care. For example, a transgender man had a stillbirth after nurses misdiagnosed him as obese rather than pregnant.[33] The proposed rule could make these occurrences more likely.

The proposed rule also seeks to unlawfully incorporate Title IX's "Danforth Amendment", which carves out abortion care and coverage from the ban on discrimination of sex in the education context. Congress did not include the Title IX exceptions, including the Danforth Amendment, either explicitly or by reference, in Section 1557. The proposed rule's unlawful incorporation of the Danforth Amendment is yet another Trump-Pence Administration attack on abortion care. These attacks could embolden illegal discrimination that will fall heaviest on those least able to seek health care elsewhere, including immigrant women and women of color, including Latinos, who already face harassment and discrimination by providers during pregnancy, contributing to the unacceptably high rates of health-related pregnancy complications and death for women of color.

Obstacles including cultural and linguistic differences, and well as restrictions based on age, economic status, immigration status, and geographic location already prohibit many Latinos from obtaining safe abortion services and from exercising their reproductive freedom. Additional denial of care relating to abortion services is wholly unnecessary and would further limit access to abortion services.

Despite the current protections afforded by the ACA, Latinos encounter additional barriers such as cost, lack of transportation and lack of geographically available clinics, insufficient culturally and linguistically competent health systems and providers, and discriminatory immigration policies that make it difficult for individuals and communities to access the full range of reproductive healthcare when they need it. Due to this, discrimination, and other barriers, Latinos experience disproportionately high rates of unintended pregnancy, sexually transmitted infections including HIV, diabetes, [34] asthma,[35] and other health issues. While pregnancy and birth rates among youth have been declining for decades, Latina youth continue to experience higher incidences of pregnancy and birth than their white peers. In 2014, Latinas between the ages of 15 to 19 had experienced birth at least twice the rate of their White peers of the same age.[36] There are many factors that contribute to this disparity including barriers to affordable

[33] Marilynn Marchione, Associated Press, *Nurse Mistakes Pregnant Transgender Man as Obese. Then, the Man Births a Stillborn Baby*, USA Today (May 16, 2019, 12:49 PM), https://www.usatoday.com/story/news/health/2019/05/16/pregnant-transgender-man-births-stillborn-baby-hospital-missed-labor-signs/3692201002/.

[34] Office on Women's Health. (2010, May 18). Minority Women's Health: Latinas and Diabetes. U.S. Department of Health and Human Services. Retrieved 10 May 2017, from https://www.womenshealth.gov/minority-health/latinas/diabetes.html

[35] U.S. Department of Health and Human Services Office of Minority Health. "Asthma and Hispanic Americans." March 13, 2017. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=60

[36] The National Campaign to Prevent Teen and Unplanned Pregnancy. (2015, July). Teen Childbearing in the United States, 2014 Birth Data.. Retrieved at http://thenationalcampaign.org/sites/default/files/resource-primary-download/fast-facts-teen-childbearingin-the-us-2014-birth-data_2.pdf

contraception, lack of sexual health information and services, including culturally competent, comprehensive sex education, and lack of financial resources. Latinas are diagnosed with cervical cancer, a disease that is almost entirely preventable, at nearly twice the rate of non-Latina White women.[37] In fact, according to the latest statistics from the Centers for Disease Control and Prevention, Latinas have the highest cervical cancer incidence rates amongst all racial and ethnic groups.[38] Furthermore, Latinas already face challenges in consistently accessing contraception that is affordable and available, preventing them from planning their futures and their families.

Moreover, immigration status plays a role in the health care that individuals can access. Immigrant Latinas also experience these inequities because they lack employment opportunities that provide insurance coverage, face extreme poverty, and lack culturally and linguistically appropriate health care providers and services. 30 percent of Latinos under the age of 18 live in poverty, making it already quite difficult to obtain needed health care services.[39] These compounded barriers and challenges in health care could only be exacerbated if this proposed rule is to go into effect.

d. Religious Exemption

We oppose the inclusion of Title IX exemptions since they do not apply to health care situations and settings. As HHS concluded in the 2016 Final Rule:

> "[S]tudents or parents selecting religious educational institutions typically do so as a matter of choice; a student can attend public school (if K–12) or choose a different college. In the healthcare context, by contrast, individuals may have limited or no choice of providers, particularly in rural areas or where hospitals have merged with or are run by religious institutions. Moreover, the choice of providers may be even further circumscribed in emergency circumstances. Second, a blanket religious exemption could result in a denial or delay in the provision of health care to individuals and in discouraging individuals from seeking necessary care, with serious and, in some cases, life threatening results. Thus, it is appropriate to adopt a more nuanced approach in the health care context, rather than the blanket religious exemption applied for educational institutions under Title IX."[40]

The 2016 final rule intentionally did not include any religious exemption. The inclusion of a religious exemption, either explicitly or by reference, is contrary to the statutory language in Section 1557, which does not include any exceptions.

The proposed rule attempts to impermissibly apply Title IX's religious exemption to Section 1557's prohibition on sex discrimination. The Department's attempt to incorporate a religious exemption violates the plain language of the statute and is contrary

[37] U.S. Department of Health and Human Services. (2012, April 10). The Afordable Care Act and Latinos. Retrieved at https://aspe.hhs.gov/report/afordable-care-act-and-latinos

[38] Centers for Disease Control and Prevention. (Last updated 2015, August 20). Cervical Cancer Rates by Race and Ethnicity. Incidence Rates by Rates/Ethnicity. Retrieved at: http://www.cdc.gov/cancer/cervical/statistics/race.htm

[39] Krogstad, J. M. (2014, September 19). Hispanics only group to see its poverty rate decline and incomes rise. Pew Research Center. Retrieved at http://www.pewresearch.org/fact-tank/2014/09/19/hispanics-only-group-to-see-its-poverty-rate-decline-and-in82comes-rise/.

[40] 81 Fed. Reg. 31380.

to the express purpose of Section 1557. If implemented, this could allow for religiously-affiliated hospitals and other health care entities to discriminate against patients based on sex, disproportionately harming LGBTQ people, people seeking reproductive health services, including abortion care, and those living at the intersection of these identities.

Allowing a religious exemption to Section 1557's protection against sex discrimination could have far reaching consequences. Incorporating Title IX's religious exemption could create new instances in which health care providers, including insurance companies, hospitals, doctor, or nurses, can allow their beliefs to determine patient care, opening the door to illegal discrimination. This could impact a broad range of health care services, including birth control, sterilization, certain fertility treatments, abortion, gender-affirming care, and end of life care. Moreover, there is already a proliferation in the types of entities that are now emboldened to use religious beliefs to discriminate against patients and the number of religiously-affiliated entities that provide health care and related services and refuse to provide care based on religious beliefs.[41] The proposed rule could encourage these entities to engage in illegal discrimination.

This could permit a religiously affiliated pharmacy to illegally refuse to prescribe contraception to someone because they are not married or refuse to provide infertility treatment to a same-sex or transgender couple. This could permit a pharmacist to illegally refuse to provide the medication for someone who is miscarrying or a hospital to refuse care to a woman who has had an abortion.

Providers, hospitals, or clinics that refuse to provide reproductive health services to a woman who is not married or because she does not conform to sex stereotypes force women to seek care elsewhere or forgo it completely. For many women of color and/or immigrant women, access to affordable contraception is often non-existent but is necessary to ensure that they can make the best decisions for them and their families. A recent study by the National Latina Institute for Reproductive Health with PerryUndem found that 4 in 10 Latina and Latino voters under age 45 (41 percent) have gone without the birth control method they wanted in the past two years because of access issues.[42] This proposed rule would only exacerbate the barriers to care that are preventing individuals from accessing the care they need.

Religious exemptions disproportionately harm LGBTQ people, especially those who are transgender, nonbinary, gender nonconforming. LGBTQ people are often refused health care services because of their sexual orientation and/or gender identity.[43] For example, 8 percent of LGBQ people were refused health care because of their sexual orientation, and 6 percent were refused care related to their sexual orientation. Similarly, 29 percent of transgender people were refused health care because of their gender identity,[44] and 12

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[41] *See, e.g.*, Lois Uttley, et al., *Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, Am. Civil Liberties Union & Merger Watch (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.

[42] Nat'l Latina Inst. for Reprod. Health & PerryUndem, *Latina/o Voters' Views and Experiences Around Reproductive Health: Results from a National Survey of Latina/o Voters* (Oct. 4, 2018), https://latinainstitute.org/sites/default/files/NLIRH%20Survey%20Report_F_0.pdf.

[43] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[44] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM),

percent were refused gender-affirming health care.[45] The proposed rule purports to allow further illegal refusals of care for LGBTQ people.

When LGBTQ people are refused treatment, it becomes difficult or impossible to find another provider, especially for those living in rural areas and for transgender people.[46] According to a 2018 study, 18 percent of LGBTQ people said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 17 percent said it would be very difficult or not possible to find the same type of service at a different clinic. Rates are higher for LGBTQ people living outside of a metropolitan area: 41 percent said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 31 percent said it would be very difficult or not possible to find the same type of service at a different clinic. Rates are also higher for transgender people: 31 percent said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 30 percent said it would be very difficult or not possible to find the same type of service at a different clinic. The proposed rule would make it harder for LGBTQ Latinxs to access the health services they need.

Latinos seeking access to abortion or other reproductive health services are also harmed by religious refusals. Geography is already a barrier for people needing abortion care. If people are refused care because of a provider's religious beliefs, it would make it difficult or impossible to receive the care they need. "As of 2014, 90 percent of U.S. counties lacked an abortion clinic. . . . Many states have only one clinic."[47] The proposed rule would make it harder for people needing reproductive care to access the health services they need. People living in the United States often must travel between 10-79 miles to reach their nearest abortion clinic, with 20 percent having to travel 42-54 miles or more.[48] "[T]hose living in rural areas typically have to travel greater distances who live in urban areas."[49] In Texas, the distance pregnant individuals have to travel to access abortion has dramatically increased as the number of providers has decreased. The number of women of reproductive age in Texas living more than 50 miles from a clinic increased from 816,000 in May 2013 to 1,680,000 in April 2014.[50] Also, the number of women living more than 200 miles from a clinic increased from 10,000 in May 2013 to 290,000 in April 2014.[51] Latino individuals seeking health care services are often misunderstood or

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https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[45] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[46] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[47] Anna North, *Abortion is Still Legal in America*, Vox (May 16, 2019, 12:19 PM), https://www.vox.com/2019/5/16/18626744/alabama-abortion-law-legal-50-states-roe.

[48] Jonathan M. Bearak, et al., *Disparities and Change Over Time in Distance Women Would Need to Travel to Have an Abortion in the USA: A Spatial Analysis*, 2 The Lancet e493, e493-e500 (2017), https://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(17)30158-5.pdf.

[49] Jonathan M. Bearak, et al., *Disparities and Change Over Time in Distance Women Would Need to Travel to Have an Abortion in the USA: A Spatial Analysis*, 2 The Lancet e493, e493-e500 (2017), https://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(17)30158-5.pdf.

[50] Texas Policy Evaluation Project. (2014, July 1). Access to abortion care in the wake of HB2. Retrieved 1 November 2016, from http://liberalarts.utexas.edu/txpep/_files/pdf/ AbortionAccessafterHB2.pdf

[51] Texas Policy Evaluation Project. (2014, July 1). Access to abortion care in the wake of HB2. Retrieved 1 November 2016, from http://liberalarts.utexas.edu/txpep/_files/pdf/ AbortionAccessafterHB2.pdf

mistreated simply because of their English language proficiency, gender identity, or other factors.

Over the past several decades, religious exemptions have helped systematically chip away at abortion access across the country. This limiting of abortion care has meant that individuals have been denied the care they need. Being denied an abortion has long-term negative impacts on an individual and reduces financial security and safety for themselves and their families. For example, women denied an abortion had almost 4 times greater odds of a household income below the federal poverty level and 3 times greater odds of being unemployed.[52] Additionally, women who were denied an abortion were more likely to not have enough money to pay for basic family necessities like food, housing and transportation.[53] A recent study found that continuing an unwanted pregnancy and giving birth is associated with more serious health problems than abortion.[54]

Religious exemptions have a particularly negative impact on people of color. Women, people of color, and those living at the intersections of these identities are disproportionately served by Catholic hospitals.[55] These institutions are "governed by strict guidelines that prohibit health care providers from providing contraceptives, sterilization, some treatments for ectopic pregnancy, abortion, and fertility services regardless of their patients' wishes, the urgency of a patient's medical condition, the provider's own medical judgment, or the standard of care in the medical profession."[56] The proposed rule would make it harder for Latinos and Latinas, especially those that are LGBTQ and/or needing reproductive care, to access the health services they need.

e. The Proposed Rule Could Embolden Providers to Discriminate Against Individuals in Title X-funded Health Centers

This proposed rule attempts to sow confusion about the critical protections against discrimination to which Title X-funded providers and others must adhere. Although Section 1557 is still the law of the land, if implemented, the proposed rule could embolden providers to participate in the Title X program and other similar programs even though they intend to allow their personal beliefs to dictate patient care. We believe that providers currently enrolled in the program would continue to act in good faith and would not discriminate against those obtaining health care. However, the Trump-Pence administration has clearly demonstrated its preference for providers who would use their religious or moral beliefs as a license to discriminate over the needs of patients and this proposed rule would further that goal.

In many states, a Title X-funded provider is one of the few places Latinas and Latinos can access reproductive health care and preventive health care services and it is critical that those providers are not discriminating against the individuals that are able to make it

[52] Bixby Ctr. for Global Reprod. Health, University of Cal. S.F., *Turnaway Study*, https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf (last visited Jul. 23, 2019).
[53] Bixby Ctr. for Global Reprod. Health, University of Cal. S.F., *Turnaway Study*, https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf (last visited Jul. 23, 2019).
[54] Bixby Ctr. for Global Reprod. Health, University of Cal. S.F., *Turnaway Study*, https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf (last visited Jul. 23, 2019).
[55] *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, Columbia Law Sch. (Jan. 19, 2018), https://www.law.columbia.edu/events/bearing-faith-limits-catholic-health-care-women-color.
[56] *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, Columbia Law Sch. (Jan. 19, 2018), https://www.law.columbia.edu/events/bearing-faith-limits-catholic-health-care-women-color.

through their doors. Half of the 4 million patients who receive care by Title X health care providers identify as people of color and 32 percent identify as Hispanic.[57] Additionally, one in 10 recipients has limited English proficiency and are able to receive the care they need, in the language in which they need it.[58] Title X-funded health centers are a lifeline for quality health care for underserved communities. Providers administer gynecological exams, contraception, counseling, pap tests, breast exams and screenings for HIV, AIDS and other STIs, and all services are provided confidentially. Their adherence to the protections Section 1557 provides is critical given their role in these underserved communities. Additionally, Title X health care providers also offer services for foreign-born individuals who are less likely to have coverage (46 percent) than their U.S.-born peers (75 percent). For those who have limited options for care, these services, which are available at an affordable price at Title X-funded health centers, can mean the difference of a person receiving care or going without care. Given that many individuals who seek care at a Title X clinic live at the intersection of identities protected by Section 1557, the fact that the proposed rule seeks to roll back the protections for those individuals is both contrary to the plain language and spirit of the law.

III. The Proposed Rule Impermissibly Attempts to Amend Unrelated Regulations to Exclude Sexual Orientation and Gender Identity Protections

The 2016 final rule did not touch other HHS health care regulations. The proposed rule attempts to erase all references to gender identity and sexual orientation in all HHS health care regulations. If implemented, this rule would eliminate express prohibitions on discrimination based on gender identity and sexual orientation from regulations that govern a range of health care programs, including private insurance and education programs. This could result in less health care and poorer health outcomes for communities across the country, including LGBTQ Latinxs and Latinos.

Prior to the passage of the ACA, being transgender was treated as being a pre-existing condition. As a result, transgender people could not get insurance coverage or affordable insurance. Under the proposed rule, states and Marketplaces could discriminate against LGBTQ people in eligibility determinations, enrollment periods, and more. Similarly, agents and brokers who assist with enrollment in marketplace plans could discriminate against LGBTQ people.

If this rule is implemented, insurance issuers could employ discriminatory marketing practices and benefit design that would harm LGBTQ individuals, including LGBTQ Latinos. For example, issuers could inquire about an applicant's sexual orientation or gender identity and use that information for underwriting or determining insurability.[59] Issuers could also charge higher premiums for LGBTQ people, or could cancel or deny coverage for LGBTQ people.[60] As a result, LGBTQ people would face additional barriers to getting the health care they need.

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[57] Office of Population Affairs. Family Planning Annual Report: 2016 National Summary. August 2017. https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf

[58] Office of Population Affairs. Family Planning Annual Report: 2016 National Summary. August 2017. https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf

[59] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

[60] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

Under the proposed rule, Medicaid managed care entities and state Medicaid programs could be emboldened to discriminate against LGBTQ beneficiaries in enrollment. Medicaid covers a disproportionate share of women from vulnerable populations such as those who are in poor health, living with low-incomes, single parents, LGBTQ, have disabilities, and women of color.[61] Nearly one-third (31 percent) of Black women of reproductive age and 27 percent of Latinas of reproductive age are enrolled in the Medicaid program.[62] LGBTQ people are more likely to live in poverty than the overall U.S. population.[63] As a result, LGBTQ people are more likely that non-LGBTQ people to use Medicaid.[64] Within LGBTQ communities, LGBTQ people of color (24 percent) are more likely than white LGBTQ people (18.8 percent) to receive Medicaid; transgender people (21.4 percent) are more likely than LGBQ cisgender people (13.4 percent) to receive Medicaid; and LGBTQ people with disabilities (44.4 percent) are more likely than LGBTQ people with no disabilities (11.8 percent) to receive Medicaid.[65] Additionally, elderly Latinos tend to have complex needs, with multiple-diseases, and are on Medicare and Medicaid (dual eligible), or to be in need of language and culturally competent services. As of 2016, over two thirds (68.1 percent) of all Medicaid beneficiaries were enrolled in a comprehensive Managed Care Organization.[66] The proposed rule would impermissibly open the door to discrimination against the many LGBTQ people, including Latinos, enrolled in Medicaid programs across the country.

V. The Proposed Rule Impermissibly Attempts to Eliminate Language Access Protections

Over 21 percent of the U.S. population, or 66 million people, speak a language other than English at home, with 25 million of them speaking English less than "very well" and thus considered LEP.[67]

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[61] Kaiser Family Foundation. "Medicaid's Role for Women." June 22, 2017. https://www. kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/ (last accessed April 19, 2018).

[62] Sonfield, A. (2017). Why Protecting Medicaid Means Protecting Sexual and Reproductive Health. Guttmacher Policy Review, 20, 39-40. Retrieved 16 March 2017, from https://www.guttmacher.org/sites/default/files/article_files/gpr2003917.pdf.

[63] *See, e.g.*, Intersecting Injustice: A National Call to Action (Lourdes Ashely Hunter, Ashe McGovern & Carla Sutherland eds., 2018), http://socialjusticesexuality.com/intersecting_injustice/.

[64] Caitlin Rooney, Charlie Whittington & Laura E. Durso, *Protecting Basic Living Standards for LGBTQ People*, Ctr. for Am. Progress (Aug. 13, 2018, 12:01 AM), https://www.americanprogress.org/issues/lgbt/reports/2018/08/13/454592/protecting-basic-living-standards-lgbtq-people/; See also Nat'l Health Law Program, et al., Medicaid as an LGBTQ Reproductive Justice Issue: A Primer, Why Medicaid is an LGBTQ Issue 2 (2019), https://healthlaw.org/resource/medicaid-as-an-lgbtq-reproductive-justice-issue-a-primer/ (citing Kerith J. Conron & Shoshana K. Goldberg, The Williams Inst., *LGBT Adults with Medicaid Insurance* 1 (2018), https://williamsinstitute.law.ucla.u/wp-content/uploads/LGBT-Medicaid.pdf (last visited May 02, 2019)).

[65] Caitlin Rooney, Charlie Whittington & Laura E. Durso, *Protecting Basic Living Standards for LGBTQ People*, Ctr. for Am. Progress (Aug. 13, 2018, 12:01 AM), https://www.americanprogress.org/issues/lgbt/reports/2018/08/13/454592/protecting-basic-living-standards-lgbtq-people/.

[66]Center for Medicaid and Medicare Services with Mathmatica Policy Research . "Medicaid Managed Care Enrollment and Program Characteristics, 2016." Spring 2018. https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2016-medicaid-managed-care-enrollment-report.pdf

[67] U.S. Census Bureau, *2017 American Community Survey 1-Year Estimates: Table S1603 Characteristics of People by Language Spoken at Home*, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_S1603&prodType=table (last visited Jul. 17, 2019); U.S. Census Bureau, *2017 American Community Survey 1-Year Estimates: Table S1601 Language Spoken at Home*, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_S1601&prodType=table (last visited Jul. 17, 2019).

For LEP individuals, language differences often compound existing barriers to access and receiving appropriate care. LEP often makes it difficult for many to navigate an already complicated health care system, especially when it comes to medical or insurance terminology. Moreover, these barriers are often compounded by discrimination based on national origin, immigration status, race, ethnicity, sexual orientation, and gender/gender identity.

Discrimination on the basis of national origin, which encompasses discrimination on the basis of limited English proficiency (LEP),[68] creates unequal access to health, particularly for LEP Latinas. LEP is often compounded with the "cumulative effects of race and ethnicity, citizenship status, low education, and poverty," resulting in more barriers to access.[69] In 2015, 64 percent of LEP individuals in living the United States spoke Spanish and more than half were female.[70] There are over 25 million individuals with LEP currently living in the United States.[71] Language assistance services are especially critical for individuals with LEP who are unfamiliar with our complex healthcare system.

Individuals with LEP may fear that speaking a foreign language could make them the target of increased scrutiny about their immigration status. Additionally, due to a person's country of origin, they may also fear immigration-related consequences at the doctor's office. Immigrants often lack access to transportation and may have to travel great distances to get the care they need. In rural areas, there may be no other sources of health care, and when individuals encounter denial of care, they may have nowhere else to go. This limits their options for accessing care and need to know they can safely access the services available to them.

Without the regulatory requirements outlined in the current regulations, people with LEP could face additional challenges in access to culturally and linguistically appropriate care, including information about accessing services and health insurance. In particular, discussions about sexual and reproductive health care can be sensitive and raise issues of privacy and confidentiality. It is critical that individuals have access to adequate language services, in a private and confidential setting, allowing for information about and access to sexual and reproductive health care to be available in a culturally and linguistically competent manner. Section 1557 provides these protections. The proposed regulations would make their scope less clear, causing confusion and opening the door to illegal discrimination.

Without adequate language assistance services, LEP individuals face difficulty enrolling in and accessing health programs and activities. Unfamiliarity with the health care system arises from unfamiliarity with its cultural norms, vocabulary, and procedures. Data and stories demonstrate that individuals with LEP often forgo primary care altogether, as a result of not understanding how to fill out enrollment applications in English or inaccurately translated non-English languages, not understanding the benefits and costs of

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[68] Lau v. Nichols, 414 U.S. 563 (1974).
[69] Kaiser Family Foundation, Overview of Health Coverage for Individuals with Limited English Proficiency, at 3.
[70] Monica Whatley and Jeanne Batalova. "Limited English Proficient Population of the United States." Migration Policy Institute. July 25, 2013. https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states-0#6
[71]Monica Whatley and Jeanne Batalova. "Limited English Proficient Population of the United States." Migration Policy Institute. July 25, 2013. https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states-0#6; U.S. Census Bureau, *American Community Survey, Selected Social Characteristics in the United States: 2011 American Community Survey 1-Year Estimates* (25,303,308 speak English less than "very well"). http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_1YR_DP02&prodType=table

services in a health plan, or not having the appropriate cultural and language brokers to communicate with English-speaking physicians and pharmacists. One study found that Latina breast cancer survivors needed simple information in Spanish about breast cancer, treatment, management of side effects, and community resources because they often felt confusion regarding terminology, expressed myths about cancer, and did not know how to pay for treatment, especially if they were undocumented.[72] Additionally, in a study conducted from 2009 to 2012, 64 percent of LEP Latina mothers of infants and toddlers were found to have clinically significant symptoms of depression.[73] Two of the contributing factors may have been economic hardship and the stress of immigration status.[74]

LGBTQ people face significant obstacles in accessing health care and these barriers are exacerbated when a person is both LGBTQ and LEP, especially if the person is also an immigrant. Many LGBTQ immigrants have limited educational opportunities in their home countries due in part to persecution they may have faced. Further, many immigrants with limited English language skills find themselves facing barriers to employment,[75] which in turn produces additional barriers to accessing health care.

a. Remote interpreting services

The 2016 final rule includes standards for video remote interpreting services. The proposed rule attempts to remove video remote interpreting standards and require only audio remote interpreting for spoken language interpretation. The type of interpreting during a medical visit should depend on the type of encounter. Keeping the current standard allows providers to determine which technology is appropriate and that when an entity uses video, it is high quality and without lagging.

b. Taglines

The 2016 final rule requires covered entities to include taglines in the top fifteen languages spoken by individuals with LEP in the state on all significant documents. Taglines, or short statements in various languages informing individuals of their right to language assistance and how to seek such assistance, must be included in significant publications, including notices of nondiscrimination. The proposed rule illegally seeks to eliminate the requirement that entities use in-language taglines. This proposal will cause harm and should not be finalized.

Taglines are useful and low-cost way to ensure that individuals are aware of their protections under the law. Combined with the elimination of the requirement to post notices of nondiscrimination, the proposed rule could leave many people, including LEP individuals, without the knowledge of their own rights and further put legal services out of reach for those who are discriminated against.

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[72] Anna Nápoles, University of Cal. S.F., Improving Inequities in Diagnosis, Treatment, and Survival among Latinas, Komen SF Bay Area Many Faces-One Voice Conference (June 17, 2013).
[73] Linda Beeber, T. Schwartz, & L. Smith, *The "Wings" Depressive Symptom Intervention for Latina Mothers* (2012), https://grantome.com/grant/NIH/R34-MH086553-02S1.
[74] Linda Beeber, T. Schwartz, & L. Smith, *The "Wings" Depressive Symptom Intervention for Latina Mothers* (2012), https://grantome.com/grant/NIH/R34-MH086553-02S1.
[75] Sharita Gruberg, et al., *Serving LGBTQ Immigrants and Building Welcoming Communities*, Ctr. for Am. Progress (Jan. 24, 2018, 9:03 AM), https://www.americanprogress.org/issues/lgbt/reports/2018/01/24/445308/serving-lgbtq-immigrants-building- welcoming-communities.

c. Language access plans

Protections around language access have long included recommendations around development of language access plans to help covered entities better meet the needs of people with LEP. The 2016 final rule did not require covered entities to develop language access plans but said if an entity has a language access plan, the Office of Civil Rights ("OCR") must consider it when evaluating compliance. The proposed rule attempts to eliminate recommendations that entities develop language access plans and remove OCR's obligation to consider these plans. The development of language access plans should remain an item that supports an entity's compliance with the law.

By eliminating critical protections for LEP individuals seeking care, the administration is discouraging entities from meeting individuals where they are, making health care inaccessible and often convoluted for marginalized or linguistically isolated communities. Language proficiency should not determine whether or not people have access to care or the quality of a person's care.

VI. The Proposed Rule Impermissibly Attempts to Eliminate Prohibitions on Discrimination in Insurance Plan Benefit Design and Marketing

Before the ACA, people with serious and/or chronic health conditions were often denied health insurance coverage or paid high prices for substandard plans with coverage exclusions, leaving many people unable to afford the health care they needed. Under the ACA, insurers can no longer charge higher premiums or deny coverage for people with pre-existing conditions. These protections have been lifesaving for many people.

Under the 2016 final rule, covered entities are prohibited from designing benefits that discourage enrollment by persons with significant health needs. For example, insurers are prohibited from placing all or most prescription drugs used to treat a specific condition, such as HIV prescriptions, on a plan's most expensive tier.[76] Additionally, covered entities are prohibited from using discriminatory marketing practices, such as those "designed to encourage or discourage particular individuals from enrolling in certain health plans."[77] The proposed rule improperly attempts to eliminate these prohibitions.

The proposed rule would make it harder for LGBTQ people and people of color, including Latinos and LGBTQ Latinos, living with disabilities and chronic conditions to afford coverage and care. The final rule's prohibition on discriminatory plan benefit designs helped people living with HIV get the medications they need. In 2016, Hispanics/Latinos accounted for 26 percent (10,292) of the 40,324 new HIV diagnoses in the United States and more Hispanics and Latinos have HIV compared to some other races and ethnicities[78] and one fifth of those living with HIV are Latino.[79] HIV

[76] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.
[77] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.
[78] Center for Disease Control and Prevention. "HIV and Hispanics/Latinos." November 1, 2018. https://www.cdc.gov/hiv/group/racialethnic/hispaniclatinos/index.html
[79] Center for Disease Control and Prevention. "CDC Factsheet: HIV and Latinos." https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-hiv-latinos-508.pdf

disproportionately affects gay, bisexual, and queer men of color and transgender women of color.[80] For example, more than 25 percent of Black and Brown transgender women are living with HIV,[81] and 60 percent (10,070) of Black or African American individuals who received an HIV diagnosis in 2017 were gay or bisexual men.[82] Additionally, more than 100,000 Latinos with stage 3 HIV (AIDS) have died since the start of the epidemic.[83] Latino men accounted for 90 percent of new HIV infections among Latinos in 2016, and 88 percent of these were among Latino gay and bisexual men[84] Many LGBTQ Latinos experience negative health outcomes because of barriers to care and discrimination, resulting in higher rates of HIV/AIDS.[85]

Also, due to systemic barriers to health care, people of color experience higher rates of chronic conditions. For example, Latinas are 17 times more likely to die from diabetes than non-Hispanic white women.[86] The proposed rule would disproportionately harm LGBTQ individuals and people of color, including those who have these intersecting identities, who live with disabilities and chronic conditions. It is critical that those with significant health needs are able to access the care and coverage they need without discrimination.

VII. The Proposed Rule Impermissibly Attempts to Undermine Notice and Enforcement Requirements and Remedies

a. Nondiscrimination notice and grievance procedure requirements

The 2016 final rule requires covered entities with at least 15 employees to adopt a grievance procedure and designate at least one employee to coordinate its Section 1557 responsibilities.[87] The 2016 final rule also requires covered entities to provide notice of nondiscrimination policies in significant communications, in physical locations where the entity interacts with the public, and on the home page of their website. The notice of nondiscrimination must include information about the characteristics protected from discrimination under Section 1557, the availability of and how to access auxiliary aids and services, the availability of and how to access language assistance services, contact information for the designated employee coordinating the entity's Section 1557 responsibilities, the entity's grievance procedures, and complaint procedures for OCR. The proposed rule improperly attempts to eliminate these provisions entirely.

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[80] Intersecting Injustice: A National Call to Action 63-64 (Lourdes Ashely Hunter, Ashe McGovern & Carla Sutherland eds., 2018), http://socialjusticesexuality.com/intersecting_injustice/.
[81] Intersecting Injustice: A National Call to Action 64 (Lourdes Ashely Hunter, Ashe McGovern & Carla Sutherland eds., 2018), http://socialjusticesexuality.com/intersecting_injustice/.
[82] *HIV and African Americans*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html (last updated March 19, 2019).
[83] Center for Disease Control and Prevention. "CDC Factsheet: HIV and Latinos." https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-hiv-latinos-508.pdf
[84] Center for Disease Control and Prevention. "CDC Factsheet: HIV and Latinos." https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-hiv-latinos-508.pdf
[85] The Henry J. Kaiser Family Foundation. (2014, April 15). Latinos and HIV/AIDS, 1-3. Retrieved at http://kf.org/hivaids/fact-sheet/latinos-and-hivaids/
[86] Office on Women's Health. (2010, May 18). Minority Women's Health: Latinas and Diabetes. U.S. Department of Health and Human Services. Retrieved 10 May 2017, from https://www.womenshealth.gov/minority-health/latinas/diabetes.html
[87] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

Section 1557 is still the law of the land and the proposed rule's inconsistency with the statute itself would cause confusion for both health care entities and patients. This would ultimately increase confusion about what the law requires and who is protected under it and making it harder for those who are discriminated against to enforce their rights. Further, the proposed rule would discourage people from reporting discrimination, making discrimination harder to track and thus harder to prevent.

Notices of nondiscrimination are critical for Latinos and Latinas, including those who are LGBTQ, immigrants, and those living at the intersections of these identities. Notices tell individuals that an entity cannot discriminate and what to do if they face discrimination, including how to file a complaint with OCR.

b. Private right of action and compensatory damages

The 2016 final rule, like the statute itself, allows for a private right of action in federal court. The proposed rule attempts to eliminate the regulatory provisions recognizing private right of action in federal court. Additionally, the 2016 final rule allows for money damages for violations of Section 1557 in both administrative and judicial actions brought under the regulation. The proposed rule attempts to eliminate the regulatory provision providing that money damages are available to those who are injured by violations of the statute.

Section 1557 is the law of the land. The proposed rule's inconsistency with the statute itself would cause confusion for both health care entities and patients, ultimately increasing confusion about what the law requires and who is protected under it and making it harder for those who are discriminated against to enforce their rights.

Many people who experience discrimination cannot access the court system due to cost.[88] When people can afford to bring judicial actions, they generally receive little in the form of compensatory relief.[89] This could make it even more expensive for people to enforce their rights, including Latinos and Latinas, deterring them from filing complaints of discrimination.

c. Enforcement Mechanisms

Section 1557 made it so individuals seeking to enforce their rights would not be limited to only the remedies provided to a particular protected group. Under the plain language of Section 1557, individuals have access to any and all of the remedies under any of the cited statutes, including Title VI, Title IX, Section 504 of the Rehabilitation Act, and the Age Discrimination Act, regardless of the type of discrimination an individual faced. The proposed rule attempts to limit remedies and enforcement mechanisms that are available to those who are discriminated against by claiming that the remedies and enforcement mechanisms for each protected characteristic (race, color, national origin, age, disability or sex) are different and limited to those available under their referenced statute. As a

[88] *See* Brittany Kauffman, *Study on Estimating the Cost of Civil Litigation Provides Insight into Court Access*, Inst. for the Advancement of the Am. Legal System (Feb. 26, 2013), https://iaals.du.edu/blog/study-estimating-cost-civil-litigation-provides-insight-court-access; Michelle Chen, *One More Way the Courts Aren't Working for the Poor*, The Nation (May 16, 2016), https://www.thenation.com/article/one-more-way-the- courts-arent-working-for-the-poor.

[89] Maryam Jameel & Joe Yerardi, Workplace discrimination is illegal. But our data shows it's still a huge problem, Vox (Feb. 18, 2019),https://www.vox.com/policy-and-politics/2019/2/28/18241973/workplace-discrimination-cpi-investigation-eeoc.

result, the proposed rule would create a confusing mix of legal standards and available remedies under a single law, and could limit claims of intersectional discrimination, going against the text and intent of Section 1557.

The proposed rule is unrealistic and overburdensome. Section 1557 recognizes the reality that discrimination "may occur not solely because of the person's race or not solely because of the person's sexual orientation or gender identity, [disability status, or national origin], but because of the combination."[90] Thus, the law aimed to make it easier for people to file complaints of intersectional discrimination in one place. The proposed rule will only make it harder for people to file complaints. For example, an afro-Latina woman who experienced compounded discrimination based on both her race and her sex would have to file two separate claims of discrimination. This would have harmful consequences for communities who have historically been discriminated against in health care settings.

VIII. Conclusion

This proposed rule could impose wide ranging harm on Latinos and Latinas. The proposed rule is just the latest attack from the Trump-Pence Administration on people seeking reproductive health care, including abortion, LGBTQ individuals, individuals with LEP, including immigrants, those living with disabilities, and people of color. Moreover, this rule would embolden compounding levels of discrimination against those who live at the intersection of these identities. The proposed rule is dangerous and contravenes the plain language of Section 1557, specifically, and the ACA broadly.

For the reasons detailed above, HHS and CMS should not finalize the proposed rule and redirect their efforts to advancing health care access and equity for all.

Thank you for the opportunity to submit comments on the proposed rule. Please contact NHLA through Jessica González-Rojas at Jessica@Latinainstitute.org or Elena Rios, MD, MSPH, FACP at nhma@nhmamd.org with any questions. Thank you for your time and consideration.

Sincerely,

National Latina Institute for Reproductive Health

[90] Brief for National LGBTQ Task Force as Amici Curiae Supporting Respondents, Masterpiece Cakeshop v. Col. C.R. Comm'n, 137 S.Ct. 2290 (2017), http://www.thetaskforce.org/wp-content/uploads/2017/10/16-111-bsac-LGBTQ-Task-Force.pdf.

EXHIBIT D-57

VIA ELECTRONIC TRANSMISSION

August 13, 2019

Secretary Alex Azar
Director Roger Severino
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F
Hubert H. Humphrey Building
Washington, DC 20201

Re: RIN- 0945-AA11, Nondiscrimination in Health and Health Education Programs or Activities

Dear Secretary Azar and Director Severino:

Planned Parenthood Federation of America (Planned Parenthood) and Planned Parenthood Action Fund (the Action Fund) submit these comments in response to the Nondiscrimination in Health and Health Education Programs or Activities, released by the Department of Health and Human Services (the Department) Office for Civil Rights (OCR) and the Office of the Secretary on May 24, 2019 and published in the federal register at 84 FR 27846 on June 14, 2019. As a trusted health care provider and advocate, Planned Parenthood takes every opportunity to weigh in on policy proposals that impact the communities we serve across the country.

Planned Parenthood is the nation's leading women's health care provider and advocate and a trusted, nonprofit source of primary and preventive care for women, men, and young people in communities across the United States. Each year, Planned Parenthood's more than 600 health centers provide affordable birth control, lifesaving cancer screenings, testing and treatment for sexually transmitted diseases (STDs), and other essential care to 2.4 million patients. Planned Parenthood health centers also provide abortion services and ensure that women have accurate information about all of their reproductive health care options. One in five women in the U.S. has visited a Planned Parenthood health center. The majority of Planned Parenthood patients have incomes at or below 150 percent of the Federal Poverty Level (FPL).

Because Planned Parenthood provides health care, education, and information for lesbian, gay, bisexual, transgender, queer, and gender-nonconforming people, as well as immigrants, women, communities of color, people with chronic illnesses and disabilities, and others who frequently experience barriers to care, we are acutely aware of the racism, homophobia, xenophobia, transphobia, and sexism that is systemically rooted in the American health care

system. Planned Parenthood frequently provides care to communities that otherwise would not be able to access care. For instance, currently, over 100 Planned Parenthood health centers in twenty-eight states offer hormone treatment for trans people. Additionally, we perform nearly 800,000 HIV/AIDS screenings annually. Our patients and supporters are the reason we advocate for policies and laws that advance health equity for all and oppose policies and laws that impede access to health care, particularly for people of color, LGBTQ people, women, and people with chronic illnesses. It is for this reason that we urge the Department to withdraw the proposed rule.

The underlying statute, Section 1557 of the Affordable Care Act (Section 1557), aimed to build upon existing civil rights law to ensure that patients and consumers have their rights protected in health care settings, programs, and activities.[1] The Department's 2016 regulation, which was promulgated six years after the Affordable Care Act (ACA) was signed into law, following two related comment periods and over 25,000 comments, explicitly prohibits discrimination based on gender identity and sex-stereotyping; prohibits discrimination on the basis of pregnancy, including termination of pregnancy; requires certain language access and interpretation services for people with limited-English proficiency; and prohibits plans from engaging in discriminatory marketing and plan design.[2]

The Department now proposes to erase most of the protections afforded under the 2016 regulation. The proposed rule is contrary to congressional intent, given Section 1557 aimed to prohibit discrimination in health care programs and activities so that *everyone* could have equitable access to health care. Moreover, the proposed rule would harm populations who already face systemic barriers to accessing health care. The Department's proposals will embolden discrimination against and harm transgender, lesbian, gay, and bisexual people; further stigmatize abortion and other pregnancy-related care; harm people with limited-English proficiency, particularly immigrants; and harm people with chronic illnesses, such as people living with HIV. While the Department cannot alter the protections afforded under the statute, the proposed rule will create confusion as it attempts to erase the civil rights protections previously specified in the 2016 regulation.

Additionally, the Department's proposed rule fails to meet the Department's obligation to provide a reasoned cost-benefit analysis. The Department claims that the rule, if finalized, would eliminate $3.6 billion in "unjustified costs" over five years,[3] but the Department fails to account for the fact that these costs will be pushed onto women, particularly women of color, as well as people who identify as lesbian, gay, bisexual and transgender. For all of these reasons, the proposed rule should be withdrawn.

I. The proposed rule will limit the overall effectiveness of Section 1557, and could harm women, LGBTQ people, people with disabilities, people with chronic illnesses, older people, and people of color seeking health care – which clearly is contrary to Congress' intent.

[1] HHS Office of the Secretary,Office for Civil Rights & OCR, Section 1557 of the Patient Protection and Affordable Care Act HHS.gov (2018), https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html (last visited Aug 11, 2019).
[2] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31469-31473 (May 18, 2016) (codified at 42 CFR 92).
[3] Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846, 27849 (June 14, 2019).

The Department claims the proposed rule is a "repeal and replacement" of significant portions of the Section 1557 regulation - but the Department is not providing any replacement. Section 1557 prohibits discrimination in the health care context on the basis of race, ethnicity, national origin, sex, age, and disability, and it represented a significant step forward to advancing health equity for people of color, women, LGBTQ people, older people and people with disabilities. The 2016 rule added specificity and standardization to ensure that people protected under the rule could receive equal protections, as Congress intended. The Department's proposal to gut the 2016 regulation, including removing the standard enforcement mechanisms, and limiting the applicability of the rule undermines Congress' intent and the effectiveness of the protections afforded under Section 1557.

A. The proposed rule will result in confusion regarding what is considered discrimination and the enforcement mechanisms available to enforce these civil rights protections –contrary to Congress' intent.

The Department's proposal to remove the 2016 rule's uniform discrimination standard and enforcement mechanisms, including the rule's provision of a private right of action in federal court, will only serve to sow confusion. As federal courts have found, it is logical to reason that Congress intended to provide uniform standards and enforcement mechanisms for communities protected under the statute; otherwise, the recourse available against discrimination would depend on whether the discrimination inflicted was on the basis of race, ethnicity, national origin, sex, age, or disability. Such a lack of uniformity would only be more complicated when the discrimination is based on a person's intersectional identiy (for instance, the person is being discriminated against for being both Black and gay, or both a woman and an immigrant), which is frequently the case given people carry multiple identities.

In *Rumble v. Fairview Health Services,* the first court case to interpret Section 1557 (and decided before the 2016 regulation was finalized), the court found that it was clear from Section 1557 and the Affordable Care Act, writ large, that Congress intended to "create a new, health-specific, anti-discrimination cause of action, that is subject to a singular standard, regardless of plaintiff's protected class status." The court goes on to explain that Congress likely referenced the different civil rights statutes mostly to identify the grounds on which discrimination is prohibited.[4] The court unequivocally expressed concern about the chaos that would result from different mechanisms and standards, describing the notion as "absurd inconsistency," and the court explained that "reading Section 1557 otherwise would lead to an illogical result."[5] The court rightfully notes that "courts would have no guidance about what standard to apply for a Section 1557 plaintiff bringing an intersectional discrimination claim."[6]

Congress' references to the existing statutes were to establish the grounds upon which discrimination was prohibited and to create not four, but one law, governing discrimination in health care. The 2016 rule was implemented consistent with that congressional intent. The Department asks whether the proposed rule will eliminate confusion.[7] The answer to this question is clearly no.

B. The Department proposes, contrary to congressional intent, to limit who must comply with the rule.

[4] *Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015).
[5] *Rumble,* 2015 WL 1197415 22-23.
[6] *Rumble*, 2015 WL 1197415 23.
[7] 84 Fed. Reg. 27888.

The Department proposes, in direct conflict with the language and meaning of the statute, to drastically limit the applicability of Section 1557. The 2016 regulation defined "health program or activity" to include all operations of an entity receiving federal financial assistance that is principally engaged in the provision or administration of health-related services or health-related coverage. The proposed rule narrows the scope to include only health programs and activities administered by HHS under Title I of the ACA and state Marketplaces. Congress outlined clearly in the statute that Section 1557 applies to "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)."[8] The Department's proposal to drastically limit the applicability of the rule, exempting federal programs, including health programs that are administered by the Department itself, and a significant number of insurers.

This change would mean that protections afforded under the nondiscrimination regulation would no longer be applicable across the Department of Health and Human Services. The Section 1557 rule would apply only to *health programs* that are administered by the Department that receive federal financial assistance, and any program or activity under Title I of the ACA. This means that the rule would no longer apply to non-financial assistance programs administered under the Department: the rule would no longer apply to the Department itself (except where related to certain provisions of the ACA), the Centers for Disease Control and Prevention, the Indian Health Service, the Health Services Research Administration, nor the Substance Abuse and Mental Health Services Administration.

The proposed rule also defies reason when it exempts certain insurers from the proposed rule's requirements. Despite the fact that health insurers provide health care coverage and frequently play a determinative role in whether a person can or cannot access health care, the proposed rule declares that health insurers are not principally engaged in the business of health care by virtue of providing coverage, and thus, not subject to the rule's requirements. Furthermore, even for the insurers who would be subject to the proposed rule, not all of the insurers' plans would be subject to the rule's nondiscrimination requirements. It is extremely concerning that short-term plans, self-funded plans, the Federal Employees Health Benefits Program, and Medicare Part B are among the plans and coverage programs that would be exempt under the proposed rule, and people enrolled within these plans would be susceptible to discrimination. Exempting these plans from nondiscrimination protections is particularly troublesome for women, LGBTQ people, and people with chronic illnesses: short-term plans in particular have been found to engage in gender rating and discriminatory pricing against people considered to have pre-existing conditions, and these plans typically have blanket exclusions for maternity coverage, gender-affirming care, contraceptives and other prescriptions.[9] In short, the proposed rule prioritizes insurers' profits over consumer health and will result in discrimination in health care, contrary to congressional intent.

II. The Department should withdraw the proposed rule because it impermissibly eliminates protections based on gender identity and sex-stereotyping.

[8] 42 USC 18116(a).

[9] A. Aron-Dine, Blocking Trump Rule on Short-Term Health Plans Would Benefit Consumers, Center on Budget and Policy Priorities (2019), https://www.cbpp.org/blog/blocking-trump-rule-on-short-term-health-plans-would-benefit-consumers.

LGBTQ people will be harmed by the Department's proposal to eliminate specific language in the 2016 final regulation stating that sex discrimination includes discrimination based on gender identity and sex stereotyping. The 2016 regulation further defined gender identity to include sense of gender and non-binary gender identity, and sex stereotyping was explained as including pre-conceived notions of masculinity and femininity. These protections have resulted in insurers, hospitals, providers, and other health care entities eliminating discriminatory practices,[10] and these provisions were a huge step forward in advancing health equity for LGBTQ people. With the proposed rule, the Department is going backwards, instead of advancing protections against LGBTQ individuals and prioritizing health equity for this community.

The Department has not adequately considered how its proposal to remove protections based on gender identity and sex-stereotyping will exacerbate existing discrimination against LGBTQ people, nor has the Department offered a justifiable explanation as to why this proposal is the best regulatory approach to maximize public health benefits. Even more, the Department has not met its obligation to consider the health and financial costs that will be imposed upon LGBTQ people.

A. The Department's proposal to remove key protections against sex discrimination based on gender identity and sex-stereotyping will greatly harm LGBTQ people seeking health care.

The Department acknowledges that the proposed rule would lead some covered entities to revert back to the discriminatory policies and practices related to gender identity and sex-stereotyping.[11] The examples the Department names include amending organizational nondiscrimination policies and training materials, but the proposed rule could result in more expansive discriminatory policies and practices in health care.[12] Without the 2016's protections, insurers, providers, hospitals and others in the health care system could revert back to policies and practices that previously harmed LGBTQ people.

The 2016 regulation includes specific prohibited activities related to gender identity that provide key protections for trangender people. Specifically, the 2016 regulation prohibits: 1) limitations on coverage for any health services that are ordinarily or exclusively available to individuals of one sex to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available; 2) prohibitions on implementing a categorical coverage exclusion or limitation for all health services related to gender transition; and 3) prohibitions on limiting coverage of a claim, imposing additional cost-sharing, or other limitations or restrictions on coverage for specific health services related to gender transition if the denial, limitation or restriction would result in discrimination against transgender individuals.[13] Lesbian, gay, bisexual and other queer people may also be harmed by removing protections based on sex-stereotyping. Discrimination because of an individual's sexual orientation is plainly a species of sex stereotyping that is impermissible under Section 1557's sex discrimination

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[10] S. Mirza & C. Rooney, Discrimination Prevents LGBTQ People from Accessing Health Care, Center for American Progress (2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[11] 84 Fed. Reg. 27876.

[12] *Id*.

[13] 45 CFR 92.207(b)(3)-(5).

prohibition.[14] Thus, erasing the rule's protections based on sex stereotyping will disproportionately impact lesbian, gay and bisexual people.

Even more, the Department is also taking this opportunity to delete other nondiscrimination protections afforded to LGBTQ people within other regulations. First, the Department proposes to remove protections aimed at preventing state and federal marketplaces from discriminating against consumers based on gender identity and sexual orientation.[15] Second, the Department is proposing to again allow health insurance issuers, including qualified health plans, to design plans, administer plans, and engage in marketing practices that discourage LGBTQ individuals from enrolling in their plans.[16] The elimination of these protections, coupled with the Department's proposals to remove specific gender-identity and sex stereotyping protections and the specific prohibition against discriminatory plan design and marketing, will remove important protections to limit discrimination against LGBTQ people. What's more, the Department is proposing to remove protections designed to prevent Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and primary care case managers (PCCMs) and related entities from discriminating based on gender identity and sexual orientation,[17] impacting a population that has limited resources to fight discrimination and subsequently, experiences worse health outcomes. This is particularly problematic given LGBTQ people with low incomes report the highest rates of receiving substandard care.[18] Similarly, the Department's proposal to remove the agency's protections against discrimination based on "the application of any rules of appearance," will remove key

[14] *See Price v. Waterhouse,* 490 U.S. 228, 251 (1989) (holding that discrimibation based on sex stereotyping is discrimination on the basis of sex, in violation of Title VII of the Civil Rights Act of 1964).
[15] 84 Fed. Reg 27871; *See also* 45 CFR 155.120(c)(1)(ii) (prohibiting the federal and state Marketplaces from discriminatinon on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation) and 155.220(j)(2) (prohibiting agents and brokers participating on the marketplaces from discriminating on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation).
[16] 84 Fed. Reg 27871; *See also* 45 CFR 147.104(e) (prohibiting health insurers from engaging in marketing practices and plans designs that discourage enrollment of individuals with significant health needs or discriminate based on an individual's race, color, national origin, disability status, age, sex, gender identity, sexual orientation, life expetency, medical dependency, quality of life, or other health conditions), and 156.200(e)(prohibiting a qualified health plans from discriminating on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation); 155.1230(b)(2) (prohibiting qualified health plans engaged in direct enrollment from engaging in discrimination on the basis of race, color, national origin, disability, age, sex, gender identity or seuxal orientation).
[17] 84 Fed. Reg 27871; *See also* 42 CFR 438.d(4) (prohibiting MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities from discriminating, or using any policy or practice that has the effect of discriminating against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability); 438.206(c)(2) (requring MCOs, PIHPs, and PAHPs to deliver services in a culturally competent manner, including to those with limited English proficiency, and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity), and 440.262 (requiring the state, in administrationing Medicaid programs, to deliver services in a culturally competent manner to all beneficiecies, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity). Related, the Department is also proposing to remove nondiscrimination provisions applicable to the Medicare Programs for All-inclusive Care of the Elberyly (PACE) programs. 42 CFR 460.98(b)(3) and 460.112(a).
[18] When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV, Lambda Legal 11 (2010) https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf.

protections that afforded protections to people, including LGBTQ people, who do not conform to gender stereotypes. [19]

Removing these protections could exacerbate discrimination against LGBTQ people. Discrimination against LGBTQ people has -- historically and currently -- taken many forms.[20] Specific instances of discrimination include, but certainly are not limited to:

- Transgender patients being intentionally mistreated**.** In 2015, OCR reached a voluntary settlement with the Brooklyn Hospital Center based on a complaint filed by a transgender woman who was assigned to a room with a man despite her gender identity.[21] In another devastating example, a transgender teenager was admitted to a hospital for self-inflicted injuries, and he was placed on suicide watch.[22] Even in this highly sensitive situation, the hospital repeatedly mis-gendered him. After he was discharged early from the hospital, he committed suicide.
- Gay people being denied necessary medical care. A man living with HIV reported that hospital staff began to treat him poorly after he disclosed that he had sex with other men. He filed a complaint alleging that doctors refused his request for antiretrovirals - on top of ignoring him and refusing to allow his family to visit.[23]
- LGBTQ people being denied preventive services. An analysis of complaints to OCR pursuant to Section 1557 included complaints of individuals being denied preventive care, such as a mammogram and a urinary tract infection screening as a result of gender identity and transgender status.[24] One transgender patient with a broken hand reported being asked unnecessary questions regarding sexuality and another transgender patient reported that while seeking treatment for a sore threat an unnecessary pelvic exam was administered.[25]

Overall, an astonishing seventy percent of transgender and gender-nonconforming respondents, and fifty-six percent of lesbian, gay, and bisexual people report experiencing discrimination in the health care system**.**[26] Transgender and gender-nonconforming people are disproportionately burdened by discrimination. According to the 2015 Transgender Survey, 33 percent of respondents complained that they were mistreated as a result of their transgender status when accessing care, and 25 percent of respondents experienced a problem with their health insurance related to being transgender including being denied coverage for gender affirming care and routine medical care.[27] Lesbian, gay, and bisexual people also reported

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[19] 84 Fed. Reg 27871; 45 CFR 86.31(b)(5)(prohibiting the discrimination in education programs based on "any rules of appearance").

[20] Lambda Legal, *supra* note 19 at 9-13.

[21] Voluntary Resolution Agreement between the U.S. Department of Health and Human Services Office of Civil Rights and Brooklyn Hospital Center, Trans. Number 12-147291, https://www.hhs.gov/sites/default/files/ocr/civilrights/activities/agreements/TBHC/vra.pdf

[22] S. Mirza & C. Rooney, *supra* note 11; Based on self-reporting, transgender people are nearly nine times more likely to have attempted suicide, and eight times more likely than the general population to have experienced serious psychological distress within the month prior to taking the survey. J. Herman, et. al., The Report of the 2015 US Transgender Survey, Nat'l Ctr. for Transgender Equality 5 (Dec. 2016), https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF.

[23] Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS, Nat'l Women's Law Ctr. (2014), https://nwlc.org/wp-content/uploads/2015/08/LGBTQ_refusals_factsheet_05-09-14.pdf.

[24] S. Mirza & C. Rooney, *supra* note 11.

[25] Nat'l Women's Law Ctr. *supra* note 24.

[26] Lambda Legal, *supra* note 19 at 10.

[27] J. Herman, *supra* note 23 at 10.

experiencing discrimination when accessing health care. Over 10 percent who were surveyed reported that a health care professional refused to touch them or used excessive precautions; over 10 percent reported that a health care professional used harsh or abusive language; and over 12 percent reported that their health care provider blamed them for their health status. LGBTQ people of color with low incomes report experiencing even worse discrimination.[28] Since the passage of Section 1557 and promulgation of the 2016 regulation, insurers, hospitals and providers have increasingly removed discriminatory policies that undermined transgender people's access to care. For instance, according to an analysis of 2019 qualified health plans, the vast majority of plans did not use transgender-specific exclusions for the third year in a row.[29] Forty percent of plans - which is an all-time high - now include plan language clearly stating that all or some medically necessary treatment for gender dysphoria must be covered. Without adequate federal protections, LGBTQ people may again be susceptible to these forms of discrimination in health care.

The Department erroneously claims that state and local entities are "better equipped to address issues of gender dysphoria or sexual orientation."[30]State laws do not provide adequate protections for LGBTQ people, particularly transgender people. While some states have created protections, nearly 50 percent of the LGBTQ population live in states without laws prohibiting insurance companies from discrimination.[31]

B. The Department has not offered a rational basis for adopting this harmful regulatory approach.

The U.S. Supreme Court has held that an agency must provide adequate reasons for its decisions. The Court has noted that an agency must "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made," and a failure to do so results in the action being deemed arbitrary and capricious, and thus, without the force of law.[32] In addition, an agency can only change an existing policy if it provides a "reasoned explanation" for disregarding or overriding the basis for the prior policy.[33] The overarching reason that the Department appears to be offering as a justification for this burdensome rule is consistency, both with the courts and between agencies. This justification fails because consistency should never take precedence over the population's health.

The Department's claimed goal for consistency across the federal government is a red-herring.[34] It defies logic given the Department must remove protections from eleven other

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[28] Lambda Legal, *supra* note 19 at 6.
[29] Out2Enroll, Summary of Findings: 2019 Marketplace Plan Compliance with Sec. 1557, https://out2enroll.org/out2enroll/wp-content/uploads/2018/11/Report-on-Trans-Exclusions-in-2019-Marketplace-Plans.pdf.
[30] 84 Fed. Reg 27874.
[31] 20 states plus D.C. have laws that prohibit insurance coverage from having transgender exclusions and ten states have Medicaid policies that exclude transgender health coverage and care. Movement Advancement Project, Healthcare Laws and Policies, http://www.LGBTQmap.org/equality-maps/healthcare_laws_and_policies.
[32] *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016) (citing *Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.*, 463 U.S. 29, 103 (1983)).
[33] *Id*. at 2125-26.
[34] 84 Fed. Reg 27849.

regulations in order to achieve this goal.[35] If the Department really aims to ensure consistency across its regulations, then it should ensure that all relevant regulations afford protections for LGBTQ people. This would achieve the Department's claimed goal for consistency across health regulations while also ensuring that the Department does not abandon its obligation to advance civil rights for all people in the U.S. Similarly, the Department reasons that it is necessary to remove prohibitions against discrimination "in the application of any rules of appearance" under Title IX because the Department is the only agency to afford this protection.[36] But, this is not a reasonable justification because the Department is tasked with promulgating regulations to protect people's health, and this approach will undoubtedly differ at times from the rulemaking approach other agencies find necessary. This is one such time. The Department's failure to protect LGBTQ individuals from discrimination in health care can be a matter of life or death. So, the justification that other agencies have removed similar protections is not sufficient - and it does not assuage the Department of its obligation to engage in rulemaking that advances and improves consumer's health.

In particular, the Department claims that it is necessary to ensure any regulation issued pursuant to Section 1557 references only the binary definition of gender in order to ensure consistency with the Department's Title IX regulations as promulgated in 1975. That argument fails as well. The Department does not consider that the medical and public health communities' understanding of the transgender community had significantly changed between 1975 and 2016.[37] As the Department itself notes within this rule, an agency is able to change its existing position for "good reasons."[38] And, it was for good reason that the Department promulgated a regulation in 2016 consistent with the scientific understanding of the needs of transgender people and the discrimination they experience.

The Department also cites inconsistent case law as the reason for removing protections based on gender-identity and sex stereotyping, ignoring the overwhelming majority of court precedent that provides protections for LGBTQ people.[39] Multiple federal courts have found that laws affording protections based on sex, including but not limited to Title IX and Section 1557, prohibit discrimination based on gender identity. Notably, five circuit courts have found that federal sex discrimination laws, including Title VII of the Civil Rights Act of 1964, Title IX of the Education Amendments Act of 1972, the Equal Protection Clause of the U.S. Constitution, the Equal Credit Opportunity Act, and Gender Motivated Violence Act, encompass protections for

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[35] *See* 84 Fed Reg. 27871.

[36] *Id.*

[37] W. Parry, Gender Dysphoria: DSM-5 Reflects Shift In Perspective On Gender Identity, HUFFPOST (Aug. 4, 2013), https://www.huffpost.com/entry/gender-dysphoria-dsm-5_n_3385287.

[38] 84 Fed. Reg 27850

[39] *See, e.g., Rumble* 2015 WL 1197415 (holding that discrimination against hospital patient based on his transgender status constitutes sex discrimination under Section 1557 of the Affordable Care Act); *Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc (W.D. Wis. 2018) (holding that a Medicaid program's refusal to cover treatments related to gender transition is "text-book discrimination based on sex" in violation of the Affordable Care Act and the Equal Protection Clause of the Constitution); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. 2016) (holding exclusion invalid under the Medicaid Act and the Affordable Care Act); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090 (S.D. Cal. 2017) (holding that discrimination against transgender patients violates the Affordable Care Act); *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. 2018) (holding that Section 1557 of the Affordable Care Act prohibits discrimination on the basis of gender identity); *Boyden v. Conlin,* No. 17-cv-264-WMC, 2018 (W.D. Wis. 2018) (holding that a state employee health plan refusal to cover transition-related care constitutes sex discrimination in violation of Title VII, Section 1557 of the ACA, and the Equal Protection Clause).

people based on gender identity.[40] Similarly, in *Cruz v. Zucker*[41] and *Rumble v. Fairview Health Services,*[42] district courts found that Section 1557's prohibition against sex discrimination incorporates a protection against discrimination on the basis of gender identity. In *Tover v. Essentia Health*, a district court did not rely on the 2016 regulation to find that an insurance plan's categorical denial of gender affirming care was sex discrimination under Section 1557, but relied directly on the statute. The court explained that, "[the] conclusion that Section 1557 prohibits discrimination based on gender identity relies solely on the plain, unambiguous language of the statute."[43] Additionally, the 2016 regulation included "sex stereotyping" as part of the protection against sex discrimination based on Supreme Court precedent. The U.S. Supreme Court established that sex stereotyping was unlawful under Title VII in *Price Waterhouse v. Hopkins,* where the Court explained that sex stereotyping occurs when a decision is made because an individual fails to match the stereotypical appearance, mannerisms, or conduct linked to their sex.[44] The EEOC and federal courts interpreting Title VII have made clear that sex stereotypes can lead to discrimination against individuals based on sexual orientation and have also applied this reasoning to non-LGBTQ people seeking relief for sex discrimination.[45]

We remind the Department that it is pervasive discrimination that led the Department to promulgate the 2016 regulation, including prohibitions on discrimination based on gender identity and sex-stereotyping.[46]As mentioned above, there were significant public comments in response to the proposed rule, and the overwhelming majority of comments supported including specific language to prohibit discrimination against LGBTQ people. The Department has not offered any evidence to claim that discrimination against LGBTQ people no longer exists, and as noted in the previous section, there is ample evidence to the contrary. In fact, the data, reports and surveys available -- a number of which are outlined within this comment letter -- do not justify the Department rescinding protections against LGBTQ people; instead they suggest the Department should be promulgating rules aimed at further combating discrimination.

C. The Department has not conducted a cost-benefit analysis that adequately considers the health and financial costs that would be imposed upon LGBTQ people.

The Department has not conducted a full regulatory analysis for the proposed rule, including an economic impact analysis, as required by Executive Orders 12866 and 13563. The Department

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[40] *See Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000); *Smith v. City of Balem,* 378 F.3d 729 (6th Cir. 2004), *Barmes v. City of Cincinnati,* 401 F.3d 729 (6th Cir. 2005), *EEOC v. R.G.* & G.R. Harris Funeral Homes, Inc., 884 F.3d 560 (6th Cir. 2018), *Dodds v. U.S. Dept. of Education,* 845 F.3d 217 (6th Cir. 2016), *Whitaker v. Kenosha Unified School Dist.*, 858 F.3d 1034 (7th Cir. 2017), *Schwenk v. Hartford,* 204 F.3d 1187 (9th Cir. 2000); *Glenn v. Brumpy,* 663 F.3d 1312 (11th Cir. 2011).

[41] *Cruz v. Zuker*, 195 F.Supp.3d 554 (S.D.N.Y 2016).

[42] *Rumble*, 2015 WL 1197415 at 14.

[43] *Tover v. Essentia Health et al*., 342 F. Supp. 3d 947, 16 (D. Minn. 2018).

[44] *Price Waterhouse v. Hopkins,* 490 U.S. 228, 251 (1989).

[45] *E.g., Veretto v. United States Postal Service*, EEOC Appeal No. 0120110873, 2011 WL 2663401, at *3 (Jul. 1, 2011) (holding that an allegation of sexual orientation discrimination is sufficient for a sex discrimination claim because discrimination was motivated by sex stereotypes); *Terveer v. Billington*, 34 F. Supp. 3d 100 (2014) (employing a similar framework in rejecting motion to dismiss plaintiff's claim of sexual orientation discrimination); *Rene v. MGM Grand Hotel, Inc.*, 305 F.3d 1061 (9th Cir. 2002) (finding a sexual orientation discrimination claim relying sex stereotyping theory viable).

[46] T. Jost, HHS Issues Health Equity Final Rule, HEALTH AFFAIRS (May 14, 2016), https://www.healthaffairs.org/do/10.1377/hblog20160514.054868/full/.

has not adequately considered the "costs" - monetary, psychological, and physical health costs - and the distributional effects that may be imposed upon lesbian, gay, bisexual, and queer (LGBTQ) people as a result of rescinding these protections. Specifically, Executive Order 12866, which was issued based on the notion that the "American people deserve a regulatory system that works for them, not against them," directs federal agencies to "assess both the costs and the benefits of the intended regulation."[47] According to OMB guidance,"the agency should use the best reasonably obtainable scientific, technical, economic, and other information to quantify the likely benefits and costs of each regulatory alternative." [48] Instead, the agency has chosen to ignore a plethora of easily obtainable data, some of which are cited within this letter. If the Department were to conduct a full economic analysis, it would determine that transgender people and lesbina, gay, and bisexual people will be disproportionately harmed by the proposed rule.[49]

Legalized discrimination in health care contributes to barriers to care and ultimately leads to worse health outcomes which also have a cost - a fact which the Department seemingly has not considered.[50]Discrimination in health care can lead to people avoiding or delaying health care services resulting in conditions worsening or preventable illnesses, and discrimination can lead to patients withholding medical information resulting in improper diagnosis or treatment. In addition to the poor health and preventable deaths caused by misdiagnosis and improper treatment, delayed care is also typically more expensive, and repeated, avoidable visits to the emergency department can also impose a financial burden on individuals and on society.[51] According to a recent survey, nearly 20 percent of LGBTQ people who experienced discrimination that year reported avoiding the health care system.[52] LGBTQ people, particularly people of color, are disproportionately more likely than non-LGBTQ people to be impoverished, and subsequently, less likely to withstand the increased financial costs (on top of the physical and mental costs) that result from discrimination.[53]

The Department seems more concerned with assessing the interests of insurers and businesses than patients and consumers. For instance, the Department touts the anticipated savings that the proposed rule would trigger from eliminating the protections based on gender

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[47] Executive Order 12866 Regulatory Planning and Review §I (Sept. 30, 1993). This requirement, as explained in related guidance, includes: an obligation to assess quantitative and qualitative benefits and costs, and an obligation to consider equity and the distributional effects by assessing "the impact of a regulatory action across the population and economy, divided up in various ways (e.g., income groups, race, sex, industrial sector, geography)." OMB Circular-A-4: Regulatory Impact Analysis: A Primer 7.

[48] OMB Circular-A-4, *supra* note 49 at 3.

[49] A Freedom of Information Act (FOIA) request for complaints, between 2010 and 2017, of discrimination based on gender identity, sexual orientation, and sex stereotyping under Section 1557 found that 31 out of 34 complaints were based on gender identity - which indicates that the distributional effects of the proposed rule would be most felt by transgender people. S. Gruberg & F. Bewkes, The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial (2018), Center for American Progress, https://cdn.americanprogress.org/content/uploads/2018/03/06122027/ACAnondiscrimination-brief2.pdf at 10.

[50] Lesbian, Gay, Bisexual, and Transgender Health, Healthy People 2020, HEALTHYPEOPLE.GOV, ://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health.

[51] Lambda Legal, *supra* note 19 at 12.

[52] S. Mirza & C. Rooney, *supra* note 11.

[53] K. Baker & L. Durso, Why Repealing the Affordable Care Act Is Bad Medicine for LGBT Communities, Center for American Progress (2017), https://www.americanprogress.org/issues/LGBTQ/news/2017/03/22/428970/repealing-affordable-care-act-bad-medicine-LGBTQ-communities/.

identity and sex stereotyping.[54] The Department even requests additional information about "the costs of compliance or remaining in compliance with a Federal prohibition of discrimination on the basis of gender identity or sexual orientation under Title IX."[55] But the Department does not similarly request information about the quantifiable and qualitative costs that would result from gutting existing protections, despite admitting that it lacks the data needed to estimate the number of individuals who currently benefit from protections related to gender identity, and subsequently, the number of individuals who would no longer receive these protections following the proposed rule. For this reason alone, the Department should withdraw the proposed rule.

Even if the costs that the Department had outlined were accurate, the Department would not have met its obligation to conduct a full regulatory analysis given the Department has not outlined benefits that outweigh the massive health and financial costs that would be imposed upon LGBTQ people. Executive Order 12866 directs the Department to choose the regulatory approach "that maximize(s) net benefits (including potential economic, environmental, public health and safety, and other advantages)."[56]Given the proposed rule is harmful to LGBTQ people, and the Department has not sufficiently justified this regulatory approach, the proposed rule should be withdrawn.

III. The proposed rule should be withdrawn because it impermissibly removes nondiscrimination protections based on pregnancy, including protections for people who have had or will have an abortion.

The proposed rule eliminates protections against discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related conditions. Subsequently, the proposed rule if finalized could embolden discrimination based on pregnancy - which could have significant consequences for communities who already experience barriers to care. In particular, the proposed rule could result in patients being denied critical care, including miscarriage management, putting them at risk of pregnancy complications. Unlike most developed countries, the maternal mortality rate in the U.S. is increasing - and Black women are most at risk of dying during or from childbirth.[57] Similarly, Native American women are already over four times more likely to die during or immediately after pregnancy than non-Hispanic white women.[58]

In particular, it is clear that the Department seeks to target abortion - again - and eliminate protections for people who have had or will have an abortion.[59] Although the Department acknowledges in the preamble to this proposed rule that the prohibition against sex discrimination includes termination of pregnancy, it refuses to state whether the Department would enforce those protections and proposes to delete the 2016 final rule's clarification that the ban on sex discrimination includes all pregnancy related care. Further, the proposed rule also

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[54] 84 Fed. Reg 27875.
[55] 84 Fed. Reg 27889.
[56] Executive Order 12866 Regulatory Planning and Review Section 1(a) (Sept. 30, 1993).
[57] R. Mayer et al., The United States Maternal Mortality Rate Will Continue To Increase Without Access To Data, Health Affairs (2019), https://www.healthaffairs.org/do/10.1377/hblog20190130.92512/full/
[58] Adrian Dominguez, et al., Community Health Profile: National Aggregate of Urban Indian Health Program Service Areas, Urban Indian Health Inst. 37 (Oct. 2016), http://www.uihi.org/wp-content/uploads/2017/08/UIHI_CHP_2016_Electronic_20170825.pdf.
[59] 84 Fed. Reg 27870.

seeks to unlawfully incorporate Title IX's "Danforth Amendment," which carves out abortion care and coverage from the ban on discrimination of sex in the education context.

These changes could create avenues for providers, insurers, programs, and activities to discriminate against or otherwise show bias against patients and consumers who have had abortions. The proposed rule would also perpetuate abortion stigma by treating abortion differently than other health care services. Abortion stigma, or negatively held attitudes about abortion, already shows up in micro and macro ways -- from shaming patients to passing laws that systematically chip away at the availability of safe, legal, compassionate abortion care.[60] Patients who are denied abortion access have been found to experience adverse mental and physical health consequences, medical complications from pregnancy, continued patterns of abuse and interpersonal violence, and other negative outcomes, such as eclampsia and death.[61]
The proposed rule is, thus, contrary to Congressional intent to prohibit discrimination in health care programs and activities for all people. Prior to Congress passing the ACA, there was no federal nondiscrimination protection in health care, and women and pregnant people, in particular, were often impacted by discriminatory coverage designs and medical research studies. Section 1557 made history by prohibiting discrimination on the basis of sex in health care, and it is one of a myriad of provisions that Congress included within the ACA to ensure women, in particular, have meaningful access to health care services.[62] The proposed rule is contrary to Congressional intent because removing protections based on termination of pregnancy will harm women and non-binary people who seek abortions or need miscarriage or ectopic pregnancy managment. Abortion is a common procedure for women: one in four women access abortion care in their lifetimes. Abortion access is also needed for people regardless of their gender identity. Studies indicate that unintended pregnancies are equally as common, if not more common, for lesbian and bisexual women, as well as gender non-conforming people, as they are for cisgender, heterosexual women.[63] Restrictions on abortion care, such as restrictions on insurance coverage of abortion, amplify existing health care disparities -- disproportionately harming those who already face barriers to accessing quality health care due to their socioeconomic status, gender, sexual orientation, and race.

In particular, Congress did not include the Title IX exceptions, including the Danforth Amendment, either explicitly or by reference, in Section 1557 - which indicates that Congress did not intend to carve out discrimination protections based on termination of pregnancy. Further, as the Department recognized in the 2016 regulation, health care and education are different given people can choose a different school, which may not always be the case in health care "[where] individuals may have limited or no choice of providers, particularly in rural

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[60] Alison Norris et al., Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences, Guttmacher Institute (Feb. 12, 2011), https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/Abortion-Stigma.pdf.
[61] Diane Greene-Foster, Turnaway Study, Advancing New Standards in Reproductive Health , https://www.ansirh.org/research/turnaway-study.
[62] For example, the ACA prohibits insurers from engaging in gender rating, requires individual and small group plans to cover essential health benefits, including maternity and newborn care, and requires most employers to cover preventive services, including a defined set of women's preventive services such as mammograms, well-woman visits, and birth control. *See e.g.* Office of Women's Health, Affordable Care Act Improves Women's Health, Womenshealth.gov (last visited August 13, 2019).
[63] Caroline S. Hartnett, Lisa L. Lindley and Katrina M. Walsemann, *Congruence across Sexual Orientation Dimensions and Risk*, WOMEN'S HEALTH ISSUES JOURNAL (2016).

areas or where hospitals have merged with or are run by religious institutions."[64]Specifically, the Department recognized that people seeking health care frequently are not able to make an advance, informed decision about where to access care. For instance, nearly 40 percent of the people who regularly visit Catholic hospitals did not know of the religious affiliation, and even those that are aware of the religious affiliation may not know what that means or may not be able to access another facility.[65] The Department explained further in the 2016 regulation that a religious exemption can further impede health care access in emergency situations where choice of provider is more circumscribed, and a denial or delay in providing health care can discourage individuals from seeking necessary care, including in serious and life-threatening situations.[66] Thus, the inclusion of the Title IX exemption, in the health care context is not only contrary to Congressional intent and unnecessary, it is also harmful.

IV. The Department should withdraw the proposed rule because the inclusion of a religious exemption will embolden discrimination on the basis of sex.

In addition to proposing to adopt Title IX's religious exemption, the Department also proposes to expand the application of existing federal refusal laws.[67] These exemptions could embolden religiously-affiliated health plans, providers, clinics, and hospitals to refuse to comply with sex discrimination protections despite the fact that these refusals already have a proven record of causing harm. For instance, Laurie Bertram Roberts was having a miscarriage and nearly died because the Catholic hospital she went to multiple times throughout the process refused to manage her miscarriage until she was on the brink of bleeding out.[68] The Department's proposed rule could open the door to more incidents like Laurie's, where a health care facility fails to provide needed medical care, putting someone's life or health at risk.

Unsurprisingly, mainstream medical groups have recognized the negative effects that refusing care can have on patients and these organizations have called for patient protections when refusals may compromise health. For example, the American Congress of Obstetricians and Gynecologists (ACOG) ethics opinion states that "in an emergency in which referral is not possible or might negatively affect a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections."[69] The American Medical Association's (AMA) constitution and bylaws similarly note that physicians are required to be "moral agents" and "being a

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[64] 81 Fed. Reg. 31380.

[65] Catholic hospitals and their affiliated health care systems follow their Ethical and Religious Directives for Catholic Health Care Services ("ERDs"), which prohibit the provision of a wide range of reproductive health care services, including contraception, sterilization, and abortion, instead of medical guidelines and standards. U.S. Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services (June 2018), http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf.

[66] 81 Fed. Reg. 31380.

[67] The applicable 1557 regulation as finalized in 2016 states "Insofar as the application of any requirement under this part would violate applicable Federal statutory protections for religious freedom and conscience, such application shall not be required." 45 CFR 92.2(b)(2).

[68] Laurie Bertram Roberts, I Went to a Catholic Hospital During My Miscarriage-And It Nearly Killed Me Vice (June 29, 2018), https://www.vice.com/en_us/article/nekpw7/i-went-to-a-catholic-hospital-during-my-miscarriageand-it-nearly-killed-me.

[69] American College of Obstetricians and Gynecologists, The Limits of Conscientious Refusal in Reproductive Medicine (2007, reaffirmed 2016), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine.

conscientious medical professional may well mean at times acting in ways contrary to one's personal ideals in order to adhere to a general professional obligation to serve patients' interests first." The constitution and bylaws further state that "having discretion to follow conscience with respect to specific interventions or services does not relieve the physician of the obligation to not abandon a patient."[70] The proposed rule flies in the face of these important medical guidelines. Further, the Department has not met its obligation to justify including a religious exemption, nor has the Department adequately considered the disproportionate impact on women, LGBTQ people, people of color, and people living in rural communities.

A. The Department cannot justify adding a religious exemption.

The Department has not offered a reasonable explanation to justify incorporating a religious exemption. As discussed above, the Department is required to offer a justification for its policy decisions, including offering a "reasoned explanation" when reversing course on an existing regulatory approach. The Department's proposal to broaden the application of existing and future federal refusal statutes and regulations is unnecessary and harmful, and the Department fails to offer any reasonable explanation for the change. When the Department promulgated the 2016 regulation, it declined to include a religious exemption within the regulation stating "ACA regulations for preventive health services, and federal provider conscience laws provide sufficient safeguards for religious concerns."[71] The laws and policies that were in place in 2016 to protect religious rights and freedom remain in place, and in fact, this administration has attempted to expand these exemptions.[72]And, the Department has not offered a justifiable reason to change its regulatory approach.

Additionally, the inclusion of a religious exemption is contrary to the Department's obligation to promulgate regulations consistent with Congress' intent for the underlying statute. Specifically, permitting a religious exemption only for the prohibition on sex discrimination unfairly tiers nondiscrimination protections and protected classes, thus undermining the entire purpose of Section 1557. Women and LGBTQ individuals deserve the same access to health care services as other individuals. Women -- particularly women of color and women living in rural areas – and LGBTQ people already experience barriers to care and emboldening denials of care exacerbates these barriers. For instance, access to comprehensive reproductive health care, including abortion, is already limited. According to a recent report, nearly half of women of reproductive age have to travel between 10 to 79 miles, and some have to travel 180 miles or more, to access an abortion.[73] The Department, in line with congressional intent, should be

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[70] American Medical Association, Physician Exercise of Conscience: Report of the Council on Ethical and Judicial Affairs, https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-ethics-and-judicial-affairs/i14-ceja-physician-exercise-conscience.pdf.

[71] It is also notable that when the Department explained its rationale for declining to include an explicit religious exemption in 2016, it noted "most organizations that commented on this issue, including professional medical associations and civil rights organizations, and the overwhelming majority of individual comments, many of whom identified themselves as religious entities, opposed any religious exemption on the basis that it would potentially allow for discrimination on the bases prohibited by Section 1557 or for the denial of health services to women." 81 Fed. Reg. 31379.

[72] *See* Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23170 (May 21, 2018) (broadening the scope of existing refusal clauses to allow health care workers to refuse to provide care).

[73] J. Mearak, et. al., Disparities and Change over time in Distance Women would need to Travel to have an Abortion in the USA; Spatial analysis, THE LANCET (Nov. 2017), http://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(17)30158-5.pdf.

seeking to bolster nondiscrimination protections, and utilize Section 1557 to mitigate the discriminatory impact that existing religious exemptions and accommodations have had on women and LGBTQ individuals.

B. The proposed rule's refusal clause will have a disproportionate impact on women and LGBTQ people.

Again, here, the Department has not conducted a sufficient economic analysis related to the inclusion of a refusal clause within the proposed rule, as required by Executive Order 12866, as well as the Regulatory Flexibility Act. Therefore, the proposed rule's analysis is deficient in at least two respects.[74] First, and critically, the Department's analysis ignores the health and financial costs resulting from refusal laws reducing or delaying patient access to abortion, gender-affirming care, and other services that LGBTQ people might need.[75] Also contrary to Executive Order 12866, the Department fails to account for how adding a refusal clause only to the prohibition against sex discrimination will disproportionately impact certain communities, namely, women, rural residents, individuals with low incomes, people of color, and LGBTQ people. The Department has seemingly not considered the public health implications of the refusal proposal, nor has the Department considered the inequities or deprivation of human dignity that result from the law permitting discrimination against people based on who they are (e.g. lesbian, gay, bisexual, or transgender), and based on the fact that they accessed health care (e.g. abortion).[76]

Health care refusals already disproportionately impact women in rural communities, Black women, and LGBTQ people. For example, nearly one-third of transgender people surveyed said a doctor or health care provider refused to treat them due to their gender identity.[77] Similarly, according to a recent report, hospitals in neighborhoods that are predominantly Black are more likely to be governed by ethical and religious directives for Catholic health care services.[78] These restrictions are even more pronounced in certain states: in Maryland, three-fourths of the births in Catholic hospitals are women of color and in New Jersey, women of color make up 80 percent of the births in Catholic hospitals. Women living in rural areas already experience provider shortages and have to travel long distances for health care, resulting in significant gaps in care and poor health outcomes.[79] By making it easier for providers to refuse care, the proposed rule would further restrict these options or cut off access to care altogether, which would compromise patient health still further.

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[74] Executive Order 12866 Regulatory Planning and Review Section 1(a) (Sept. 30, 1993).
[75] S. Mirza & C. Rooney, *supra* note 11.
[76] OMB guidance explains that "some important benefits and costs (e.g. protection of human dignity, equity, or privacy...may be difficult or impossible to quantify or monetize given current data and methods;" however, agencies should carry out a careful evaluation of non-quantifiable and non-monetized benefits and costs. OMB Circular-A-4 at 12.
[77] S. Mirza & C. Rooney, *supra* note 11.
[78] K. Shepherd, et. al., Bearing Faith: The Limits of Catholic Health Care for Women of Color, Columbia Law School 9 (January 2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf?mc_cid=51db21f500&mc_eid=780170d2f0.
[79] The American College of Obstetricians and Gynecologists, Health Disparities in Rural Women (2014, reaffirmed 2016), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc=1&ts=20160402T0931414521.

V. The Department's proposal to eliminate requirements around language access protections will lead to a lack of knowledge about patient rights, less health care access overall, and exacerbated barriers to care.

The Department should make it easier, not harder, for providers, insurers, and other covered entities to provide language access services. As the number and diversity of immigrants in the United States increases, so too does the imperative for the health care system to meet the needs of every segment of the population.[80] Patients should have access to culturally and linguistically appropriate care, to include oral and written language services, in health care settings. Anything less demonstrates a lack of commitment to health equity and access, as culturally and linguistically appropriate care is foundational to one's health.[81]As a provider of comprehensive sexual and reproductive health care services, including but not limited to contraception, STI testing and treatment, cancer screenings, and abortion care, Planned Parenthood is especially concerned that the often sensitive nature of these services can cause undue burdens on people with limited English proficiency, who already face barriers to care and may need to rely on a partner, child, or other family member to interpret for them, even when they do not want to share health information with relatives and companions. Patients with limited English proficiency, the majority of whom are immigrants, already facing barriers to care, deserve the right to privacy and confidentiality of care. For some patients, access to language services proves to be a determining factor in whether care can be accessed at all as such the Department should be working to expand the language access protections afforded in its 2016 rulemaking around the Section 1557-- not roll them back.

A. The proposed changes to the language access protections run contrary to the statutory intent.

The Department will harm people with limited English proficiency by narrowing the language access requirements that covered entities must meet. Specifically, the Department is undermining insurance coverage, and subsequently, health care access for people with limited English proficient populations. An estimated 19 million limited English proficient people are covered by insurance,[82]and these individuals deserve the full range of services, programs, activities, and knowledge that those who are fluent in English do. The changes outlined in the proposed rule will undermine the quality of insurance coverage, contrary to a key purpose of the ACA.[83] Limiting language access protections would cause burdensome hurdles that would have a negative net outcome on the nation's health, and would bar a significant population's meaningful participation in a variety of health programs and activities, including health insurance. This goes directly against the ACA's charge to ensure that individuals have access to coverage and appropriate medical care. Further, Congress has taken significant action to

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[80] J. Radford, Key findings about U.S. immigrants, Pew Research Center (2019), https://www.pewresearch.org/fact-tank/2019/06/17/key-findings-about-u-s-immigrants/

[81] A.R. Green & C. Nze, Language-Based Inequity in Health Care: Who Is the "Poor Historian"? AMA JOURNAL OF ETHICS (2017), https://journalofethics.ama-assn.org/article/language-based-inequity-health-care-who-poor-historian/2017-03.

[82] Asian & Pacific Islander American Health Forum, Analysis of American Community Survey Public Use (2017).

[83] The ACA sought to improve quality in the health care system by imposing minimum benefit standards on plans and creating quality metrics for the delivery system. *See* e.g. E. Hoo, et. al., Health Plan Quality Improvement Strategy Reporting Under the Affordable Care Act: Implementation Considerations, Commonwealth Fund (April 6, 2012), and J. Volk & S. Corlette, The Role of Exchanges in Quality Improvement: An Analysis of the Options (2010).

mandate and preserve language access, including in its enacting of the Educational Amendments Act of 1974-- ensuring equal educational opportunity for those who are still learning English.[84] The Department is obligated to promulgate regulations consistent with Congress' intent.

The Department itself has previously recognized the need to advance language access. The Department in its 2003 guidance on limited English proficiency stated that "we must ensure that federally-assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English."[85] This has been a guiding principle of the Department's commitment to health care access and equity for more than a decade and a half, as health is contingent upon equitable and meaningful access for all populations. However, in its 2019 proposed rulemaking, the Department's suggested changes fall directly in conflict with that goal and will ultimately harm individuals and communities.

B. The proposed provisions regarding language access do not consider the needs of limited English proficient individuals, who already face significant barriers to care.

As mentioned above, the Department has not conducted a full regulatory analysis for the proposed rule, including an economic impact analysis, as required by Executive Orders 12866 and 13563. In particular, the Department has not adequately considered the "costs" - monetary, psychological, and physical - nor the distributional effects that will be imposed upon limited English proficient patients as a result of rescinding these protections. Further, the Department's distributional analysis fails to acknowledge the disparate impact on people with limited-English proficiency, including foreign born populations, which already face significant barriers to care. As a part of its evaluation of the costs of its proposed rule, the Department is obligated to analyze "distributional effects," which consists of "the impact of a regulatory action across the population and economy, divided up in various ways (e.g., income groups, race, sex, industrial sector, geography)."[86] If the Department conducted an adequate analysis, it would find that the proposed rule would have the unacceptable consequence of widening existing inequities for groups that already face considerable challenges. The foundational principle of language access is critical to many of the protections that the Department itself has previously laid out for those who have limited English proficiency.[87]

Specifically, in its proposed rulemaking, the Department proposes a repeal of the requirement that covered entities inform the public of their legal rights via notice. A nondiscrimination notice is a practical and efficacious way of ensuring that the people are aware of their rights and which language services and aids are available, how to access said services, and how to handle

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[84] T. Ramons, *When Access to Language Means Access to Justice*, Shriver Center on Poverty Law (June 2018) https://www.povertylaw.org/clearinghouse/articles/Ramos; LEP.gov homepage, LEP.gov - Limited English Proficiency (LEP): A federal Interagency Website, https://www.lep.gov/faqs/faqs.html (last visited Aug 11, 2019).

[85]HHS Office of the Secretary,Office for Civil Rights & OCR, Guidance for Federal Financial Assistance Recipients - Title VI HHS.gov (2013), https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-vi/index.html (last visited Aug 11, 2019).

[86] Congressional Research Service, An Overview and Analysis of H.R. 3010, the Regulatory Accountability Act of 2011 (March 23, 2012).

[87] HHS Office of the Secretary,Office for Civil Rights & Ocr, Limited English Proficiency (LEP) HHS.gov (2015), https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html (last visited Aug 11, 2019).

discrimination and complaints. Without these notices, people may not even be aware that they have rights, let alone have the ability to advocate for them. However, in its evaluation of the costs and benefits of its proposed rulemaking, the Department only weighed the costs to covered entities, and not the benefits to consumers, in its evaluation. We urge the Department to reconsider its analysis to focus on consumers and patients who benefit from having access to such notices. The Department has also not provided an alternative as to how individuals will learn of their rights, particularly those who are LEP and for whom such notices are often one of the few avenues to do so.

Similarly, the proposed removal of references to voluntary language access plans is also misguided**.** In the proposed rule, all references to covered entities making proactive language access plans are removed, despite the fact that these were voluntary and not a requirement under the 2016 rulemaking. The Department's justification is that such plans are not justified by need - but its historic emphasis around language access plans proves otherwise. Language access plans have long been a key component of covered entities' strategies to ensure that they are meeting their obligations under 1557 and Title VI of the Civil Rights Act of 1964 -- to avoid discrimination on the basis of national origin. The removal of references to language plans means that covered entities may no longer be encouraged to proactively ensure that the needs of their limited English proficient patients and consumers are met. Not having adequate translation and interpretation services also means that costs are imposed on the health care system in the form of avoidable hospitalizations, lower rates of follow up, and limited use of preventive care. Compounding the problem, the Department proposes to remove requirements regarding in-language taglines about the availability of translation and interpretation on significant documents. These taglines are instrumental to ensuring access to needed care and information without much administrative burden. Removal of taglines on the front end can also lead to more administrative needs down the road, which would go against the ACA's charge of reducing administrative costs to ensure that resources can be put toward medical care.

The proposals will exacerbate existing gaps in language access, especially around communication with providers, understanding of medications, and lower rates of follow up. The proposed rule will exacerbate these gaps, particularly through its repeal of the requirement. In 2018, 60 percent of Latino adults reported having trouble communicating their health care needs due to language and culture barriers. Spanish-speaking limited English proficient Latinos report worse health outcomes than those who speak English. And despite not being as focused upon in work around language access, nearly one-third of Asian Americans have limited English proficiency, and AAPIs make up 22 percent of the limited English proficient population. Despite this, there is very little data about AAPIs, their health needs, and interventions that work to ensure that they are able to access care. Similarly, very few targeted interventions exist for Black immigrants, including those from Africa and the Carribbean, despite the persistent health disparities and implicit bias that exist due to systemic racism in the health care system. As a result, many limited English proficient people continue to have difficulties understanding benefits and coverage, despite the language access protections finalized in 2016. As such, the Department needs to expand such protections, not roll them back, in order to meet its stated goal of improving the nation's health.

In addition to financial, logistical, and cultural barriers, the linguistic barriers that limited English proficient populations face make them uniquely at risk of not knowing, and thus, not asserting their rights. For example, immigrants use fewer health resources to begin with-- but it is not for a

lack of need.[88] The barriers that limited English proficient communities continue to face already lead to higher rates of preventable death, lower rates of preventive screening, a greater mistrust in the medical system, and other negative experiences and outcomes.[89] This lack of use raises questions about the extent to which limited English proficient populations know their rights and how these rights are communicated to them. The Department admits that the rule may impose costs, such as decreasing access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services." However, the significance of these impacts is not adequately measured or weighed in terms of what this will ultimately mean for patients and consumers.

The harm that would result from the proposed rule comes at a time where there has been marked increase in individuals delaying or forgoing care entirely due to the generally hostile climate around immigration, including via other rules promulgated by this administration.[90] Delaying and forgoing care will have long-term negative health effects. Without meaningful and strong protections, the estimated 25 million people in the United States who are limited English proficient would face further barriers to access and outright exclusion from services and programs that they are legally entitled to and that are, quite literally, life saving. Despite these costs, the Department chooses instead to focus on the costs to covered entities associated with providing language services on the front end, which will ultimately avoid the much higher costs to patients and material costs to covered entities associated with delaying or foregoing care.

VI. The Department's proposal to remove prohibitions against discriminatory marketing and plan design will undoubtedly impact vulnerable communities, including those with HIV.

The ACA has made great strides in addressing many long-standing discriminatory practices by health insurers, including requiring guaranteed issue of coverage in the individual and small group health insurance markets so that a person may not be denied health insurance due to a preexisting condition.[91] Additionally, Section 1311 of the ACA requires the Department to establish plan certification standards that ensure qualified health plans do "not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs."[92] Thus, it is concerning that the Department is now acting contrary to Congressional intent and proposes to eliminate the 2016 rule's prohibition against health insurers marketing and designing plans that discriminate on the basis of race, color, national origin, sex, age, or disability – a prohibition that has significantly increased access to coverage and care for people living with chronic illnesses, particularly people living with HIV. Interestingly, the Department asks about "the costs incurred for design of health benefits, with any detailed information facts, surveys, audits, or reports." However, the Department does not similarly ask about the benefits of prohibiting discrimination in plan design

[88] S.R. Johnson, Study finds Immigrants use fewer U.S. Healthcare Resources, Modern Healthcare (2018), https://www.modernhealthcare.com/article/20180808/NEWS/180809934/study-finds-immigrants-use-fewer-u-s-healthcare-resources.
[89] E. Wilson et al., Effects of Limited English Proficiency and Physician Language on Health Care Comprehension, SOCIETY OF GENERAL INTERNAL MEDICINE (2005).
[90] C. Boyd-Barrett, Fear Pushes More Immigrants to Avoid Seeking Medical Care, California Health Report (2018), https://www.calhealthreport.org/2018/02/05/fear-pushes-immigrants-avoid-seeking-medical-care/.
[91] 42 USC 300gg-1.
[92] 42 USC 300gg-11.

– but, this information is included here for the Department's consideration as it aims to meet its requirement to consider public health costs.

For example, before 2016, a significant number of health plans placed HIV/AIDS medications on the plan's highest cost sharing tier and imposed prohibitively high coinsurance rates that undermined the ability of individuals to obtain life-saving medications. An analysis of Marketplace plans revealed a dangerous trend of high cost sharing for HIV/AIDS medications: more than 20 percent of silver-level Marketplace plans required coinsurance of 40 percent or higher for all HIV/AIDS drugs in the class.[93] Additionally, in a study published in the New England Journal of Medicine in January 2015, researchers at the Harvard School of Public Health examined 48 qualified health plans and found that a dozen of these plans placed medications for HIV/AIDS in the highest cost-sharing tiers.[94] Further, issuers frequently imposed burdensome step therapy and prior authorization requirements on life-saving medications for people living with HIV/AIDS, rendering prescription drugs under such plans out of reach for the individuals who need them most. Compared with employer plans, Marketplace plans were found more likely to restrict access to HIV/AIDS medications using step therapy and prior authorization.[95] The proposed rule by removing protections against discriminatory plan design undermines protections for people living with HIV and other people with chronic illnesses.

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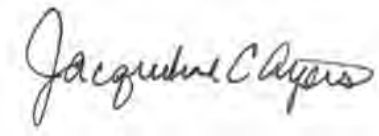
Planned Parenthood strongly urges the Department to put the health and lives of all people in this country first and foremost. If the Department finalizes this regulation, it will not have met the Department's mission to "advance the health and well-being of *all* Americans,"[96]nor will the Department have met OCR's specific obligation to protect and advance civil rights.[97] The Department is therefore under a legal and moral obligation to withdraw the proposed rule.

Sincerely,



Jacqueline C. Ayers
Vice President, Government Relations & Public Policy
Planned Parenthood Federation of America
Planned Parenthood Action Fund

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[93] Avalere Health, An Analysis of Exchange Plan Benefits for Certain Medicines (2014), http://avalere.com/expertise/life-sciences/insights/avalere-analysis-cost-sharing-for-specialty-medicines; *See e.g.*, National Health Law Program & The AIDS Institute, *Re: Discriminatory Pharmacy Benefits Design in Select Qualified Health Plans Offered in Florida, Administrative Complaint filed with the HHS Office for Civil Rights* (May 28, 2014), https://healthlaw.org/resource/nhelp-and-the- aids-institute-complaint-to-hhs-re-hiv-aids-discrimination-by-fl/.

[94] D.B. Jacobs & B.D. Sommers. (2015). Using Drugs to Discrimination – Adverse Selection in the Insurance Marketplace. NEW ENGLAND J. OF MEDICINE, 399.

[95] PhRMA and Avalere Health. (2014). Access to HIV/AIDS Medications in Exchange Plans. Available at http://www.phrma.org/sites/default/files/pdf/exchanges-hiv-aids.pdf.

[96]HHS Office, Introduction: About HHS, HHS.gov (2018), https://www.hhs.gov/about/strategic-plan/introduction/index.html#mission (last visited Aug 11, 2019).

[97]HHS Office of the Secretary,Office for Civil Rights & OCR, OCR Leadership, HHS.gov (2019), https://www.hhs.gov/ocr/about-us/leadership/index.html (last visited Aug 11, 2019).

EXHIBIT E

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; Indigenous Women Rising; NO/AIDS Task Force (d/b/a CrescentCare); and Transgender Emergency Fund of Massachusetts,

Plaintiffs,

v.

United States Department of Health and Human Services; Alex M. Azar II, *in his official capacity as secretary of the U.S. Department of Health and Human Services*; Roger Severino, *in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services*; and Seema Verma, *in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*,

Defendants.

Civil Action No. 1:20-cv-11297

DECLARATION OF RACHAEL LORENZO,
EXECUTIVE DIRECTOR, INDIGENOUS WOMEN RISING

I, Rachael Lorenzo, declare as follows:

1. I am a founder of Indigenous Women Rising (IWR), a Native-led and Native-centered reproductive justice collective that uplifts Indigenous community organizing and ensures reproductive justice movements are inclusive of Indigenous people and families. I currently serve

as the organization's executive director. Our mission is to honor Native and Indigenous People's inherent right to equitable and culturally safe health options through accessible health education, resources, and advocacy.

2. IWR was created to help Indigenous people access nondiscriminatory, culturally sensitive pregnancy-related care, including contraception, abortion care, and complete and accurate information about pregnancy options. IWR's services have never been in greater demand than they are today, and the strain on our resources due to this skyrocketing demand has only become more dire since I submitted my prior declarations. Multiple factors have contributed to this strain, including the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022). But, I have also observed increased discrimination and denials of reproductive health care and coverage, as well as increased fear of such, under the regulation "Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority," 85 Fed. Reg. 37,160 (June 19, 2020) (the "Rollback Rule"). I submit this declaration to set forth my observations of how the Rollback Rule has greenlit and exacerbated sex, national origin, and intersectional discrimination against Native people who need pregnancy-related care and how this has hampered IWR's operations. I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

Indigenous Women Rising's Mission

3. IWR started in 2014 as a campaign to bring attention to the fact that Indigenous people who can become pregnant and rely on the United States Indian Health Service (IHS) for health care were being denied access to emergency contraception. Now, IWR has expanded to provide broader support for Indigenous people in accessing health care, focusing on providing access to abortion care through our Abortion Fund, providing access to midwifery and doula care

through our Emergence Fund, and providing sexual and reproductive health care information and education through both Funds. To ensure that our clients are able to access the health care they need, our organization has had to devote increasingly significant resources to identify and counteract the discriminatory conduct by health care providers that the Rollback Rule has prompted.

4. As I described in my prior declarations, Native people who can become pregnant have collectively experienced generational and individual health care discrimination, reproductive coercion, and trauma. These acts have come in many forms, including sexual assault and rape,[1] forced sterilization,[2] coerced use of contraceptives,[3] infant and family separation,[4] forced assimilation,[5] and myriad other forms of systemic reproductive oppression.[6] Today, Native people experience higher rates of discrimination based on race when going to a doctor or health clinic than white Americans (23% compared to 5%),[7] and as a result 15% of Native people surveyed reported avoiding seeking medical care for themselves or their family out of fear that they would be discriminated against or treated poorly (compared to 3% of white Americans).[8] These fears are

[1] *See* SARAH DEER, THE BEGINNING AND END OF RAPE: CONFRONTING SEXUAL VIOLENCE IN NATIVE AMERICA (3d ed. 2015).
[2] *See* U.S. Nat'l Library of Medicine, *1976: Government Admits Unauthorized Sterilization of Indian Women*, https://www.nlm.nih.gov/nativevoices/timeline/543.html.
[3] *See* Rachel Benson Gold, *Guarding Against Coercion While Ensuring Access: A Delicate Balance*, 17 GUTTMACHER INST. 8, 10–11 (2014), https://www.guttmacher.org/sites/default/files/article_files/gpr170308.pdf (detailing policies requiring use of long-acting reversible contraceptives to receive public benefits or avoid harsh criminal punishments in states where the majority of Native Americans reside, *see infra* footnote 18).
[4] *See, e.g.*, Bryant Furlow, *A Hospital's Secret Coronavirus Policy Separated Native American Mothers from Their Newborns*, PROPUBLICA (June 13, 2020), https://www.propublica.org/article/a-hospitals-secret-coronavirus-policy-separated-native-american-mothers-from-their-newborns; Christie Renick, *The Nation's First Family Separation Policy*, THE IMPACT (Oct. 9, 2018), https://imprintnews.org/child-welfare-2/nations-first-family-separation-policy-indian-child-welfare-act/32431.
[5] *See* Becky Little, *How Boarding Schools Tried to 'Kill the Indian' Through Assimilation*, HISTORY (Nov. 1, 2018), https://www.history.com/news/how-boarding-schools-tried-to-kill-the-indian-through-assimilation.
[6] *See, e.g.*, Lauren van Schilfgaarde et al., *Tribal Nations and Abortion Access: A Path Forward*, 46 HARV. J. L. & GENDER 1, 8–17 (2023).
[7] Mary G. Findling et al., *Discrimination in the United States: Experiences of Native Americans*, 54 HEALTH SERVS. RES. 1431, 1435 (2019).
[8] *Id.* at 1436.

not unfounded; another study revealed that "clinician-level biases and racism" against Native pregnant people "often contributed to delayed or absent care that led to deaths."[9] Thus, it is no surprise that Indigenous people capable of pregnancy are experiencing a maternal mortality crisis in the United States. According to the Centers for Disease Control and Prevention, in general Native women are 2.5 times more likely than white women to die during pregnancy, labor, and within a year after childbirth[10]; in urban areas specifically, that rate increases to 4.5 times more likely.[11] The majority of these deaths were deemed "preventable."[12] Likewise, in 2021, the infant mortality rate was higher for Native infants (7.46 deaths per 1000 live births) than for white infants (4.36 deaths per 1000 live births).[13] Disparities are also pronounced in access to sexual and reproductive health care and information in general. Only 69% of Native women have had prenatal care in the first trimester, compared to 89% of white women.[14] Further, Native women living in urban areas suffer significantly higher rates of sexually transmitted diseases than Native men or

[9] *See* Madeline Y. Sutton, et al., *Racial and Ethnic Disparities in Reproductive Health Services and Outcomes, 2020*, 137 OBSTETRICS & GYNECOLOGY 225, 229 (Feb. 2021) (collecting reviews of recent cases of pregnancy-related deaths amongst Black and American Indian or Alaska Native women).

[10] Emily E. Peterson, et al., *Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017*, 68 MORBIDITY & MORTALITY WKLY. REP. 423, 424 (May 10, 2019), https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6818e1-H.pdf; *see also* Elizabeth Chuck & Haimy Assefa, *She Hoped to Shine a Light on Maternal Mortality Among Native Americans. Instead, She Became a Statistic of It*, NBC NEWS (Feb. 8, 2020), https://www.nbcnews.com/news/us-news/she-hoped-shine-light-maternal-mortality-among-native-americans-instead-n1131951 (describing the death of Stephanie Snook, a member of the Tsimshian and Tlingit tribes of Alaska, and her newborn twins, even after she was forced to travel to Seattle, Washington to access a high-risk maternal-fetal specialist because none were available in her local community).

[11] *See* URBAN INDIAN HEALTH INST., COMMUNITY HEALTH PROFILE: NATIONAL AGGREGATE OF URBAN INDIAN HEALTH PROGRAM SERVICE AREAS 37 (Oct. 2016), https://www.uihi.org/wp-content/uploads/2017/08/UIHI_CHP_2016_Electronic_20170825.pdf.

[12] SUSANNA TROST, ET AL., CTRS. FOR DISEASE CONTROL & PREVENTION, PREGNANCY-RELATED DEATHS AMONG AMERICAN INDIAN OR ALASKA NATIVE PERSONS: DATA FROM MATERNAL MORTALITY REVIEW COMMITTEES IN 36 US STATES, 2017-2019 3 (2022), https://www.cdc.gov/reproductivehealth/maternal-mortality/docs/pdf/Pregnancy-Related-Deaths-AIAN-Data-MMRCs-2017-2019-H.pdf.

[13] Danielle M. Ely. & Anne K. Driscoll, *Infant Mortality in the United States, 2021: Data From the Period Linked Birth/Infant Death File*, 72 NAT'L VITAL STATS. REPS. 1, 3 (Sept. 12, 2023), https://www.cdc.gov/nchs/data/nvsr/nvsr72/nvsr72-11.pdf.

[14] ACOG, Committee No. 649, Racial and Ethnic Disparities in Obstetrics and Gynecology (Dec. 2015), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/12/racial-and-ethnic-disparities-in-obstetrics-and-gynecology.

white people generally.[15] This all increases IWR's clients' vulnerability to discrimination based on sex, race, or national origin, and the intersections of the these identities, and thus their need for our services.

5. IWR's clients also predominantly receive their health care from IHS, which is notorious for providing substandard, and even dangerous, care.[16] For many Indigenous communities, especially those in rural areas, IHS and tribal health care facilities are the only source of health care services.[17] But IHS has historically been underfunded and has never provided adequate care to Native people.[18] IHS facilities do not have enough health care professionals to provide quality care: in 2021, the overall vacancy rate for medical officers was 26%, for pharmacists was 15%, for nurses was 29%, and for dentists was 19%.[19] And access to services outside of IHS facilities is largely unavailable. In theory, if an IHS facility is unable to provide needed care, then IHS and Tribes may contract for health services from private providers through the IHS Purchased/Referred Care Program (PRC). But in practice this system doesn't work—in FY 2020 alone, IHS data shows that over 250,000 services requested under this program, worth

[15] *See* URBAN INDIAN HEALTH INST., *supra* note 11, at 28-32.

[16] *See* van Schilfgaarde, *supra* note 6, at 15 (describing various public reports of substandard and dangerous care at IHS facilities, including the 2015 story of a pregnant Native woman who was repeatedly rebuffed by IHS providers while she was experiencing contractions until she ultimately gave birth, without medical assistance, in a restroom at the IHS facility).

[17] Indian Health Servs., The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress 3 (2016), https://tinyurl.com/yxuxftw6. In urban settings, Native people also turn to IHS's Urban Indian Health Programs for health care. *See generally* URBAN INDIAN HEALTH INST., *supra* note 11.

[18] In addition to the issues with IHS funding that I highlighted in my prior declarations, I will note that because IHS is a discretionary program with limited funding, it relies on Congressional appropriations each fiscal year, which contributes to uncertainty, operational challenges, and disruptions of care when Congress is delayed in passing appropriations. *See* Latoya Hill & Samantha Artiga, *Health Coverage Among American Indian and Alaska Native and Native Hawaiian and Other Pacific Islander People*, KFF HEALTH NEWS (Nov. 30, 2023), https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-among-american-indian-and-alaska-native-and-native-hawaiian-and-other-pacific-islander-people/. Although in FY 2023, Congress enacted advanced appropriations for IHS, which will provide greater stability in the event of a government shutdown, funding will continue to be constrained to appropriated amounts under this plan. *Id.*

[19] ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, OFFICE OF HEALTH POLICY, HOW INCREASED FUNDING CAN ADVANCE THE MISSION OF THE INDIAN HEALTH SERVICE TO IMPROVE HEALTH OUTCOMES FOR AMERICAN INDIANS AND ALASKA NATIVES 13 (July 2022), https://aspe.hhs.gov/sites/default/files/documents/1b5d32824c31e113a2df43170c45ac15/aspe-ihs-funding-disparities-report.pdf.

an estimated $1.1 billion, were denied or deferred.[20] Thus, services that cannot be provided at an IHS facility and must be funded through the PRC are often "rationed based on medical need."[21] This makes IWR a particularly important resource for our community.

The Rollback Rule Has Strained IWR's Abortion Fund

6. As I have discussed in my past declarations, IWR's Abortion Fund helps Indigenous people access abortion care and nonbiased, comprehensive information about pregnancy options. Since my last declaration, we have changed our policies to now pay clinics for a portion or *all* of the procedural costs of an abortion because of the increased need in our community. We also have expanded the practical support we provide to clients; we give direct aid to cover lodging, gas, air and bus fare, food, child- and eldercare, and other expenses related to ensuring that people can get to an appointment that is often outside of their home community, as well as aid to support after-abortion care, including traditional Indigenous post-abortion ceremonies.[22]

7. The Abortion Fund's grantmaking work is critical in part because IHS is subject to the Hyde Amendment, which prohibits certain federal funds, including funding for IHS facilities, from being used to pay for an abortion except in the case of incest, rape, or life endangerment.[23] Even in these permitted circumstances, however, most IHS facilities have historically failed to

[20] Hill & Artiga, *supra* note 18.
[21] *Id.*
[22] *See* Noel Lyn Smith & Maddy Keyes, *Indigenous Communities Navigate Abortion after* Roe, NEWS21 (Aug. 17, 2023), https://americaafterroe.news21.com/stories/indigenous-people-abortion-access-roe-v-wade/.
[23] *See* 25 U.S.C. § 1676 (extending any limitations on the use of U.S. Department of Health and Human Services (HHS) funds including in HHS appropriations laws with respect to the performance of abortion to apply to funds appropriated to IHS); Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2023, Public Law 117–328, 506–507, 136 Stat. 4459, 4908 (2022); Continuing Appropriations Act, 2024 and Other Extensions Act, Public Law 118–15 (2023) (providing that no IHS funds ''shall be expended for any abortion'' or ''for health benefits coverage that includes coverage of abortion,'' except ''if the pregnancy is the result of an act of rape or incest; or . . . in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.'').

provide or refer for *any* abortion care,[24] often based on abortion stigma. For example, IWR clients have told me that IHS providers have attempted to pressure them against seeking abortion care, regardless of the circumstances, because there are "already too few Native people."

8. IWR also provides critical information about pregnancy options, contraceptive methods, and abortion care via the Abortion Fund. Our clients often look to us to explain their pregnancy and contraceptive options and what to expect when obtaining abortion care because they generally do not receive such information from IHS facilities or other clinics and hospitals serving predominantly Native populations. For example, I was personally denied information about pregnancy options when I experienced a non-viable pregnancy in 2013; my doctor told me I would have to "wait it out" instead of providing me with information about miscarriage management and abortion care, and I ultimately waited multiple months until I miscarried and had to go to the emergency room to receive the medical attention I had needed all along. Since my last declaration, IWR has continued to provide basic education about abortion care to about three-quarters of our clients. We also provide contraceptive counseling to many of our clients, even though this information should be provided by their medical care team.

9. By further stigmatizing abortion and reinforcing the idea that the government holds negative attitudes toward abortion care, the Rollback Rule has added strain to IWR's Abortion Fund and emboldened and encouraged refusals of abortion care and information, even in emergency situations. The 2016 Rule's explicit prohibitions against discrimination based on "pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom" in the definition

[24] *See* Shaye Beverly Arnold, *Reproductive Rights Denied: The Hyde Amendment and Access to Abortion for Native American Women Using Indian Health Service Facilities*, 104 AM. J. PUB. HEALTH 1892, 1892 (2014) (detailing that 85% of IHS facilities were out of compliance with federal law—meaning that they did not provide abortion care or information about abortion, that only 5% of IHS facilities were equipped to provide abortion care, and that during a 20-year study period, only 25 abortions were performed at IHS facilities).

of discrimination "on the basis of sex" made clear that Section 1557 provided critical protections against policies that single out and exclude abortion from otherwise generally comprehensive health service offerings. By deleting this regulatory definition of "on the basis of sex," unlawfully adding sweeping exemptions for the provision and coverage of abortion and for religious institutions, and singling out abortion in the preamble, the Rollback Rule sows confusion and signals to health care entities that they can refuse to provide abortion care and information about abortion care without consequence, even in cases allowable under the Hyde Amendment and in emergency situations when a patient's life or health is at risk.

10. This confusion is particularly harmful for our clients who live in or travel to states that have challenged federal protections for access to reproductive health care. IWR serves clients living in or traveling to the states of Texas, Nebraska, Kentucky, Kansas, Arizona, North Dakota, South Dakota, and Mississippi. Indeed, "[t]hree quarters (75%) of [Native] people live in the Southern (34%) and Western (41%) regions of the country," with 7% living in Texas and 7% living in Arizona.[25] Some of these states filed litigation in federal court challenging the 2016 Rule in which they represented that the 2016 Rule "forced" them to provide abortion care at state health care facilities even in medical emergencies, to post patient notices of non-discrimination encompassing the full scope of Section 1557's protections against sex discrimination, and to train employees not to discriminate in accordance with Section 1557. *See Franciscan All., Inc. v. Burwell*, Brief in Support of State Plaintiffs' Renewed Motion for Summary Judgment, Doc. No. 133 at 50, 7:16-cv-00108-O (N.D. Tex. Feb. 4, 2019). Two of these states have challenged the federal government's enforcement of protections for access to emergency abortion care under EMTALA. *See State of Idaho v. United States*, Emergency Application for a Stay Pending Appeal,

[25] Hill & Artiga, *supra* note 18.

Doc. No. 1, 23-727 (U.S. Nov. 20, 2023); *State of Texas v. Becerra*, Brief for Plaintiffs-Appellees, Doc. No. 60-1, 23-10246 (5th Cir. June 30, 2023). And one of these states has been so emboldened by the Rollback Rule as to assert in a challenge to access to medication needed to treat certain pregnancy complications that, contrary to decades of law, the phrase "on the basis of sex" does not protect against pregnancy discrimination because Section 1557's "implementing regulations" do not "address pregnancy discrimination." *See Texas v. Becerra*, Amended Complaint, Doc. No. 4 at ¶ 20, 7:23-cv-00022 (W.D. Tex. Feb. 10, 2023). Under the Rollback Rule, combined with the Supreme Court's decision in *Dobbs*, these states have been emboldened to encourage—and in some cases even force—health care facilities to deny access to reproductive health care, even in medical emergencies.[26]

11. Not surprisingly, we have received a substantial uptick in calls and requests for support from clients who are in the midst of suffering a pregnancy complication for which an emergency abortion is the necessary treatment, but who have been denied that care by the hospitals in their communities. More and more individuals in these desperate circumstances are forced to seek assistance from funds like ours—often in terrifying, time-sensitive, life or death circumstances—to travel away from their home communities to access life- and health-saving emergency abortion care. Even when these clients can travel to seek care (which is not always the case), medical conditions typically make obtaining abortion care more logistically complicated—

[26] *See, e.g.*, Caroline Kitchener, *An Ectopic Pregnancy Put Her Life at Risk. A Texas Hospital Refused to Treat Her*, THE WASHINGTON POST (Feb. 23, 2024), https://www.washingtonpost.com/politics/2024/02/23/texas-woman-ectopic-pregnancy-abortion/?utm_campaign=wp_must_reads&utm_medium=email&utm_source=newsletter&wpisrc=nl_mustreads.

and expensive.[27] IWR has been forced to expend time, labor, and resources to fill these gaps in care caused by the Rollback Rule.

12. Denying this care is sex discrimination, pure and simple. There is no circumstance in which the Department of Health and Human Services has suggested cisgender men should be turned away from receiving emergency medical care no matter the cost to their health, lives, and future fertility. Yet the Rollback Rule signals to hospitals that Section 1557 has nothing to say about turning pregnant patients away from emergency care by purporting to incorporate Title IX's abortion-provision-and-coverage and religious-educational-institution exemptions and deleting explicit protections against pregnancy- and abortion-based discrimination. If, instead of issuing the Rollback Rule, HHS had reaffirmed that under Section 1557 any hospital that receives federal financial assistance and has the competency to provide emergency gynecologic or obstetric care must provide that care on an equal basis as all other forms of emergency care, regardless of a state's abortion laws, it could have mitigated some of this tragedy. Instead, the Rule just emboldens these denials of care. *See supra* ¶¶ 9–10. It is outrageous that IWR and other abortion funds have been forced to pick up the pieces, devoting staff time to counseling terrified patients and navigating logistics and expending precious resources funding basic life- and health-saving medical care that local hospitals should have provided in the first place.

13. Additionally, although Section 1557 should prohibit pregnancy discrimination, the Rollback Rule has instead only exacerbated our client's fear of it, leading to increased costs for

[27] *See State of Texas v. Zurawski*, Brief of *Amicus Curiae* National Network of Abortion Funds in Support of Appellees and Affirmance, at 20–21, No. 23-0629 (Tex. Nov. 21, 2023), https://reproductiverights.org/wp-content/uploads/2023/12/Natl-Network-of-Abortion-Funds-amicus-in-Z-v-TX-11-23.pdf (describing myriad complications with navigating access to emergency abortion care, including that few providers are able to perform abortion care on patients with complex medical needs; that the lack of providers means patients often have to travel greater distances; that specialized travel may be required due to a patient's medical condition; that patients facing an emergency medical condition are more likely to already be in medical debt; and that complex abortion care can cost upwards $30,000 for the procedure alone, not including logistical expenses).

our Abortion Fund. Many of our clients are delaying visiting a physician to confirm pregnancy or to obtain counseling about pregnancy options out of fear of discrimination or inability to access competent, nondiscriminatory care, which in turn means they come to us needing abortion later in pregnancy (which is more expensive). On the other hand, some clients are turning directly to IWR for assistance to access the care they need rather than risking discrimination by seeking care at a hospital or IHS facility first, putting increased strain on our finances and operations.

14. Because of the lack of clear guidance on federal protections against discrimination in the Rollback Rule, the average amount of grant funding IWR provides to each client of the Abortion Fund has increased significantly since my last declaration, and overall funding outlays have skyrocketed. In 2022, we distributed $109,800. However, in the *first half* of 2023 (between January and June alone), our Abortion Fund distributed $160,000 of funding, assisting clients from 26 states with accessing care; this includes $132,300 on procedural costs, ranging from $60 to $15,000, and $27,700 in practical support. As costs for each individual have risen, we have been forced to reduce the total number of people we assist each month.[28]

15. In a post-*Dobbs* legal landscape, and in the absence of clarity from HHS about Section 1557's prohibition on pregnancy-, including abortion-based, discrimination, many of our clients are also experiencing heightened fears that they will experience discrimination *after* they have made reproductive health decisions, including their decisions to access abortion care. Abortion care is extraordinarily safe, but it is protocol for abortion providers to instruct patients to go to an emergency room in the unlikely event they experience uncommon bleeding following a procedure. And in some circumstances, clients will seek follow up care to confirm termination of their pregnancies after obtaining a medication abortion. IWR clients are more frequently

[28] *See* Kate Kelly & Marisa Schwartz Taylor, *A Year of Upheaval on Abortion's Front Lines*, THE N.Y. TIMES (July 20, 2023), https://www.nytimes.com/interactive/2023/07/20/us/roe-dobbs-abortion-networks-services.html.

expressing fear that they will be discriminated against for having had an abortion if they disclose this information while visiting a hospital or IHS facility. People ask us all the time now: "Can I be tested for an abortion?" This fear is not entirely unfounded; there is a long and dark history of health care providers taking punitive measures—ranging from forcing medical procedures to reporting the patient to child protective services or law enforcement—against pregnant, birthing, and miscarrying people, predominantly people of color, based on the providers' disagreement with the pregnant person's reproductive health care decisions.[29] This fear of discrimination causes some of our clients to worry that they will either need to withhold information about their health or forgo care altogether, with potentially devastating consequences. The Rollback Rule's deletion of explicit protections against discrimination based on pregnancy and termination of pregnancy only exacerbates this fear and the resultant harm to patient health.

16. As a result, IWR has had to devote significant resources to guiding our clients through these perilous circumstances, including training all staff who work on the Abortion Fund's warm line on how to reassure callers not just of abortion's efficacy and safety but also of their rights, including their rights to be free from discrimination because of their reproductive health decisions and to refuse to disclose the circumstances of their pregnancy loss. Further, we have had to promote and train a staff member for a new role of Associate Director of the Abortion Fund to specialize in addressing callers' growing concerns that they might be refused care or face discrimination or other consequences for having obtained it. This all has cost IWR significant staff time and expense. If HHS had made clear that Section 1557 prohibits discrimination based on

[29] *See, e.g.*, LAURA HUSS, FARAH DIAZ-TELLO & GOLEEN SAMARI, IF/WHEN/HOW: LAWYERING FOR REPRODUCTIVE JUSTICE, SELF-CARE CRIMINALIZED: THE CRIMINALIZATION OF SELF-MANAGED ABORTION FROM 2000 TO 2020 30-34 (2023), https://ifwhenhow.org/wp-content/uploads/2023/10/Self-Care-Criminalized-2023-Report.pdf; Cecilia Nowell, *The Long, Scary History of Doctors Reporting Pregnant People to the Cops*, MOTHER JONES (Apr. 15, 2022), https://www.motherjones.com/criminal-justice/2022/04/self-induced-abortion-herrera-texas-murder-hospital/; MICHELLE GOODWIN, POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD (2020).

pregnancy, abortion, and miscarriage regardless of state abortion bans and does not incorporate exemptions that allow denials of care, it would have substantially mitigated our clients' post-*Dobbs* fears, as well as the confusion among clients and health care providers alike about their respective rights and obligations. Instead, the Rollback Rule did precisely the opposite—emboldened discrimination, compounded confusion, and exacerbated the strain on IWR's resources.

The Rollback Rule Has Strained IWR's Emergence Fund

17. IWR launched our Emergence Fund (formerly called the "Midwifery Fund") in May 2020 to help Indigenous people access quality, culturally competent midwifery care, doula care, breast and chest feeding support, placenta encapsulation, herbal and traditional medicine support for pregnancy and birth, and birthing and family supplies, such as diapers. We initially launched the fund with a focus on New Mexico, and in 2023 we expanded the reach of our services nationwide. Since April 2023, we have received 26 requests for help.

18. The Emergence Fund was created and expanded out of a tremendous need to help Indigenous people access quality, nondiscriminatory, stigma-free pregnancy-related care—a need which the Rollback Rule has only exacerbated. Midwifery and doula care is particularly crucial to Indigenous pregnant people, who carry into their birth experiences the trauma of the history of involuntary sterilizations of birthing Native people[30] and who, as previously discussed, continue to experience discrimination when accessing health care.[31] Further, Indigenous pregnant people frequently must travel outside of their communities to give birth. This is because many IHS

[30] *See* U.S. Nat'l Library of Medicine, *supra* note 2.
[31] *See* Findling et al., *supra* note 7, at 1435.

facilities do not have adequate, if any, obstetric and gynecological services.[32] Indeed, Native American and Alaskan Indian pregnant people living in rural communities are the most likely among racial and ethnic groups to live furthest from hospital-based obstetric care; more than half of rural zip codes with majority Native American and Alaskan Indian populations are located more than 30 miles from the nearest hospital with an obstetric unit, and in over a quarter of these areas, residents must travel more than 60 miles to access hospital-based obstetric care.[33]

19. Even though Congress intended Section 1557 to eradicate in federally funded health programs discrimination based on sex, national origin, and all of the other grounds enumerated in the cited civil rights statutes, the Rollback Rule instead has served to greenlight discrimination against Native pregnant people by purporting to carve IHS out of Section 1557's protections and foment confusion about providers' obligation to provide nondiscriminatory, culturally competent, stigma-free obstetric and gynecological care. By deleting the 2016 Rule's explicit protections against discrimination on the basis of "pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, [or] childbirth or related medical conditions" and incorporating an unlawful religious-institution exemption into Section 1557, the Rule has invited and emboldened health care providers to discriminate against Native people who seek any form of obstetric or gynecological care, including contraceptive care and counseling and care related to pregnancy and childbirth. All too often, we hear from our clients that health care providers, including providers at IHS, have

[32] *See* Nada Hassanein, *Native Americans Given Promise of Health Care. For Rural Moms, It's an Empty One*, USA Today (Aug. 11, 2022), https://www.usatoday.com/in-depth/news/health/2022/08/11/rural-native-americans-suffer-lack-maternal-health-care-access/10084897002/ ("Most IHS hospitals … don't provide childbirth care… There are only nine IHS-run health care facilities in six states that have a labor and delivery program, according to the agency. Tribes offer a handful of their own labor and delivery units in Arizona, Oklahoma and Alaska. About 75% of American Indian and Alaska Native births occur in non-Indigenous health care centers.").

[33] *See* Peiyin Hung et al., *Spatial Access to Hospital-Based Obstetric Units Among Racial/Ethnic Minoritized Communities in Rural and Urban America*, Rural & Minority Health Policy Brief (Aug. 2022), https://www.sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/mrg_obstetrics_hung_forhp_8.8.22.pdf.

failed to provide them medically appropriate and culturally sensitive pregnancy-related care, including evidenced-based information and counseling about pregnancy and contraception options.

20. The Rollback Rule has caused more people to apply for assistance from the Emergence Fund to avoid experiencing discrimination when accessing birth-related care. Midwives and doulas function as a safeguard against discrimination during childbirth, assist pregnant people with advocating for their rights, and, when necessary, hold medical providers accountable for harm.[34] Our Emergence Fund helps to match families with a midwife or doula that will best suit their needs. We have compiled a referral network of midwives and doulas that contains a host of information critical to our clients seeking care, including what kinds of insurance they take, their fee, their experience working with Indigenous people, whether they travel, their policies around different spiritual beliefs and practices, and other information that will be useful for Native people in obtaining nondiscriminatory, high quality, and culturally sensitive pregnancy-related care. We carefully screen the midwives and doulas in our network through a detailed intake form to ensure that they will provide nondiscriminatory, culturally competent care. Community-based midwife and doula care programs like ours has been shown to reduce health disparities and improve maternal health outcomes.[35] Members of our community, especially those who have already received inconsistent, discriminatory, coercive, and substandard pregnancy-related health care, increasingly seek the services of the Emergence Fund as a means of self-protection because

[34] *See* Nora Ellmann, Ctr. for Am. Progress, Community Based Doulas and Midwives: Key to Addressing the U.S. Maternal Health Crisis 9-10 (Apr. 2020), https://www.americanprogress.org/wp-content/uploads/sites/2/2020/04/DoulasMidwives-report.pdf.

[35] *See* Alexis Robles-Fradet & Mara Greenwald, *Doula Care Improves Health Outcomes, Reduces Racial Disparities, and Cuts Costs*, NAT'L HEALTH L. PROGRAM BLOG (Aug. 8, 2022), https://healthlaw.org/doula-care-improves-health-outcomes-reduces-racial-disparities-and-cuts-cost/.

the Rollback Rule has sent the signal that HHS will not protect us from such discrimination by traditional health care providers.

The Rollback Rule Has Frustrated Accomplishment of IWR's Mission

21. As detailed above, demands on IWR's funding have drastically increased since my last declaration because we have had to devote substantial resources to offset the toll the Rollback Rule has taken on our community—from emboldening denials of emergency abortion care to prompting our clients to fear seeking reproductive health care without our guidance and support. Because our resources are limited, we have had to forgo key parts of our mission to address the harms to our community caused by the Rollback Rule.

22. IWR continues to be funded through individual donations and grants from foundations. We do not receive any funding from state, federal, or tribal governments. Most of the funding we receive is unrestricted, and we reallocate to meet the most urgent demands facing our community.

23. Given IWR's limited budget and the factors straining our resources, we have had to shut down our operations on multiple occasions since my last declaration as the strain on our organization has increased. Specifically, since my last declaration was submitted on June 17, 2021, we have had to close our Funds between the date of that declaration until August 30, 2021, November 22–28, 2021, December 18, 2021–January 3, 2022, April 1–May 16, 2022, June 1–June 20, 2022, July 23–August 1, 2022, August 19–September 6, 2022, October 20–November 1, 2022, December 1, 2022–January 30, 2023, April 18–May 1, 2023, May 15–22, 2023, June 21–30, 2023, August 7–18, 2023, and December 1, 2023–January 8, 2024. We hired a fourth Abortion Fund staff member and trained all our staff on how to work the Abortion Fund warm line in order to try

to prevent future closures due to staffing constraints, but we anticipate that future closures will be necessary if we run out of money during any future budgetary period.

24. Additionally, we have been forced to forgo providing other services critical to accomplishing our mission of supporting the health of Native communities. After the leader of our sex education program left our organization, we were unable to hire someone else to take over those efforts due to budgetary constraints. We also have had to consolidate the positions of Tribal Liaison and Director of the Emergence Fund due to funding constraints. I personally took a substantial pay cut in 2021 and 2022, reducing my monthly salary to $1,500. And finally, because our staff size has grown rapidly to meet our community's needs at this moment, and in order to ensure that we can discuss issues with our clients in a safe and secure environment, we have twice had to obtain new office space since my last declaration. But on neither occasion have we been able to afford to furnish our office right away; currently, we have only two desks for a staff of ten people.

* * *

25. The Rollback Rule has harmed and will continue to harm the Indigenous people that IWR serves by emboldening covered health entities—including IHS—to deny critical reproductive and pregnancy-related health care and information, causing serious and long-lasting physical, mental, and emotional consequences. In turn, the Rule has harmed and will continue to harm IWR by increasing the strain on our Abortion Fund and Emergence Fund in a time when our capacity is already limited due to the public health crisis that has been unfolding since the Supreme Court overturned the federal constitutional right to abortion in *Dobbs v. Jackson Women's Health Organization.*

I declare under the penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on March 14, 2024, at Albuquerque, New Mexico.

/s/ Rachael Lorenzo
Rachael Lorenzo
Executive Director, Indigenous Women Rising

EXHIBIT F

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; and Transgender Emergency Fund of Massachusetts,

Plaintiffs,

v.

United States Department of Health and Human Services; Alex M. Azar II, *in his official capacity as secretary of the U.S. Department of Health and Human Services*; Roger Severino, *in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services*; and Seema Verma, *in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*,

Defendants.

Civil Action No. 1:20-cv-11297

DECLARATION OF ALLISON SCOTT

1. I, Allison Scott, swear that the following is true, accurate and complete to the best of my knowledge under the laws of the United States:
2. I am the Director of Impact & Innovation at the Campaign for Southern Equality, a nonprofit organization based in Asheville, North Carolina, dedicated to advancing LGBTQ civil rights across the South, both legally and in the lived experiences of Southerners.
3. I have served in this role as a leading member of the Campaign for Southern Equality in a paid employee capacity since 2016 and was previously involved in the organization on a

volunteer basis starting in 2015. My role includes developing and implementing programs, managing a majority of the staff, reporting back to our Board of Directors, fundraising and foundation relationship management, and overseeing the organization's budget. As such, I have detailed knowledge of all of the Campaign for Southern Equality's programs, staffing, and finances. I have personal knowledge of the facts stated set forth herein except as to those stated on information and belief, and as to those, I am informed and believe them to be true. If called as a witness, I could and would competently testify to the matters stated herein.

4. The Campaign for Southern Equality advocates for LGBTQ people to survive and thrive throughout the South. Our mission is to promote full equality for LGBTQ Southerners in all spheres of life and across race, class, and gender.

5. We use a range of strategies to achieve these goals. These include direct services, direct action, litigation, grant-making, and long-term organizing strategies to respond to immediate—and often urgent—community needs that support a new generation of LGBTQ leaders and build political voice and power over the long term. One of the most critical needs identified by our members is access to safe and supportive health care, and as such it is one of the main areas our work focuses on.

6. The Campaign for Southern Equality has about 50,000 members throughout the nation, particularly in the South, with an outsized footprint in North Carolina, South Carolina, Tennessee, Alabama, and Mississippi. Our members help shape the organization's long-range goals and priorities and direct the organization's mission and direction. Many members contribute financially to support the Campaign for Southern Equality's work, but

members who have limited financial resources may contribute through participating in the organization's programs.

7. As a result of a proliferation of bans on gender affirming care for transgender youth and growing restrictions related to access for trans adults, we have pivoted to make health access issues the leading edge of our work. In addition to the many existing programs and initiatives of Campaign for Southern Equality to increase access to care for LGBTQ southerners, we launched the Southern Trans Youth Emergency Project (STYEP) in January 2023 and have expanded the program throughout the year, with more growth anticipated in 2024. This comprises about 60% of our overall work and our entire staff of 13 is engaged in implementing the program. Our existing healthcare access initiatives[1] include updating the Trans in the South guide, providing limited advocacy for individuals facing health insurance denials, continuing the LGBTQ Health Initiative through our partnership with Western NC Community Health Services, conducting focus groups about our members' access to care, grantmaking to grassroots organizations providing gender affirming care, training service providers to treat LGBTQ patients with cultural competency, and providing know your rights pop up clinics.

8. It is plainly evident to me that federal regulation plays a pivotal role in the uptick of state bills that restrict access to gender affirming care in the states of many of our members. When federal regulation attempts to gut protections in health care as the Rollback Rule has, hostile state legislatures are emboldened to introduce and pass bills that restrict care to our members, there is a chilling effect both on providers who fear legal repercussions for

[1] These initiatives are described more fully in the declaration submitted by our Executive Director, Jasmine Beach-Ferrara in this matter executed on November 17, 2020, (hereinafter "the 2020 Declaration") and are incorporated herein by reference.

providing medically necessary, gender affirming care as well as on transgender patients and their families who forgo needed care due to fear of mistreatment.

9. Regrettably, the anticipated effects of the Rollback Rule, as outlined in the 2020 Declaration and ensuing legislative efforts to restrict access to care have come to fruition. We are hearing growing numbers of stories of people experiencing barriers to access care. These new developments include: 1) state bans on access to care for transgender youth; 2) overcompliance with these bans, which are creating additional barriers to care for people who should be able to legally access care; 3) restrictions on Medicaid coverage for gender affirming care across ages; and 4) restrictions targeting adults' access to gender affirming care. We are also supporting members who are facing the increasingly common issue of primarily only being able to access out of network care because they are now traveling to other states to access a provider in the face of these harmful bills that limit medically necessary gender affirming care.

10. In response to this crisis related to health care access we rapidly scaled STYEP and it has grown beyond our initial projections in terms of scope of work, staffing required, and funding required. We are now providing these services in 15 states where bans or restrictions are in place, including Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, Missouri, North Carolina, Ohio, Oklahoma, Tennessee, Texas, South Carolina, and West Virginia. Our health-related programming in 2024 requires significant new financial investments, including hiring two new team members to staff STYEP, a contractor to update Trans in the South guide, and through STYEP, giving out almost $400,000 in emergency grants to families of transgender youth and adults, and to frontline organizations focused on transgender health access.

11. It is critical that the implementing regulations of Section 1557 fully enforce the spirit and letter of the statute and controlling precedent to make clear to state legislators and health care providers that such legislation and failures to provide medically necessary care to members of our community are plain violations of federal law. Both the members of Campaign for Southern Equality and the organization's finances and priorities have paid and continue to pay the cost of the Rollback Rule.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on March 11, 2024 at Asheville, North Carolina.

/s/ *Allison Scott*
Allison Scott

EXHIBIT G

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; and Transgender Emergency Fund of Massachusetts,

Plaintiffs,

v.

United States Department of Health and Human Services; Alex M. Azar II, *in his official capacity as secretary of the U.S. Department of Health and Human Services*; Roger Severino, *in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services*; and Seema Verma, *in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*,

Defendants.

Civil Action No. 1:20-cv-11297

DECLARATION OF GRACE STERLING STOWELL

1. I, Grace Sterling Stowell, swear that the following is true, accurate and complete to the best of my knowledge under the laws of the United States:
2. I am the Executive Director of the Boston Alliance of Lesbian, Gay, Bisexual, Transgender, Queer Youth (BAGLY). Our organization is a nationally recognized model of lesbian, gay, bisexual, transgender, and queer (LGBTQ+) youth leadership and services and has worked with over 40,000 young people since its founding in 1980. BAGLY is a Plaintiff in this action, acting on behalf of itself, its clients, and other

recipients of its services. I submit this affidavit in support of Plaintiffs' Motion for Summary Judgment.

3. I joined BAGLY shortly after it was founded in 1980 and served as a volunteer leader until I was hired as its first paid Executive Director in 1995. Now, with a graduate degree in Counseling Psychology, and over 40 years' experience working on behalf of LGBTQ+ youth, I have developed significant expertise and understanding of their needs and best practices to address those needs.

4. During these past four decades, I have led the expansion of BAGLY from an all-volunteer, grassroots social support group in Boston, to an established nonprofit providing programs that support youth leadership, health and wellness, and advocacy organization for over twenty-five hundred LGBTQ+ youth in Boston annually and an additional twenty five hundred total LGBTQ+ youth and young adults throughout Massachusetts through the Alliance of Lesbian, Gay, Bisexual, Transgender, Queer Youth (AGLY) network.

5. I am also an active leader in local and national movements to expand community organizing, political advocacy, and resources for LGBTQ+ youth programs, services and public policy advocacy.

6. I am a founding member of the Massachusetts Commission on LGBTQ+ Youth, and the National Youth Advocacy Coalition in Washington, D.C. In addition to serving on the Massachusetts Commission on LGBTQ Youth, I also serve as a steering committee member of the Massachusetts Transgender Political Coalition (MTPC), and Breaktime, an organization working to end the cycle of young adult homelessness.

7. My work has been recognized by The International Court Council and the National Gay & Lesbian Task Force's "Stonewall Trans Heroes 40," and I was the recipient of the 2010 Susan J. Hyde Activism Award for Longevity in the Movement, in recognition of more than 35 years of leadership in the social justice and GLBT communities. I also received the Transgender Legal Defense and Education Fund's Legacy Award in 2023, the Spirit of Justice an award from GLAD, the Boston Celtics Heroes Among Us award and the YW Boston Academy of Women Achievers award, for my leadership in these areas.
8. As one of the nation's oldest LGBTQ+ youth-led, adult-supported organizations in the nation, BAGLY is uniquely positioned to provide holistic prevention and interventions for LGBTQ+ youth and young adults, with a specific focus on youth with intersectional identities and experiences. If called as a witness, I could and would competently testify to the matters stated herein.
9. BAGLY serves approximately 2,500 youth and young adults annually through its community center located in downtown Boston. BAGLY's programs and services seek to increase access to health care for LGBTQ+ youth and young adults and focus on the following three programs: 1) Health and Wellness, 2) Stabilization and Success, and 3) Youth Leadership and Advocacy.
10. BAGLY's Health and Wellness program utilizes three primary services strategies: 1) social support, 2) prevention and education, and 3) clinical services and resources. We utilize social support by offering a drop-in center that is open Monday through Friday. Our peer-led prevention and education strategy provides accurate information regarding sexual health. Our clinical services and resources strategy encompasses free and confidential HIV and STI testing and treatment, PrEP enrollment, and health care

navigation to external health care providers for services not offered in house. BAGLY's free mental/behavioral health services make up another aspect of our clinical services. Behavioral health services include Tea Time—drop in counseling for transgender and nonbinary youth, as well as short term therapy.

11. BAGLY primarily serves youth and young adults from Massachusetts, but increasingly also provides services for youth who are relocating to the state due to discriminatory and hostile environments, including from Florida and Texas, both of which have anti-trans laws including those that ban access to gender affirming care. The vast majority of BAGLY's youth participants (over 90%) identify as nonbinary or transgender. This reflects a significant increase since 2020. Many of our participant young people come to Boston specifically because, despite the legal protections for LGBTQ+ people in the state, community members outside of Boston face further hurdles accessing affirming care.
12. The work that BAGLY does in collaboration with other youth -serving organizations helps to support a safety net for young people throughout Massachusetts. Many of BAGLY's youth would not receive needed medical or mental health care if BAGLY's services were not available.
13. The need for BAGLY's health care services continue to be higher than what we have capacity to provide as we are the only free, LGBTQ+-led healthcare provider in the area. We have taken several measures to scale up our work seeking to accommodate this demand. In 2022 we secured larger office space, and we have introduced short term therapy to our programming in addition to drop-in counseling. We have increased the staff providing healthcare programming from one full time staff member in 2020 to one

full-time and one half-time staff member, and doubled the therapists we work with from one to two and brought on two clinical supervisors. BAGLY is also currently working with social work associations to become a placement for social work students to further increase our capacity to meet the demand for behavioral health services.

14. Despite our many efforts to increase the organization's capacity to meet this need the demand for BAGLY's health care services continue to exceed our capacity. Waitlists for our services continue to be long, as do the waitlists for external LGBTQ+ affirming providers. Also due to state budget shortfalls and a highly competitive funding environment, significant sources of our funding are also uncertain.

15. On June 14, 2019, the United States Department of Health and Human Services (HHS) issued a Notice of Proposed Rulemaking, which attempted to gut the nondiscrimination provisions of the Affordable Care Act which protect against denial of care the basis of sexual orientation and gender identity. *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27,846 (proposed June 14, 2019) ("2019 Proposed Rule").

16. On June 19, 2020, HHS published a final rule that adopts the entirety of the 2019 Proposed Rule, with only a few minor changes that do not affect its impact on LGBTQ+ people. *See* Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts 438, 440, 460) ("the Rollback Rule"). The Rollback Rule eliminates the express protections against discrimination for LGBTQ+ people, exempts most insurers from having to comply with the nondiscrimination provisions of 1557, and removes helpful, clear guidance regarding what constitutes discrimination on the basis of sex including that blanket denials of

coverage for transition related health care are per se violations of section 1557, among other things. These aspects of the Rollback Rule do not support the purpose of the Affordable Care Act to expand coverage and access to health care for all Americans and to lower health care costs.

17. The Rollback Rule makes more confusing what the rights of LGBTQ+ are when accessing health care. The young people who participate in BAGLY's services are already afraid of facing discriminatory treatment by health care providers, and Rollback Rule exacerbates their confusion and fears. BAGLY provides health care navigation and benefits enrollment and we now have to spend more time reviewing and explaining insurance plans to avoid blanket exclusions of gender affirming care, and finding affirming in-network providers, for example.

18. I believe that the Rollback Rule's attempt to exclude LGBTQ+ people's protections under section 1557 laid the groundwork for the proliferation of anti-trans state laws that ban or severely limit access to gender affirming care.

19. The hostile climate towards LGBTQ+ people, and particularly transgender and nonbinary people in healthcare, including through the Rollback Rule, continues to strain BAGLY's resources by increasing the demand for our services. The youth and young adults BAGLY serve are being deeply impacted by the legislative onslaught of anti-trans state bills, increased incidents of hate violence against LGBTQ+ young people, and the hateful rhetoric being employed by school boards and politicians across the country. BAGLY's youth and young adult participants are in touch with current events through social media, and feel the devasting impact of these events regardless of locale. Many of the young people who access BAGLY's programs and services experience worsened mental health,

and increased fear, anxiety, depression, and isolation that sometimes results in self-harm and other high-risk behaviors as a result of this hostile climate. This in turn increases the demand for BAGLY's services, and in particular those of our Health and Wellness program, which are already at capacity.

20. This increasingly hostile climate also profoundly impacts BAGLY's staff as we are part of the communities we serve. This understandably includes challenges to morale and productivity, as well as the need for more sick time and other paid time off.

21. When first enacted, I believed that section 1557 would not allow for the kinds of state legislation that are commonplace today that ban or otherwise limit access to gender affirming care. From what I understand about the Rollback Rule and from what I have observed over the course of the last few years, the Rollback Rule has rendered the protections of 1557 toothless. Without strong enforcement of and clear guidance about the protections of 1557 to combat the anti-trans and queer sentiment plaguing so much of this country, it is no surprise that hostile states are attacking gender affirming healthcare, particularly of our youth.

22. As someone who has been engaged in this work for decades, I believe that there is a direct connection between the legal landscape and demand for our services. This belief is based on my understanding of political climate as it correlates with reports of the youth and young adults who participate in our programs and trends I have witnessed regarding demand for BAGLY's services. It is imperative that federal regulation of section 1557 comports with and fully enforces the law to curb the crisis of state bills that limit access to gender affirming care and drive young people to BAGLY's door.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on March 12, 2024 at Boston, Massachusetts.

/S/ Grace Sterling-Stowell
Grace Sterling-Stowell

EXHIBIT H

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; and Transgender Emergency Fund of Massachusetts, Plaintiffs, v. United States Department of Health and Human Services; Alex M. Azar II, *in his official capacity as secretary of the U.S. Department of Health and Human Services*; Roger Severino, *in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services*; and Seema Verma, *in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, Defendants.	Civil Action No. 1:20-cv-11297

DECLARATION OF AARON M. GONZALES

1. I, Aaron M. Gonzales swear that the following is true, accurate and complete to the best of my knowledge under the laws of the United States:
2. I am the Director of Program Operations at Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY) where I provide critical leadership as a member of BAGY's senior leadership team. The Director of Program Operations ensures that BAGLY's programmatic structures, processes and teams have the capacity to deliver high quality, high impact programming to meet the needs of the LGBTQ youth and young adult

community. I joined BAGLY's staff in January 2, 2009. I submit this affidavit in support of Plaintiffs' Motion for Summary Judgment.

3. In my role I oversee the operations of all of BAGLY's programs. I have personal knowledge of the facts set forth herein, except as to those stated on information and belief, and as to those, I am informed and believe them to be true. If called as a witness, I could and would competently testify to the matters stated herein.

4. As one of the nation's oldest LGBTQ+ youth-led, adult-supported organizations in the nation, BAGLY is uniquely positioned to provide holistic prevention and interventions for LGBTQ+ youth and young adults, with a specific focus on youth with intersectional identities and experiences. BAGLY's three primary programs—1) Health and Wellness, 2) Stabilization and Success, and 3) Youth Leadership and Advocacy—were established to create a continuum of services and activities that address some of the most critical issues facing LGBTQ+ youth and young adults. By increasing protective factors that support and ensure survival, fostering connections to peers and trusted adults, developing connections to community, providing free mental and behavioral health services, and supporting healthy youth development and decision-making, BAGLY's programs provide comprehensive and effective best practices for LGBTQ+ youth and young adults.

5. All of BAGLY's services and programming seek to increase access to care for BAGLY's youth and young adults.

6. BAGLY's Health and Wellness Program provides a safe, non-exploitative environment where LGBTQ+ youth and young adults can find supportive adults, create social networks, and gain community. In addition, BAGLY also aids LGBTQ+ youth in navigating low-barrier pathways to LGBTQ+ competent physical and mental health programming and

providers. BAGLY provides a safe space that is positively associated with the promotion of positive socioemotional, behavioral, and educational outcomes for LGBTQ+ youth.

7. LGBTQ+ youth face social stigma about their sexual choices or identities. Stigma can take many forms, such as discrimination, harassment, family rejection, social rejection, or violence. For LGBTQ+ youth, these experiences can put their health at risk. LGBTQ+ youth are four times more likely to attempt suicide than their heterosexual and cisgender peers.[1] 69% of LGBTQ+ youth reported feeling persistently sad and hopeless. For heterosexual youth, that figure was 35%.[2]

8. BAGLY's Health and Wellness Program utilizes three strategies to create a safe and supportive environment where LGBTQ+ youth feel connected to people who care is a proven way to promote their health and well-being. Services include social support, prevention and education, and clinical services and resources.

9. BAGLY offers social support through ourCommunity Center creating youth-led infinity spaces, and youth leadership development opportunities. Allowing LGBTQ+ youth to make friends, share experiences, and access support, information, and referrals, related to sexual orientation, gender identity, sexual and mental health, or any other issues of concern.BAGLY offers prevention and education services by incorporating a spectrum of harm reduction strategies from safer use, to managed use, to abstinence. Through these services BAGLY services to meet people "where they are at." BAGLY offers a peer-led health education workshop series that focuses on a multitude of health care topics, such as HIV Testing, PrEP enrollment, gender-affirming care, and reproductive care using a

[1] CENTERS FOR DISEASE CONTROL, *LGBTQ+ Youth: Addressing Health Disparities with a School based Approach*, https://www.cdc.gov/lgbthealth/youth.htm.
[2] *Id.*

foundation of self-advocacy. BAGLY also offers clinical services and resources through the Clinic@ BAGLY. The Clinic@BAGLY provides a youth-centered, harm reduction approach to accessing comprehensive prevention, education, and referrals. The clinic provides a variety of services including HIV and STI screenings, PrEP enrollment assistance, pregnancy testing, linkage and referral services, insurance enrollment, and healthcare navigation to culturally competent mental health providers free of charge. This strategy also encompasses behavioral health services including include Tea Time—drop in counseling for transgender and nonbinary youth, as well as short term therapy.

10. Through BAGLY's Stabilization and Success Program (SandS Program), youth have the opportunity to build a foundation for security by creating pathways that eliminate significant barriers such as access to education, employment, financial literacy, food, and housing. According to Centers for Disease Control (CDC) data, homelessness and housing instability were reported at higher rates among transgender and nonbinary youth, including 38% of transgender girls/women, 39% of transgender boys/men, and 35% of nonbinary youth, compared to 23% of cisgender LGBQ youth.[3]

11. LGBTQ+ youth who experienced homelessness or housing instability reported higher rates of mental health challenges, compared to their stably housed LGBTQ peers. 58% of youth who reported past housing instability and 62% of youth who were currently homeless reported having seriously considered suicide in the last year—compared to 35% of youth who had not experienced housing instability, BAGLY's SandS Program utilizes three strategies to create a safe and supportive environment where LGBTQ+ youth feel connected to people who care is a proven way to promote their stabilization and success.

[3] *Id.*

12. The primary objective of BAGLY's Direct Support strategy is to help youth secure immediate basic needs such as access to food, hygiene products, and situational appropriate clothing and direct aid. Providing basic needs creates pathways to increasing stability. Leadership opportunities include the SandS Peer Leaders and paid and volunteer opportunities.
13. BAGLY's Independent Living Support strategy recognizes that without a stable housing situation, individuals face numerous barriers to education, employment, and overall well-being. By prioritizing housing as the first step, youth can focus on building a solid foundation from which young people can rebuild their lives. Using additional resources such as workshops on financial literacy, budgeting, and "how to be a good roommate" reduces the cycle of homelessness or housing instability.
14. BAGLY's education and employment support strategy prioritizes building a livelihood by creating access to tutoring, HISeT testing, higher education, resume building, and job seeking. BAGLY's programming provides tools and resources to help them overcome challenges and maintain their employment and housing in the long term.
15. BAGLY's third programmatic area is Youth Leadership & Advocacy (YLA). LGBTQ+ youth face targeted, ongoing, and increasingly severe threats to their rights, safety, and healthy development. They are stigmatized, discriminated against, and systematically denied opportunities for leadership and voice in the discourse and decisions that directly affect their lives.
16. On June 14, 2019, the United States Department of Health and Human Services (HHS) issued a Notice of Proposed Rulemaking, which attempted to gut the nondiscrimination provisions of the Affordable Care Act which protect against denial of care the basis of

sexual orientation and gender identity. *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27,846 (proposed June 14, 2019) ("2019 Proposed Rule").

17. On June 19, 2020, HHS published a final rule that adopts the entirety of the 2019 Proposed Rule, with only a few minor changes that do not affect its impact on LGBTQ+ people. *See* Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts 438, 440, 460) ("the Rollback Rule"). The Rollback Rule eliminates the express protections against discrimination for LGBTQ+ people, exempts most insurers from having to comply with the nondiscrimination provisions of 1557, and removes helpful, clear guidance regarding what constitutes discrimination on the basis of sex including that blanket denials of coverage for transition related health care are per se violations of section 1557, among other things. These aspects of the Rollback Rule do not support the purpose of the Affordable Care Act to expand coverage and access to health care for all Americans and to lower health care costs.

18. The Rollback Rule makes more confusing what the rights of LGBTQ+ are when accessing health care. The young people who participate in BAGLY's services are already afraid of facing discriminatory treatment by health care providers, and Rollback Rule exacerbates their confusion and fears. BAGLY provides health care navigation and benefits enrollment and we now have to spend more time reviewing and explaining insurance plans to avoid blanket exclusions of gender affirming care, and finding in-network providers, for example.

19. I believe that the Rollback Rule's attempt to exclude LGBTQ+ people's protections under section 1557 laid the groundwork for the proliferation of anti-trans state laws that ban or severely limit access to gender affirming care. In 2023, over 520 anti-LGBTQ+ bills were introduced in legislatures across the country, a record number. Massachusetts has not been exempt from a rise in anti-LGBTQ+ activity targeting schools, libraries, healthcare providers, drag performers, and individuals in communities across the Commonwealth. These incidents and rhetoric directly impact LGBTQ+ young people's physical safety, mental health, and access to rights and opportunities. LGBTQ+ youth who hold multiple marginalized identities, including youth of color, disabled youth, and low-income youth, are especially disenfranchised.

20. BAGLY's YLA Program therefore works to train and develop LGBTQ+ youth leaders to create positive and systemic change in their communities and the world through three core strategies: training, opportunities, and advocacy and action. Through BAGLY's Training strategy, we offer dialogue- and skills-based training that utilizes popular education and anti-oppression pedagogies to foster critical consciousness, sociopolitical development, and positive identity development. Trainings include BAGLY's one-year LGBTQ+ youth/peer leader training curriculum, conferences, teach-ins, and the upcoming LGBTQ+ youth community organizer fellowship training. Through BAGLY's opportunities strategy we offer experiential learning opportunities that promote self-esteem, develop college and career readiness skills and increase youth voice and decision-making in the organization and community. Opportunities include the Youth Leadership Committee, paid and volunteer youth leader positions, and event planning committees. Through BAGLY's Advocacy & Action strategy we offer youth-led community organizing, education, and

legislative and public policy to promote positive change and counter-attacks on the LGBTQ+ community. Opportunities include the Speakers Bureau, the Queer Activist Conference, and the upcoming community organizer fellowship.

21. The youth and young adults who participate in BAGLY's programs and services are at high risk of not receiving needed health and wellness care. This is because 40% of the young people who participate in our programs live in poverty, 24 % of whom are unstably housed. To make our services accessible to this population we provide free services and cover any otherwise uncovered health care costs such as copays, as cost would render care prohibitive for most. BAGLY does not collect health insurance information for in-house health services because approximately 28% of the young people we work with do not have health insurance and 18% refuse to use their health insurance because of their concerns about cost and/or privacy. For these reasons, I believe many of the young people who receive services at BAGLY would not receive needed medical or mental health care if they were not available.
22. The need for BAGLY's health care services continue to be higher than what we have capacity to provide as we are the only LGBTQ-led, and free healthcare provider in the area.
23. Today, BAGLY serves approximately 2,500 youth and young adults annually, a significant increase from 2020 when we served approximately 520 young people annually. While we have increased our capacity, waitlists for our services continue to be long, as do as waitlists for LGBTQ+ affirming external providers.
24. I believe based on my vantage point that this increased demand is a result of the increasingly hostile climate towards LGBTQ+ people across the country, particularly for transgender and nonbinary youth. Our staff hear from transgender and nonbinary youth

from states where anti-transgender legislation has been passed who are looking to relocate as a result. Massachusetts is an attractive destination to the communities we serve because our state has legal protections for LGBTQ+ people as well as the PATCH Act—legislation which protects the health information of young people from being disclosed to their parents even if they are covered by their parents' insurance policies. Boston specifically is particularly popular because of the community and services available here compared with those in the rest of the state. We have seen a drastic increase in the number of young people who access our services who identify as nonbinary or transgender from 45% in 2020 to 90% today.

25. Because of my role, I have intimate knowledge about what is on the minds of the young people we work with. Our young people continue to express fear of facing discrimination for being LGBTQ+ when seeking health care, which is why we provide as much care in-house as possible, and also provide health care navigation to obtain care from affirming providers externally. The youth and young adults who participate in BAGLY's programs continue to express confusion regarding their rights to access health care and what behavior by health care providers constitutes discrimination.

26. The youth and young adults BAGLY serve are being deeply impacted by the legislative onslaught of anti-trans state bills, increased incidents of hate violence against LGBTQ+ young people, and the hateful rhetoric being employed by school boards and politicians across the country. BAGLY's youth and young adult participants are in touch with current events through social media, and feel the devasting impact of these events regardless of locale. Many of the young people who access BAGLY's programs and services experience worsened mental health, and increased fear, anxiety, depression, and isolation that

sometimes results in self-harm and other high-risk behaviors as a result of this hostile climate. This in turn increases the demand for BAGLY's services, and in particular through our Health and Wellness program, which are already at capacity.

27. The increased demand for services and the hostile climate towards our communities are straining staff, some of whom are struggling against burnout. As members of the LGBTQ+ community we are personally impacted by the targeted and escalated attacks we are witnessing against our communities across the country. Staff are increasingly challenged by the limits of what our services can provide in the face of a more uncertain future.
28. It is imperative that federal regulation of section 1557 comports with and fully enforces the law to curb the crisis of state bills that limit access to gender affirming care and drive young people to BAGLY's door.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on March 12, 2024 at Boston, Massachusetts.

/S/ Aaron M. Gonzales
Aaron M. Gonzales

EXHIBIT I

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

BOSTON ALLIANCE OF GAY, LESBIAN, BISEXUAL AND TRANSGENDER YOUTH, TRANSGENDER EMERGENCY FUND OF MASSACHUSETTS, CALLEN-LORDE COMMUNITY HEALTH CENTER, CAMPAIGN FOR SOUTHERN EQUALITY, CRESCENTCARE, DARREN LAZOR, EQUALITY CALIFORNIA, FENWAY HEALTH, and INDIGENOUS WOMEN RISING

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, XAVIER BECERRA, in his official capacity as Secretary of the U.S. Department of Health and Human Services, MELANIE FONTES RAINER, in her official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services, CHIQUITA BROOKS-LASURE, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services,

Defendants.

Civil Action No. 1:20-cv-11297

DECLARATION OF JORDINA SHANKS, INTERIM CEO OF FENWAY HEALTH

I, JORDINA SHANKS, declare under penalty of perjury and in accordance with the laws of the United States and of Massachusetts that:

A. Introduction

1. I am the Interim Chief Executive Officer of Plaintiff Fenway Health. In this capacity, I am responsible for the leadership, direction, and overall management of the

organization. I oversee the acquisition and utilization of Fenway Health's resources, including the recruitment, retention, and motivation of a diverse, high-performing leadership team and staff. I cultivate and support collaboration, serving as Fenway's primary voice in local, regional, national and international forums. Serving as an ambassador and influencer, I work closely with external constituents and partners to advance Fenway's impact. I am responsible for cultivating and supporting collaboration across all of Fenway Health's parts, which are its federally qualified health center, The Fenway Institute, and AIDS Action.

2. Fenway Health is a federally qualified health center whose mission is to provide healthcare to the LGBTQ+ community and to all people through access to highest quality healthcare, education, research, and advocacy. I use the term LGBTQ+ to refer to lesbian, gay, bisexual, transgender, queer, intersex, or gender diverse people. Fenway Health aims to increase access to care for existing and new patients and to work towards greater racial and ethnic health equity within its community.

3. A significant part of Fenway Health's patient population is LGBTQ+. About 61% of our patients are LGBQ; about 16% of our patients are transgender and gender diverse. Fenway Health's patient population also has limited financial resources. In 2022, about 35% of Fenway Health's patient population lives at or below the federal poverty line. Fenway Health served 253 patients who were homeless during that time. Fenway Health's patient population also faces other barriers to advocating on their own behalf. For example, in 2022, Fenway Health saw 1,386 patients who were best served in a language other than English.

4. In 2022, Fenway Health served about 33,000 patients at its three locations in Boston, including many patients who travel from significant distances for care. Our patients hail from 44 different states, including Massachusetts, with significant numbers travelling for care from

Rhode Island, New Hampshire, New York, Maine, Connecticut, Florida, California, New Jersey, Vermont, Texas, Pennsylvania, Virginia, and Illinois.

5. Through its telehealth program, Fenway Health also provides healthcare services to people who are not able to visit our offices. During the pandemic when interstate telehealth restrictions were lifted, we served patients in 38 different states. In fact, among the 446 new transgender and gender diverse patients who came to us during the first six months of the COVID-19 pandemic, 17% were from out of state. From March through August 2020, a total of 3,189 transgender and gender diverse patients utilized our telehealth medical and behavioral health services. Many of these were existing patients but we did have new patients from out of state whose first appointment was via telehealth. Fenway Health cared for close to as many unique TGD patients during this 6-month period via telehealth as it did via in-person services during calendar year 2019. Due to changes in state telehealth regulations, as of August 31, 2021, we no longer schedule telehealth visits for patients located outside of Massachusetts.

6. Fenway Health has a specific emphasis on providing healthcare services to LGBTQ+ people. Fenway Health's Transgender Health Program provides primary care; hormone therapy; mental health services; and support groups for transgender, nonbinary, gender diverse, and questioning individuals and their families. Fenway Health also operates a Transgender Youth Clinic that provides primary care and gender affirming treatment for transgender and gender diverse youth under age 18, working with them to develop a treatment plan that considers both the goals of treatment and any care needs based on age, development, medical and mental health conditions. There is also a research focus on and about the health and well-being of transgender and gender diverse people at The Fenway Institute.

7. Fenway Health also operates programs focusing on research, training, education, and policy development. These programs develop clinical techniques, training materials, and model policies, and also provide training and technical assistance to health centers and HIV care providers across the nation in order to optimize access to quality healthcare for LGBTQ+ populations and people living with HIV. In 2021, Fenway Health clinicians and researchers published *Transgender and Gender Diverse Health Care: The Fenway Guide*, the first case-based textbook to address the comprehensive health care needs of transgender and gender diverse adults. The textbook offers a roadmap for clinicians who seek to provide culturally responsive care that meets the primary, preventive, and specialty health care needs of transgender and gender diverse adult patients.

B. HHS Rulemaking

8. I am aware that the United States Department of Health and Human Services (HHS) issued a Notice of Proposed Rulemaking related to the nondiscrimination provisions of the Affordable Care Act on June 14, 2019. *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27,846 (proposed June 14, 2019) ("2019 Proposed Rule"). In response to the 2019 Proposed Rule, Fenway Health, via the Fenway Institute, submitted a Comment Letter to HHS. *See* The Fenway Institute, Comment Letter on 2019 Proposed Rule (Aug. 13, 2019), https://bit.ly/3dWDa6t. The Comment Letter was written on behalf of a group of health care providers, policy advocates and elected officials, and expressed well-founded opposition to the 2019 Proposed Rule. For example, the Comment Letter noted that "[t]he proposed removal of [sexual orientation and gender identity] nondiscrimination provisions from [] regulations governing Medicaid enrollment and services, state and federal health insurance

exchanges, insurance coverage, Qualified Health Plans, and PACE Program would hurt LGBT people who have disproportionately benefited from many of these programs."

9. It is my understanding that on June 19, 2020, HHS published a final rule that adopts, with only minor or technical alterations, the entirety of the 2019 Proposed Rule. *See* Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts 438, 440, 460) ("the Rollback Rule"). The Rollback Rule largely ignores or summarily dismisses the concerns that Fenway Health and thousands of other commenters raised.

C. The Rollback Rule Emboldens an Atmosphere of Discrimination Against our Patients

10. The Rollback Rule emboldens an atmosphere of discrimination against our patients and causes fear among Fenway Health's patient population that historical discrimination in access to healthcare services and health insurance coverage is allowed to continue.

11. Many LGBTQ+ patients at Fenway Health have historically been refused medical care by other providers, including routine care unrelated to gender dysphoria, simply because they are LGBTQ+. Such discrimination has been reported to Fenway providers and staff members on countless occasions. These experiences are consistent with the 2022 U.S. Transgender Survey, a survey conducted by the National Center for Transgender Equality exploring the health and wellbeing of 92,329 transgender people across the country. *See* Sandy E. James et al., Early Insights: A Report of the 2022 U.S. Transgender Survey (Feb. 2024), https://perma.cc/9JML-V7GV ("2022 Transgender Survey"). The 2022 Transgender Survey serves as a follow-up to the 2015 U.S. Transgender Survey, an earlier survey that reached 27,715 transgender respondents. *See* Sandy E. James et al., Report of the 2015 U.S. Transgender Survey (2016), https://perma.cc/KA45-LQEN ("2015 Transgender Survey"). According to the 2022 Transgender Survey, of the

respondents who saw a health care provider within the last 12 months, almost half (48%) reported discrimination because they were transgender, including "being refused health care, being misgendered, having a provider use harsh or abusive language when treating them, or having a provider be physically rough or abusive when treating them." 2022 Transgender Survey at 16.

12. I am aware of many Fenway Health patients who have encountered health care providers hostile to or unaccepting of LGBTQ+ patients and people seeking reproductive health care. For example, many patients have come to Fenway Health for alternative insemination (AI) services due to being discriminated against in other AI settings. Such discrimination and fear of discrimination has led some Fenway patients to seek out non-discriminatory care with us despite living outside of Massachusetts.

13. By repealing HHS's prior interpretation of "on the basis of sex," the Rollback Rule lends support to health care providers, insurers and institutional actors who are fundamentally opposed to serving Fenway's patients in a non-discriminatory manner. Such individuals and entities openly discriminate under the Rollback Rule. For example, Franciscan Alliance, a Catholic healthcare provider, declared that their organization "employs physicians who offer endocrinology hormone services, hysterectomies, mastectomies, and psychiatric support. The [2016] Rule would force Franciscan to offer these services as part of a medical transition, which would violate both Franciscan's best medical judgment and its religious beliefs." Appendix to Plaintiffs' Brief in Support of Their Motion for Partial Summary Judgment or, in the Alternative, Preliminary Injunction at App.9, Franciscan Alliance, Inc. v. Price, No. 7:16-cv-00108-O, 2017 WL 3616652, (N.D. Tex. Aug 23, 2016). My interpretation of this statement is that Franciscan Alliance providers feel free to deny gender affirming care in the absence of the definitional protections of the 2016 Rule, forcing their patients to seek out more accommodating providers, such as Fenway Health.

In my view, other healthcare providers are likely to behave in a similar manner to Franciscan Alliance. In response to the Biden Administration's 2022 Proposed Rule re-interpreting Section 1557 regulations, several providers expressed objections to providing gender affirming and reproductive health care. *See, e.g.*, Nondiscrimination in Health Programs and Activities (RIN Number 0945–AA17), Comment IDs HHS-OS-2022-0012-59993; HHS-OS-2022-0012-27125; HHS-OS-2022-0012-31019; HHS-OS-2022-0012-47787.

14. The discrimination occasioned by the Rollback Rule also limits access to care for Fenway's patients. More than 600 hospitals in the U.S. are Catholic, many of which are governed by the Ethical and Religious Directives for Catholic Healthcare Services ("directives"). Catholic Health Association, *U.S. Catholic Health Care* (2023); see, e.g., Covenant Health, *Why Catholic Health Care*, https://covenanthealth.net/who-we-are/why-catholic-health-care/. These directives are known to discriminate against people for seeking pregnancy-related care, including but not limited to miscarriage management and pregnancy termination, as well as sterilization procedures used to permanent prevent pregnancy and treat gender dysphoria. R. Pradhan & H. Recht, *The Powerful Restraints on Medical Care in Catholic Hospitals Across America* (Feb. 17, 2024), https://perma.cc/B759-YGAR.

15. There are many Catholic-affiliated hospitals and health care entities in the state of Massachusetts and in the other states where our patients live. Catholic Health Association, Catholic Health Care Directory, https://www.chausa.org/for-members/directories/catholic-health-care-directory. It is the belief of our patients and staff that Catholic-affiliated providers continue to discriminate against transgender people, despite state antidiscrimination laws. These bad experiences can worsen existing conditions for our patients.

16. The Rollback Rule incorrectly asserts certain health insurers to be exempt from Section 1557's scope and permits them to categorically exclude gender-affirming care or other sex-based treatments. Such exclusions exacerbate the existing issue that, nationally, more than one-quarter (26%) of transgender people report having issues with their insurance in the past year related to being transgender. 2022 Transgender Survey at 17. I am familiar with the case of Boyden v. Conlin, which illustrates the impact of the Rollback Rule on insurance coverage. Officials in charge of a Wisconsin state health insurance plan voted to cover gender confirming surgery because they believed that the 2016 Rule compelled it. However, once they heard this Rule would be challenged in the Franciscan Alliance case, they prepared to reinstate the exclusion, based on "the belief that the Texas court's entry of an injunction absolved defendants of any legal obligation to provide coverage." Boyden v. Conlin, 341 F. Supp. 3d 979, *1002 (W.D. Wis. 2018). The federal government has and continues to acknowledge the fact that "[m]any health plans are still using exclusions such as 'services related to sex change' or 'sex reassignment surgery' to deny coverage to transgender people for certain health care services." Healthcare.Gov, Transgender Health Care, https://perma.cc/25UA-S75S. This reflects the experience of Fenway Health where some of our transgender and gender diverse patients do not have insurance coverage for gender affirming care received at our facility. This insurance coverage tends to be out-of-state health insurance or self-insured health plans.

17. Insufficient insurance coverage and fear of discrimination due to the Rollback Rule worsen health outcomes, particularly for people who already disproportionately bear the burden of health disparities. *See* 2015 Transgender Survey, *supra*. Fenway Health providers believe that delaying or forgoing necessary medical care has been shown to inhibit the return to excellent or very good health, and to lower quality-of-life scores. There is evidence that this already happens,

and that health outcomes for transgender people have grown worse in the years since the Rollback Rule: the 2022 Transgender Survey found that of the transgender respondents who had seen a health care provider in the last year, nearly one-half (48%) reported discrimination in healthcare settings, compared to 33% in 2015; while 24% of all transgender respondents reported that they avoided going to the doctor when they needed to because they feared discrimination, compared to 23% in 2015. *Compare* 2022 Transgender Survey at 16 *with* 2015 Transgender Survey at 93, 96. Additionally, in 2022, just 6% of transgender respondents reported "Excellent" overall health, compared to 12% in 2015; while the percentage of transgender respondents reporting "Poor" health has almost doubled (from 5% in 2015 to 9% in 2022). *Compare* 2022 Transgender Survey at 16 *with* 2015 Transgender Survey at 104.

D. The Rollback Rule Causes Fenway Health to Divert Crucial Resources

18. The Rollback Rule causes Fenway Health to expend resources associated with training staff to address the confusion about the requirements of federal law. Fenway Health staff have discussed Section 1557 regulations and its impact on patients in staff meetings.

19. The Rollback Rule also causes Fenway Health to expend resources associated with our responsibility to our patient community. For example, shortly after the Proposed Rollback Rule was issued, the Fenway Institute invested time and resources necessary to publish a report describing the impact of the proposal on our patient population and the broader community. It is available here: https://perma.cc/6PPZ-LHU2. On August 7, 2019, we held a community education forum to help our patients understand the impact of the Rollback Rule, which roughly two-dozen people attended. A video from the community forum is available here: https://www.youtube.com/watch?v=bey9ojtnzrE. Following the publication of the Rollback Rule,

staff members have expended resources discussing the impact of the Rule in various support groups and individual patient interactions. For example, on July 1, 2020, we held a community forum to discuss the Rollback Rule and other legal updates. A video from the community forum is available here: https://www.youtube.com/watch?list=PLCt8jO7qjtPB67WKit76ZKcHvzz3wOvrl&v=wKyjzWfTOTc

20. Based on the atmosphere of emboldened discrimination occasioned by the Rollback Rule, Fenway Health's patients face discrimination and increased fear of being discriminated against. This results in increased strain on our resources and capacity. For example, over the last few years, Fenway Health has had to restructure our program serving transgender youth and adolescents. We have dedicated more resources towards navigating discriminatory insurance-related barriers that block our transgender patients from accessing life-saving, medically-appropriate medications (including prior authorizations and appeals processes) and connecting with legal assistance when necessary.

21. The Rollback Rule emboldens the very discrimination that causes some of Fenway Health patients to delay or forgo addressing their health care needs. Acute conditions are less responsive to treatment and sometimes are no longer treatable; it is also costlier to provide health care at advanced stages of illness, as opposed to preventive care. This increase in acute conditions harms patient health, increases the costs of care provision, and worsens community health outcomes in the populations we serve (conflicting with a central goal of the Fenway Health mission). Some of our patients have delayed care due to past discriminatory experiences or fear of future discriminatory treatment, particularly when obtaining labwork or seeing specialists outside of Fenway Health. One patient experienced discrimination at an outside pharmacy and delayed

obtaining testosterone for several months; this compounded the patient's depression and anxiety about health care settings.

22. In response to emboldened discrimination, Fenway Health has had to expend significant resources to ensure the continued physical safety of our patients and staff. The uptick in threats to our facilities in recent years has led to a corresponding need for increased security measures. Staff members in our Transgender Health Program now meet with our security team on a monthly basis, and our security team must engage in additional safety coordination when our Transgender Health staff members travel off-site. We have had to change the way our online support groups and family orientations are set up to prevent harassment in the form of "Zoom bombing." The atmosphere of harassment has also led to a decrease in the amount of educational materials we are able to publish, as we have been forced to choose between sharing online resources with other providers and patients, and protecting the safety of our own providers, staff, and patients.

23. The Rollback Rule also negatively affects the ability of Fenway Health patients to pay for healthcare services and associated costs. For example, one of Fenway Health patients shared that they fear their local health care provider would discriminate against them due to their gender identity. As a result, they travelled for hours by plane and car to Fenway Health for basic primary care. As another example, some Fenway Health patients have insurance coverage that have discriminatory coverage exclusions of gender affirming care. These patients end up paying much more for gender affirming care than they would have if their insurance coverage did not have discriminatory policies. We find ourselves investing more staff resources into helping patients apply for grants that can support travel to receive gender affirming care and surgery costs.

24. Some health insurance plans understand the Rollback Rule to allow them to offer plans that discriminate in their benefit design. Fenway Health expends resources and administrative time to understand, apply, and appeal associated coverage decisions. Staff have had to hold increasingly more team meetings to address issues with out-of-state health insurance and medical management coordination, often discussing whether denials are due to discriminatory laws and policies or due to non-discriminatory medical guidelines.

25. The Rollback Rule strains Fenway Health's resources and operations dedicated to helping patients navigate and understand health insurance coverage. Fenway Health provides patient navigation services to its patients, including insurance verification, financial assistance, and understanding a plan's covered services (including for services that are subject to discriminatory coverage policies). Such services cannot be billed to insurance.

26. The Rollback Rule also strains Fenway Health's ability to provide appropriate referrals to our LGBTQ+ patients. Without the protections of the 2016 Rule, we are not able to assure patients that they will receive non-discriminatory care without deep investigation into the practices of any given provider or health system. This is especially problematic for our patients who require care from a specialist and live or are moving out-of-state and may be subject to discrimination and denial of care. Our staff spends significant amount of time calling providers in these areas to assess whether policies and practices are discriminatory.

Dated: 03/19, 2024 at Boston, Massachusetts.

Jordina Shanks
Interim Chief Executive Officer
Fenway Health