August 13, 2019
U.S. Department of Health and Human Services
Centers for Medicare and Medicaid; Office for Civil Rights (OCR); Office of the Secretary
Attention: Section 1557 NPRM, RIN 0945-AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

VIA ELECTRONIC SUBMISSION

Re: Comments on Notice of Proposed Rule on Nondiscrimination in Health and Health Education Programs or Activities

We are writing to express our deep concern and full opposition to the Notice of Proposed Rulemaking ("the proposed rule" or "the NPRM") on Nondiscrimination in Health and Health Education Programs or Activities, published by the Department of Health and Human Services ("HHS" or "the agency"), the Centers for Medicare and Medicaid Services ("CMS"), the Office for Civil Rights ("OCR"), and the Office of the Secretary on June 14, 2019.[1] The proposed rule harmfully targets women, pregnant people, and the LGBTQI community for discrimination on the basis of sex, and in so doing violates the Administrative Procedure Act (the "APA"), standards of constitutional law, and international human rights norms. We strongly urge the agency to withdraw this NPRM in its entirety.

Since 1992, the Center for Reproductive Rights has used the power of law to advance reproductive rights as fundamental human rights worldwide. Our litigation and advocacy over the past 26 years have expanded access to reproductive health care around the nation and the world. We have played a key role in securing legal victories in the United States, Latin America, Sub-Saharan Africa, Asia, and Eastern Europe on issues including access to life-saving obstetric care, contraception, safe abortion services, and comprehensive sexuality information. We envision a world where every person participates with dignity as an equal member of society, regardless of gender; where every woman is free to decide whether or when to have children and whether or when to get married; where access to quality reproductive health care is guaranteed; and where every woman can make these decisions free from coercion or discrimination.

As articulated below, this NPRM should be withdrawn in its entirety because:

- The NPRM violates the APA and is contrary to law.
- By eliminating the definition of "sex" and limiting enforcement mechanisms and remedies for patients experiencing discrimination on the basis of sex, the NPRM will embolden providers to deny care and harm individuals seeking necessary health care.
- The NPRM disregards human rights laws and principles.

I. The NPRM Violates the Administrative Procedure Act.

The proposed rule violates the APA on multiple grounds: HHS fails to justify the proposed rule based on underlying facts and data and fails to engage in an appropriate cost-benefit analysis,

[1] 84 Fed. Reg. 27,846 (June 14, 2019) (to be codified at 42 C.F.R. pts. 438, 440, and 460).

including by making no attempt to calculate or even consider patient harm. Moreover, the proposed rule is arbitrary, capricious, and not in accordance with law, because it obscures necessary definitions identifying discrimination on the basis of sex and inappropriately minimizes the scope of federal enforcement for such discrimination. For all of these reasons, HHS should withdraw the proposed rule in its entirety.

Under the APA, "agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "contrary to a constitutional right," or "in excess of statutory jurisdiction," shall be set aside.[2] An agency must provide "adequate reasons" for its rulemaking, in part by "examin[ing] the relevant data and articulat[ing] a satisfactory explanation for its action including a rational connection between the fact found and the choice made."[3] 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."[4] Ultimately, "a reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy."[5]

A. This Proposed Rule Is Not Justified by Underlying Facts and Data.

Executive Order 13563 requires that, when engaging in rulemaking, each agency make a "reasoned determination that [a regulation's] benefits justify its costs."[6] It also states that "each agency is directed to use the best available techniques to quantify anticipated present and future benefits and costs as accurately as possible."[7] But the proposed rule makes no attempt to conduct a reasoned cost-benefit analysis, instead first stating that it "cannot estimate" the impact of the proposed rule but later appearing to go on and do just that—without providing any factual basis for their analysis. For example, as stated in the NPRM itself, although past rulemaking "likely induced many covered entities to conform their policies and operations to reflect gender identity as protected classes under Title IX," HHS is uncertain about the total number of covered entities that would change their policies and grievance processes to reflect the understanding of sex discrimination set forth in the proposed rule.[8] Likewise, the proposed rule "lacks the data necessary to estimate the number of individuals who currently benefit from covered entities' policies governing discrimination on the basis of gender identity who would no longer receive those benefits as a consequence of the rule."[9] Instead, HHS attempts to justify this rulemaking with a convoluted cost-benefit analysis that weighs incalculable and incomprehensible quantities against each other. For example, the preamble confusingly attempts to weigh the so-called "intangible benefits" that covered entities would enjoy with increased freedom to adapt Section

[2] 5 U.S.C. § 706(2)(A).
[3] *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016) (citing *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 103 (1983)). Typically, a court will find an agency action to be arbitrary and capricious if the agency "has relied on 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." *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43 (internal citations omitted); *Envtl. Def. Fund, Inc. v. Costle*, 657 F.2d 275, 283 (D.C. Cir. 1981) ("While we are admonished from rubber stamping agency decisions as correct, our task is complete when we find that the agency has engaged in reasoned decision-making within the scope of its Congressional mandate.") (internal citations and quotations omitted).
[4] *Id.*; *see also Perez v. Mortgage Bankers Ass'n*, 135 S. Ct. 1199, 1209 (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).
[5] *See FCC v. Fox TV Stations, Inc.*, 556 U.S. 502, 519 (2009).
[6] Exec. Order No. 13563, 76 FR 3821 at Sec. 1(b) (Jan. 18, 2011).
[7] *Id.* at Sec. 1(c).
[8] 84 Fed. Reg. 27,876 (June 14, 2019).
[9] *Id.*

1557's compliance requirements against the "value of knowledge of civil rights," which the preamble describes as "difficult to quantify."[10]

The cost-benefit analysis omits entirely any mention of the significant costs the rule would impose on women and other patients who are denied access to care, despite well-documented research that shows the significant health care costs women experience when they face health care denials.[11] For example, there is no attempt to address the implications of deleting "termination of pregnancy" from the definition of "on the basis of sex," nor to quantify the costs to patients facing discrimination as a result of having a previous termination of pregnancy. However, a provider's refusal to provide a health care service, or other discriminatory conduct towards a patient, means that patient must then spend additional time and resources searching for another willing provider for health care. Such service denials result in delays for patients seeking a wide range of health care, including abortion care.

Delays have the effect of increasing the overall cost of an abortion,[12] as well as raising the cost of each step of obtaining an abortion. This includes not just the cost of the procedure, but also incidental costs such as being required to travel farther to obtain an abortion, thereby incurring additional travel and related expenses, such as lost wages and childcare.[13] As a result, health care denials that result in a delay in care can significantly drive up the cost of care for a woman seeking an abortion.

Health care refusals without adequate safeguards may also have negative consequences on the long-term socioeconomic status of women. A recent study in the American Journal of Public Health found that women who were denied a wanted abortion had higher odds of poverty six months after denial than did women who received abortions, and that women denied abortions were also more likely to be in poverty for four years following denial of abortion services.[14] The agency does not even attempt to quantify these broader medical, social, and economic costs that result from service refusals, and entirely fails to take these costs into account in justifying this NPRM.

Under this proposed rule, patients experiencing discrimination from providers on the basis of a *past* termination of pregnancy could also face discrimination in accessing a broad range of health care services. For example, a provider could turn away a potential patient after reviewing their medical history—even if the termination was years prior or if the patient is seeking unrelated services, such as allergy testing.

The proposed rule additionally eliminates Section 1557's private right of action allowing patients to sue covered entities for any and all alleged violations of the proposed rule. The cost-benefit analysis lacks any consideration or measurement of the significant costs of this deletion for individuals experiencing discrimination on the basis of sex in health care.[15] HHS fails to specify any benefits to removing the private right of action, or weigh those benefits against the costs

[10] *Id*.
[11] National Women's Law Center, *When health care providers refuse: The impact on patients of providers' religious and moral objections to give medical care, information or referrals* (Apr. 2009), https://www.nwlc.org/wp-content/uploads/2015/08/April2009RefusalFactsheet.pdf.
[12] Rachel K. Jones et al., Differences in Abortion Service Delivery in Hostile, Middle-Ground and Supportive States in 2014, WOMEN'S HEALTH ISSUES (2018), http://www.whijournal.com/article/S1049-3867(17)30536-4/abstract.
[13] Rachel K. Jones & Jenna Jerman, How Far Did US Women Travel for Abortion Services in 2008, 22 J. WOMEN'S HEALTH 706 (2013).
[14] Diana Greene Foster et al., Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States, 108 AM. J. PUB. H. 407 (2018), http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304247.
[15] 84 Fed. Reg. 27,883 (June 14, 2019).

imposed on individuals, who would be solely reliant on HHS to enforce Section 1557's protections.

Relatedly, the proposed rule fails to weigh the cost of compliance with the proposed changes to the language access requirements. Instead, the proposed rule weighs the cost of compliance under Section 1557's 2016 Final Rule (the "Final Rule") and, rather than proposing less drastic alternatives that would reduce the regulatory burden while improving language access and expanding awareness of the right to be free from discrimination in health care, entirely eliminates the requirements for multi-language tagline mailings and the issuances of non-discrimination notices.

B. The Proposed Rule Is Arbitrary, Capricious, and Contrary to Law.

The proposed rule is arbitrary, capricious, and contrary to law. Not only is the proposed rule inconsistent with recent HHS rulemaking and the agency's own mission, but the agency fails to consider the extensive history of health care discrimination that LGBTQI[16] individuals and individuals seeking reproductive care have experienced. The proposed rule further lacks reasoned explanations justifying HHS' policy reversals. Moreover, the proposed rule's position that sex discrimination does not encompass gender identity and sex stereotyping, and its failure to take a clear position on termination of pregnancy is contrary to civil rights laws, constitutional principles, congressional intent of the Patient Protection and Affordable Care Act ("ACA"), the plain language of Section 1557, and Section 1554 of the ACA.

1. The Proposed Rule Runs Contrary to HHS' Mission and the Agency's Own Arguments in Other Recent Rulemaking, and Creates Inconsistency and Confusion About Coverage of Its Rules.

By its own statement, HHS' mission is to "enhance the health and well-being of all Americans, by providing for effective health and human services."[17] But the proposed rule does not even attempt to address how allowing discrimination on the basis of gender identity, sex stereotyping and termination of pregnancy in the health care setting would preserve, much less enhance, the health and well-being of patients. It is well-documented that discrimination already limits access to services for more vulnerable populations. In the past, HHS' OCR has investigated numerous complaints from transgender patients about being denied certain health care services due to the patient's gender identity, ranging from routine to life-saving care.[18] In one such case, a transgender patient was denied a genetic screening for breast cancer because the insurer said the test was only for women, even though the screening was recommended by a doctor.[19]

The proposed rule further creates inconsistencies with HHS' recently finalized "Denial of Care" Rule, which expands federal denial of care laws beyond their intended scope and allows a dangerously broad range of health care entities and health care workers to deny care to patients.[20] In so doing, the agency exceeds its statutory authority.[21] In contrast, the proposed rule narrows

[16] This letter uses LGBTQI when appropriate as it is the most inclusive terminology; however, at times we use LGBTQ or LGBT to accurately reflect the cited reference.
[17] U.S. Department of Health and Human Services, *About HHS* (Mar. 26, 2018), https://www.hhs.gov/about/index.html.
[18] Dan Diamond, *Transgender patients' complaints to HHS show evidence of routine discrimination*, POLITICO (Mar. 7, 2018), https://www.politicopro.com/health-care/article/2018/03/transgender-patients-complaints-to-hhs-show-evidence-of-routine-discrimination-390755.
[19] *Id*.
[20] 84 Fed. Reg. 23,170 (May 21, 2019).
[21] *See* Complaint at 2, *County of Santa Clara v. U.S. Dep't of Public Health and Human Services*, No. 5:19-cv-02916 (N.D. Cal. May 28, 2019).

its scope of application of non-discrimination protections to the narrowest possible denominator—and falls short of its statutory authority in its interpretation of Section 1557. Neither rule prioritizes ensuring patients' access to care, in defiance of HHS' own mission. And as a result, both rules could encourage providers who wish to discriminate to do so while disregarding HHS' mission to ensure access to care.

Both the Denial of Care Rule and the proposed rule cover health programs that receive federal financial assistance. The Denial of Care Rule applies an expansive definition of "federal financial assistance" to include:

> (1) Grants and loans of Federal funds;
>
> (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, or at a consideration which is reduced for the purpose of assisting the recipient or in recognition of the public interest to be served by su ch sale or lease to the recipient; 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.[22]

By contrast, this NPRM does not offer a formal definition of federal financial assistance, instead describing it merely as including "credits, subsidies, or contracts of insurance" provided by HHS.[23] The Denial of Care Rule's expansive definition ensures that the scope of entities covered is as broad as possible, while the NPRM's description indicates that the agency will interpret federal financial assistance narrowly in the context of Section 1557 to cover a far smaller scope of entities. As a result, HHS plans to enforce protections against discrimination for a far smaller number of people, while simultaneously broadening the number of entities who are eligible to claim an exemption from Section 1557 and discriminate against their patients.

Similarly, the NPRM narrows covered "health program or activit[ies]" to include only entities that are "principally engaged in the business of health care" and specifically excludes "businesses principally or otherwise engaged in the business of providing health insurance"[24] unless those insurers receive federal financial assistance. As the NPRM explains in its preamble, this further narrows the application of the rule by limiting application of the nondiscrimination provisions to the portion of an entity's operations which receive Federal financial assistance, but not to the entity's entire operations.[25] As a result, the proposed rule would, for example, "generally not apply to short term limited duration insurance because, as the agency understands it, providers of Short Term Limited Duration Insurance ("STLDI") are either (1) not principally engaged in the business of health care, or (2) not receiving Federal financial assistance with respect to STLDI plans specifically."[26]

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[22] *Id*. at 23,264.
[23] 84 Fed. Reg. 27,891 (June 14, 2019).
[24] *Id.*
[25] *Id*. at 27,863.
[26] *Id*.

In doing so, the proposed rule limits application of its nondiscrimination provisions to a vastly narrower range of entities than the Denial of Care Rule covers. The Denial of Care Rule ensures a broad application of its denial of care provisions by determining that "health service program" includes the *provision or administration* of "*any* health or health-related services or research activities, health benefits, health or health-related insurance coverage, health studies, or *any other service related to health or wellness*, whether directly; through payments, grants, contracts, or other instruments; through insurance; or otherwise."[27] HHS has offered no reasoned explanation for these wildly different interpretations. In other words, the agency appears to have cherry-picked interpretations that tailor the scope of application of each rule to accommodate the apparent goal of limiting the application of nondiscrimination provisions and permitting widespread health care denials. This makes this rulemaking arbitrary and capricious.

2. The Proposed Rule Fails to Consider the History of Health Care Discrimination Experienced by LGBTQI Individuals.

HHS lacks support for its sudden departure from Section 1557's 2016 Final Rule's legal interpretation of the applicable civil rights laws. The NPRM provides no "reasoned explanation" for disregarding the extensive history of health care discrimination that LGBTQI individuals and individuals seeking reproductive care have suffered. For example, the Final Rule relied on research demonstrating the barriers confronted by LGBTQ individuals, including denials of medical treatment, lack of protection from gender identity discrimination, and challenges in obtaining health insurance coverage.[28] One such survey, cited by the Final Rule, found that a quarter of transgender individuals reported being subjected to harassment in medical settings.[29] The Final Rule also relied upon research finding that eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a doctor or other health care provider had refused to see them because of their actual or perceived sexual orientation in the year before the survey.[30] HHS received "many comments expressing anecdotal evidence of these statistics."[31]

Additional research further confirms the pervasiveness of these barriers. In a recent study, nearly one in five LGBTQ people, including 31 percent of transgender people, said that it would be very difficult or impossible to get the health care they need at another hospital if they were turned away.[32] That rate was substantially higher for LGBTQ people living in non-metropolitan areas, with 41 percent reporting that it would be very difficult or impossible to find an alternative provider.[33] Here, HHS provides no reasoned 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. This is arbitrary and capricious and particularly problematic because

[27] 84 Fed. Reg. 23,197 (May 21, 2019).
[28] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,375, 31,460 (May 18, 2016) (codified at 45 C.F.R. pt. 92).
[29] *Id.*
[30] *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.
[31] *Id.*
[32] 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.
[33] *Id.*

the clear congressional intent of the ACA was to expand health care coverage without discrimination.[34]

3. The Proposed Rule Fails to Provide a Reasoned Explanation for the Agency's Reversals in Policy.

The proposed rule is also arbitrary and capricious because HHS fails to provide a valid reasoned explanation for their reversals in policy.[35] The Final Rule underwent a thorough notice and comment process that allowed public input from a broad range of stakeholders at multiple points in the process. In 2013, OCR published a Request for Information to solicit input on issues arising under Section 1557. In 2015, the office issued a proposed rule and again invited comment by all interested parties. As HHS noted, the comments received represented a wide variety of stakeholders, including "civil rights/advocacy groups, including language access organizations, disability rights organizations, women's organizations, and organizations serving lesbian, gay, bisexual, or transgender (LGBT) individuals; health care providers; consumer groups; religious organizations; academic and research institutions; reproductive health organizations; health plan organizations; health insurance issuers; State and local agencies; and tribal organizations," as well as more than 20,000 individuals.[36] This diverse set of comments informed the Final Rule, which was issued in May of 2016.

The agency erroneously equates an explanation of the changes *between* past policies and the proposed rule with a required reasoned explanation *justifying* the NPRM. For example, although the proposed rule explains the differences between the Civil Rights Restoration Act of 1987 (the "CRRA") standard and the ACA standard implemented in the Final Rule, it fails to detail why the agency now believes the CRRA standard is more appropriate—which is particularly important, given that the ACA was enacted far more recently than the CRRA, and was explicitly not limited by Congress to CRRA limits.[37] Likewise, the NPRM proposes a reversion from Section 1557's Final Rule, which established a significantly broader scope for compliance than prior civil rights legislation—for example, requiring compliance from "all entities principally engaged in providing or administering health care or health insurance."[38] But in narrowing their interpretation of the scope of Section 1557, HHS makes no effort to justify their change through a reasoned analysis. Instead, the agency merely explains that past rulemaking was innovative and established a new precedent.[39] These deficits are arbitrary and capricious.

The agency also fails to justify broadening Section 1557's religious exemptions, and why HHS believes that change is appropriate now when it declined to do so previously.[40] Because past rulemaking implementing these policies relied heavily on public input, the failure to document the justification for these changed policy interpretations is arbitrary and capricious.

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[34] *Senate Debate on Health Care Reform Legislation*, C-SPAN (Dec. 19, 2009), https://www.c-span.org/video/?290819-9/senate-debate-health-care-reform-legislation.
[35] *Encino Motorcars*, 136 S. Ct. at 2125-26.
[36] 81 Fed. Reg. 31,376 (May 18, 2016).
[37] 84 Fed. Reg. 27,862. (June 14, 2019).
[38] *See id.* at 27,850.
[39] *Id.*
[40] The Final Rule stated, "Although some commenters urged us also to incorporate Title IX's blanket religious exemption into this final rule, we believe that applying the protections in the laws identified above offers the best and most appropriate approach for resolving any conflicts between religious beliefs and Section 1557 requirements….we decline to adopt commenters' suggestion that we import Title IX's blanket religious exemption into Section 1557." *See* 81 Fed. Reg. 31379-80 (May 18, 2016).

4. The Proposed Rule Is Contrary to Law and Constitutional Principles.

The proposed rule violates constitutional rights and will disadvantage women and LGBTQI individuals on the basis of sex. By removing explicit protections against discrimination on the basis of termination of pregnancy, gender identity, and sex stereotyping, the proposed rule runs contrary to longstanding civil rights laws and constitutional principles. Federal law prohibits discrimination on the basis of sex.[41] The Supreme Court has interpreted protections put in place by Congress to prohibit discrimination on the basis of sex in a number of ways, including employment,[42] pregnancy,[43] and education.[44]

a. The Proposed Rule's Position That Discrimination "On the Basis of Sex" *May* Include Only Certain Categories of "Termination of Pregnancy" Is Not Justified and Is Contrary to Law.

By removing Section 1557's previous definition of "sex" discrimination, the proposed rule purports to merely "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."[45] Instead, the proposed rule appears to deviate from longstanding rulemaking and regulatory precedent clearly establishing discrimination on the basis of pregnancy termination as a prohibited form of sex discrimination under Title IX.[46] Not only does the NPRM fail to "adopt a position on whether discrimination on the basis of termination of pregnancy can constitute discrimination on the basis of sex,"[47] but footnote 159 suggests that, if anything, OCR may investigate only certain pregnancy terminations ("such as discrimination on the basis of miscarriage or discrimination on the basis of medical complications resulting from a termination of pregnancy"[48]) as unlawful discrimination on the basis of sex. The proposed rule fails to justify this suggested change; however, the inclusion of this footnote foreshadows a potentially major shift to selectively enforce protections for pregnancy discrimination in a manner that is contrary to established law.

b. The Proposed Rule's Position That Sex Discrimination Does Not Encompass Sexual Orientation or Gender Identity Is Not Justified and Is Contrary to Section 1557, Title IX, and Title VII Case Law.

The proposed rule suggests that Section 1557's 2016 Final Rule "explicitly declined to include discrimination on the basis of sexual orientation" in the definition of discrimination on the basis of sex.[49] In fact, HHS declined to take a position on whether discrimination on the basis of sex encompasses sexual orientation in promulgating the Final Rule. The agency intentionally emphasized that prohibitions on sex-based discrimination "includ[e], at a minimum, sex discrimination related to an individual's sexual orientation where the evidence establishes that

[41] *See* 42 U.S.C. § 2000e-2(a); 20 U.S.C. § 1681.
[42] *See Johnson v. Transp, Auth.*, 480 U.S. 616 (1987); *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989).
[43] *See United Auto. Workers v. Johnson Controls*, 499 U.S. 187 (1991).
[44] *See No. Haven Bd. of Educ. v. Bell*, 456 U.S. 512 (1982); *Davis v. Monroe County Bd. Of Educ.* 526 U.S. 629 (1999).
[45] 84 Fed. Reg. 27,848 (June 14, 2019).
[46] 45 FR 30955, May 9, 1980, available at https://www2.ed.gov/policy/rights/reg/ocr/edlite-34cfr106.html#C.
[47] 84 Fed. Reg. 27,870, fn. 159 (June 14, 2019).
[48] *Id.*
[49] *Id.* at 27,847.

the discrimination is based on gender stereotypes." [50] However, in this proposed rule, HHS is actively taking the position that sex discrimination does not encompass sexual orientation and attempts to justify this reversal in policy by improperly relying on a pending federal district court decision: *Franciscan Alliance v. Azar*.

The proposed rule repeatedly cites the preliminary injunction issued by the Northern District of Texas in *Franciscan Alliance,* which prohibits HHS from enforcing the Final Rule's prohibitions against discrimination on the basis of gender identity or termination of pregnancy, as a basis for its decision to eliminate gender identity protections encompassed by the Final Rule. But the court has not ordered HHS to make any regulatory changes to Section 1557, nor has it issued a final decision on the merits in the case, which would be subject to appeal.[51] Simultaneously, the agency makes no attempt to discuss the many final decisions issued by district courts considering similar questions that granted relief to individuals who claimed discrimination on the basis of gender identity under Section 1557, nor to reconcile the pending litigation in *Franciscan Alliance* with this body of case law.[52] HHS cannot justify its proposed changes by relying on litigation positions in unsettled matters while failing to acknowledge the number of cases supporting the Final Rule's interpretation of sex discrimination prohibited by Section 1557.

The proposed rule additionally offers an incomplete and flawed analysis of the case law upholding prohibitions against discrimination on the basis of gender identity under Title IX and Title VII. The proposed rule states that "four appellate courts have addressed the issue" of whether to recognize gender identity discrimination claims under Title IX, but fails to explicitly acknowledge that all four cases cited held that transgender students may bring sex discrimination claims under Title IX.[53] Similarly, the NPRM briefly cites two cases to show a split among appellate courts "over the legal question whether discrimination on the basis of gender identity is prohibited by Title VII," but in so doing, mischaracterizes current law.[54] For example, the proposed rule misdescribes *Etsitty v. Utah Transit Authority*, including the following parenthetical for *Etsitty*: "Title IX does not prohibit gender identity discrimination."[55] That sentence, however, does not appear in *Etsitty* which instead said, "We assume, without deciding" that "a claim may extend Title VII protection to transsexuals who act and appear as a member of the opposite sex."[56]

The NPRM also lacks a complete legal analysis of Title VII's protections against discrimination on the basis of sex, further undermining HHS' attempted justifications for the proposed changes. A number of circuit courts have held that Title VII's protection against discrimination on the basis of sex encompasses gender identity and the EEOC has likewise issued decisions since 2012 holding discrimination on the basis of sex includes gender identity, change of sex, and/or

[50] 81 Fed. Reg. at 31,390 (May 18, 2016).
[51] *Franciscan Alliance v. Azar*, 227 F. Supp. 3d 660 (N.D. Tex. 2016).
[52] *See Flack v. Wis. Dep't of Health Servs.* 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).
[53] 84 Fed. Reg. 27,8855 (June 14, 2019). The cases at issue are *Doe ex rel. Doe v. Boyertown Area Sch. Dist.*, 893 F.3d 179 (3d Cir. 2018); *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034 (7th Cir. 2017); *G.G. ex rel. Grimm v. Gloucester Cnty. Sch. Bd.*, 82 F.3d 708 (4th Cir. 2016); *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217 (6th Cir. 2016).
[54] 84 Fed. Reg. 27,855 (June 14, 2019).
[55] *Id*.
[56] *Etsitty*, 502 F.3d at 1224.

transgender status.[57] These holdings have importance here because Title IX adopts the substantive and legal standards of Title VII, as the proposed rule acknowledges.

c. Discrimination "On the Basis of Sex" Encompasses Sex Stereotyping and Gender Identity Discrimination.

Gender identity is immutably tied to the protected characteristic of "sex" and cannot be divorced from sex discrimination. Title VII of the Civil Rights Act of 1964 established that it is unlawful for covered employers to discriminate against any individual "because of such individual's race, color, religion, sex, or national origin."[58] Discrimination based on sex stereotyping is encompassed within Title VII's prohibition on sex discrimination, as recognized by the Supreme Court.[59] In turn, a growing number of federal courts have held that sex stereotyping discrimination encompasses discrimination related to an individual's gender identity because such discrimination is based on a failure to conform to stereotypes associated with each sex.[60] Accordingly, Title VII's robust protections against sex discrimination include discrimination based on sex stereotyping and gender identity.

Likewise, Title IX confers a "full range of remedies" consistent with its broad intent to rectify sex discrimination.[61] Title IX was enacted by Congress to ensure that "no person in the United States shall, on the basis of sex, be…subjected to discrimination,"[62] and the Supreme Court has held that the language of Title IX is "broad" and "sweep[ing]."[63] Carving out exceptions from Title IX's protections against sex discrimination based on antagonism or indifference towards people who have terminated a pregnancy or LGBTQI individuals subverts the plain meaning of the statute. By removing explicit protections against discrimination on the basis of sex stereotyping, termination of pregnancy, and gender identity, HHS is seeking to depart from the plain meaning of both Title VII and Title IX.

Federal laws protect the right to be free from discrimination on the basis of sex as a statutory right. The agency's assertion in the proposed rule that state and local entities are better suited than the federal government to address issues of gender identity would undermine that right and is contrary to constitutional law principles. "Sex" is a protected characteristic subject to heightened scrutiny, including as it applies to gender identity, because of the extensive history of pervasive sex discrimination.[64] Protections for discrimination on the basis of sex are provided by *federal* law 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."[65] Whether or not you can be subject to discrimination cannot and should not be determined by

[57] *See Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005); *Rosa v. Parks W. Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000); *Schwenck v. Hartford*, 204 F.3d 1187 (9th Cir. 2000); *see also Macy v. Holder*, EEOC DOC 0120120821, 29012 WL 1435995 (E.E.O.C. Apr. 20, 2012).
[58] 42 U.S.C. § 2000e-2(a).
[59] *See Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989).
[60] *See Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008).
[61] *See Fitzgerald v. Barnstable Sch. Comm.*, 555 U.S. 246, 255 (2009).
[62] 20 U.S.C. § 1681.
[63] *See Jackson v. Birmingham Bd. Of Educ.*, 544 U.S. 156, 175 (2005) ("Title IX is a broadly written general prohibition on discrimination"); *No. Haven Bd. Of Educ. V. Bell*, 456 U.S. 512, 521 (1982) (stating that Title IX must be accorded a "sweep as broad as its language").
[64] *United States v. Virginia et al.*, 518 U.S. 515 (1996).
[65] *Cannon v. Univ. of Chicago*, 441 U.S. 677, 708 (1979) (citing *Steffel v. Thompson*, 45 U.S. 452, 463 (1974)).

where you happen to live, and the agency's suggestion to the contrary runs counter to this longstanding principle. Therefore, the proposed rule should be withdrawn in its entirety.

d. The Proposed Rule Is Contrary to Congressional Intent and the Plain Language of Section 1557, Short of Statutory Rights, and Violates Section 1554 of the ACA.

The ACA had a transformative impact on all aspects of health care, increasing the scope of benefits and improving access to coverage for millions of Americans. In passing the ACA, Congress understood and explicitly intended to "make[] access to quality health care a right for every American" and to "end discrimination in health care."[66] The proposed rule falls short of this stated intent, instead facilitating discrimination over health care protections for LGBTQI individuals and people who have terminated pregnancies.

The proposed rule likewise contradicts the plain statutory text of Section 1557 by improperly narrowing the scope of application to health care programs and activities administered by executive agencies. The statute states that its provisions shall apply 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."[67] Because the ACA explicitly did not adopt the limits expressed in the CRRA, and because the ACA was expressly intended to expand insurance access to individuals experiencing discrimination not otherwise addressed in existing civil rights laws,[68] the statutory text of the ACA should be read broadly. But the proposed rule would limit application of Section 1557 to the specific operations and lines of business for which insurers receive federal financial assistance, making compliant insurance increasingly less available.[69] HHS' proposed narrowing denies plan holders of such insurers necessary and important protections in contradiction to the agency's authority delegated by Congress, and thus proposes to limit the scope of application in a manner short of the agency's statutory authority to act.

Further, the proposed rule is contrary to law because it "creates unreasonable barriers to the ability of individuals to obtain appropriate medical care" by encouraging denials of care, thereby "imped[ing] timely access to health care services" in violation of Section 1554 of the ACA.[70] Section 1554 forbids the Secretary of HHS from promulgating "any regulation" that "creates unreasonable barriers to the ability of individuals to obtain appropriate medical care," "impedes timely access to health care services," and "limits the availability of health care treatment for the full duration of a patient's medical needs." The NPRM fails to address the requirements of Section 1554 and provides no reasoned explanation for the proposed limits ignoring that the proposed rule will create unreasonable barriers to medical care in violation of Section 1554.

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[66] *Senate Debate on Health Care Reform Legislation*, C-SPAN (Dec. 19, 2009), https://www.c-span.org/video/?290819-9/senate-debate-health-care-reform-legislation.
[67] 81 Fed. Reg. 31,375-76 (May 18, 2016).
[68] Congress saw that "[t]his fundamental inequity in the current system is dangerous and discriminatory." 155 CONG. REC. S12027 (daily ed. Dec. 1, 2009) (statement from Senator Gillibrand); *see also* 156 CONG. REC. H1711 (daily ed. Mar. 19, 2010) (statement of Rep. Speier) ("[W]omen have been discriminated against [in the health insurance system] for decades . . . .").
[69] *See* 84 Fed. Reg. 27,850 (June 14, 2019).
[70] 42 U.S.C. § 18114.

II. The Proposed Rule Will Likely Cause Harm, Reduce Access to Necessary Health Care, Encourage Discrimination on the Basis of Sex, and Will Create Confusion in Implementation.

Though prior notice and comment periods clearly documented the need for agency guidance interpreting Title IX's statutory protections against discrimination based on sex,[71] the proposed rule removes Section 1557's established definition of "sex" without proposing a subsequent replacement as guidance for compliance and enforcement. Instead, the proposed rule may create confusion about the limitations of statutory protections against discrimination based on termination of pregnancy. In a footnote in the preamble to the proposed rule, HHS states that "[a]lthough this proposed rule does not adopt a position on whether discrimination on the basis of termination of pregnancy can constitute discrimination on the basis of sex, it does not mean that OCR could not consider such claims of discrimination, such as discrimination on the basis of miscarriage or discrimination on the basis of medical complications resulting from a termination of pregnancy."[72] In this proposed rule, HHS specifically declines to provide clarity and instead hints that discrimination on the basis of termination of pregnancy that is the result of an abortion may *not* be subject to investigation and enforcement—sending a message that providers can engage in sex discrimination with impunity.

Similarly, the NPRM clearly indicates an intention to eliminate prohibitions on gender-based discrimination for the transgender and non-binary communities by deleting explicit protections for sex stereotyping and gender identity. Instead, the NPRM elects to merely refer back to the language of the Title IX statute, which does not define "on the basis of sex."[73] Non-binary individuals are entirely absent from the proposed rule's analysis, despite the fact that this NPRM will likely impact the non-binary community negatively due to discrimination on the basis of gender identity.[74]

Although removing the definition of sex will not permit discrimination based on sex stereotyping, gender identity, or termination of pregnancy, all of which inherently revolve around immutable "sex" characteristics that are statutorily protected, HHS appears to nonetheless be signaling permission to discriminate against the LGBTQI community and people who have terminated their pregnancies by messaging no interest in or intent to enforce sex discrimination protections involving sex stereotyping, gender identity or termination of pregnancy.

The NPRM asserts that this revision better aligns with inter-agency policies about the limitations of prohibitions against discrimination based on sex,[75] though it is in fact inconsistent with other agency interpretations of other civil rights laws and with the principles of protections for civil rights generally. Other agencies have taken enforcement actions and issued guidance on

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[71] 81 Fed. Reg. 31,386 (May 18, 2016).
[72] 84 Fed. Reg. 27,870, fn. 159 (June 14, 2019).
[73] *See* 81 Fed. Reg. 31,384 (May 18, 2016). Non-binary people are "people whose gender is not male or female." This includes people who "have a gender that blends elements of being a man or a woman, or a gender that is different than either male or female," and people who "don't identify with any gender." *See Understanding Non-Binary People: How to Be Respectful and Supportive*, NATIONAL CENTER FOR TRANSGENDER EQUALITY (Oct. 5, 2018), https://transequality.org/issues/resources/understanding-non-binary-people-how-to-be-respectful-and-supportive.
[74] *See* Shabab Ahmed Mirza & Caitilin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, CENTER FOR AMERICAN PROGRESS (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/; *Fact Sheet: Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS*, NATIONAL WOMEN'S LAW CENTER, May 2014, http://www.nwlc.org/sites/default/files/pdfs/lgbt_refusals_factsheet_05-09-14.pdf (citing *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV*, LAMBDA LEGAL (2010), http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf).
[75] 84 Fed. Reg. 27,851-52 (June 14, 2019).

interpreting Title IX's protections against discrimination based on sex.[76] Congress enacted Title IX, the ACA, and other civil rights laws to ensure protections against discrimination based on sex and this proposed rule contravenes those intended protections.

If enacted, this change will likely cause immediate and dramatic harm to vulnerable patients who have historically faced staggering rates of discrimination in health care.

A. The Proposed Rule Will Likely Increase Abortion Stigma and Result in Increased Harm to Women and Other Pregnant People.

The proposed rule, rather than clarifying patient protections or provider obligations under the law, creates confusion about whether a patient's termination of pregnancy is a permissible basis for discrimination.

HHS proposes to remove the Final Rule's definition of "sex" which explicitly protected against discrimination on the basis of termination of pregnancy—but Title IX's protections nevertheless still prohibit such discrimination.[77] Title IX states, "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance."[78] Longstanding regulatory guidance and rulemaking conducted by the Department of Education in their implementation of Title IX clearly maintains that discrimination based on "termination of pregnancy" is discrimination on the basis of sex. For example, regulations effectuating Title IX in 1975 explicitly prohibit sex discrimination on the basis of "pregnancy, childbirth, false pregnancy, termination of pregnancy, or recovery therefrom."[79]

The proposed rule ignores this precedent, and instead attempts to suggest that the impact of this new rulemaking should be a broadening of exemptions for discrimination on the basis of termination of pregnancy.

In addition, the preamble to the proposed rule sows confusion by stating that even though the agency is engaging in proposed rulemaking, it "does not adopt a position on whether discrimination on the basis of termination of pregnancy can constitute discrimination on the basis of sex," and goes on to confusingly say that "does *not* mean that OCR could not consider such claims of discrimination, such as discrimination on the basis of miscarriage or discrimination on the basis of medical complications resulting from a termination of pregnancy."[80] Engaging in proposed rulemaking that muddies, rather than clarifies individual's rights and HHS' enforcement authority is poor policymaking. The proposed rule provides no clear guidelines on this issue.

There are serious physical and socioeconomic consequences for patients who are denied a wanted abortion. A recent study following participants for five years found that women who were denied wanted abortions and gave birth had statistically poorer long-term health outcomes

[76] See Dep't. of Educ., Office for Civil Rights, Questions and Answers in Title IX and Single Sex Elementary and Secondary Classes and Extracurricular Activities (2014); Dep't. of Educ. and Dep't. of Just. joint Dear Colleague Letter on Transgender Students (May 13, 2016) (Title IX guidance).
[77] 20 U.S.C. § 1681.
[78] *Id.*
[79] 45 FR 30955, May 9, 1980, available at https://www2.ed.gov/policy/rights/reg/ocr/edlite-34cfr106.html#C.
[80] 84 Fed. Reg. 27,870, fn. 159 (June 14, 2019) (emphasis added).

than women who received their abortions.[81] Women denied abortion services are more likely to experience serious complications from the end of pregnancy including eclampsia and death; more likely to stay tethered to abusive partners; more likely to suffer anxiety and loss of self-esteem in the short term after being denied abortion; and less likely to have aspirational life plans for the coming year.[82] In contrast, women who received an abortion were 50 percent more likely to set an aspirational plan and achieve it—such as finishing their education, getting a better job, giving a good life to their children, being more financially stable—compared to women who were denied an abortion.[83] Neither the preamble nor the regulatory impact analysis make any attempt to quantify these costs or impacts.

Abortion access is a fundamental health care need, and it is wholly inappropriate for HHS, whose mission is to ensure that Americans can get the health care they need, to propose regulations advancing ideology and stigma at the expense of patient health. Patient access to care is likely to suffer as a direct result of this rulemaking: in a 2012 national survey, 17 percent of pregnant persons reported believing their regular health care provider would treat them differently if they knew their patients had had an abortion.[84] Such discrimination goes far beyond the denial of abortion services: the proposed rule appears to permit a provider to single out patients whose medical histories document past abortion care—or even to go so far as to deny post-abortion care to a patient experiencing subsequent complications.

We strongly oppose the proposed rule's attempt to cloud the protections against discrimination based on termination of pregnancy.

B. The NPRM Will Have Significant Harmful Impacts on the LGBTQI Community.

The language of the proposed rule's preamble implies that HHS will not enforce any discrimination on the basis of gender identity, even though there is clear case law that gender identity discrimination is sex discrimination.[85] A growing number of federal courts have recognized that sex stereotyping discrimination encompasses discrimination connected to an individual's gender identity.[86] Yet the proposed rule also erases protections against sexual orientation and gender identity discrimination in ten other Medicaid, private insurance, and education program regulations unrelated to Section 1557.[87]

The proposed rule will be devastating to LGBTQI individuals, who already face discrimination, delays, and denials in accessing the health care they need. A 2017 nationally representative survey found that eight percent of lesbian, gay, bisexual, and queer people and 29 percent of

[81] 27% of women who gave birth reported fair or poor health compared with 20% of women who had first-trimester abortion and 21% who had second-trimester abortion. *See* Lauren J. Ralph, Eleanor Bimla Schwarz, Daniel Grossman, & Diana Greene Foster, Self-reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study, *Annals of Internal Medicine* (2019), https://annals.org/aim/article-abstract/2735869/self-reported-physical-health-women-who-did-did-terminate-pregnancy.
[82] Turnaway Study, Advancing New Standards in Reproductive Health, https://www.ansirh.org/research/turnaway-study.
[83] Ushma Upadhyay, M. Antonia Biggs, & Diana Greene Foster, The effect of abortion on having and achieving aspirational one-year plans, 15 BMC WOMEN'S HEALTH 102 (2015).
[84] Shellenberg KM, Tsui AO. Correlates of perceived and internalized stigma among abortion patients in the USA: an exploration by race and Hispanic ethnicity. 118 Int. J. Gynecol. Obstet. S152, S154 (2012).
[85] 84 Fed. Reg. 27,848-49 (June 14, 2019).
[86] *See Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005); *Rosa v. Parks W. Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000); *Schwenck v. Hartford*, 204 F.3d 1187 (9th Cir. 2000).
[87] 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.

transgender people reported that a doctor or other health care provider had refused to see them because of their actual or perceived sexual orientation in the year before the survey.[88] When transgender people are able to access care, 33 percent report being harassed, denied care, or even assaulted by health care professionals.[89] Additionally, LGBT individuals have reported "that health care professionals have used harsh language towards them, refused to touch them or used excessive precaution, or blamed the individuals for their health status."[90]

The proposed rule will only increase the number of LGBTQI individuals who are discouraged from seeking care because of the discrimination they experience in the health care setting.[91] Under the proposed rule, a provider could deny care to a transgender person just because they are transgender, regardless of whether they were seeking services that have anything to do with their transgender status. Fourteen percent of lesbian, gay, bisexual, and queer individuals who experienced discrimination on the basis of their sexual orientation or gender identity in the past year avoided or postponed needed medical care.[92] In a 2015 national survey, nearly one-quarter of transgender individuals reported delaying or avoiding medical care when sick or injured, at least partially due to medical providers' discrimination and disrespect.[93]

Finding another doctor is not possible for all LGBTQI patients who experience discrimination in accessing health care. In a 2017 nationally representative survey, nearly one in five LGBTQ people, including 31 percent of transgender people, said that it would be very difficult or impossible to get the health care they need at another hospital if they were turned away.[94] That rate was substantially higher for LGBTQ people living outside of metropolitan areas, with 31 percent reporting that it would be very difficult or impossible to find an alternative provider.[95] There is also a long history of the LGBTQI community experiencing discrimination in accessing the medication they need from pharmacies. The same survey found that eight percent of LGBTQ people, including 16 percent of transgender people, reported it would be very difficult or impossible to find the same type of service they need at a different pharmacy.[96]

Further, the proposed rule will cause harm to intersex individuals. The proposed rule eliminates prohibitions on discrimination that would protect from discrimination based on "the presence of atypical sex characteristics and intersex traits" in the removal of Section 1557's definition of "sex."[97] Intersex individuals make up 1.7 percent of the world population.[98] Adults with intersex

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[88] *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.

[89] *Fact Sheet: Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS,* NATIONAL WOMEN'S LAW CENTER, May 2014, http://www.nwlc.org/sites/default/files/pdfs/lgbt_refusals_factsheet_05-09-14.pdf (citing *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV*, LAMBDA LEGAL (2010), http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf).

[90] *Id.*

[91] The Final Rule considered the discrimination LGBT individuals experience in the health care context and the negative health consequences of such discrimination. *See* 81 Fed. Reg. 31,460 (May 18, 2016).

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

[93] *The Report of the 2015 U.S. Transgender Survey*, NATIONAL CENTER FOR TRANSGENDER EQUALITY (Dec. 2016), http://www.ustranssurvey.org/reports.

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

[95] *Id.*

[96] *Id.*

[97] 84 Fed. Reg. 27,855 (June 14, 2019).

[98] 81 Fed. Reg. 31,375, 31,389 (May 18, 2016).

conditions report facing discrimination in health care settings and denial of care once their atypical anatomy is known.[99] Studies have shown that up to 80 percent of intersex patients have changed their care based on discomfort with their medical providers.[100]

The proposed rule contains no guidance on enforcement of discrimination on the basis of gender identity. The preamble suggests that HHS will not enforce anti-discrimination laws that prohibit discrimination on the basis of gender identity and sex stereotyping, implying that at best HHS will be enforcing such discrimination based on how the case law evolves.[101]

C. The Proposed Rule's Explicit Incorporation of Federal Refusal Laws Will Likely Encourage More Provider Discrimination On the Basis of Sex.

We oppose the proposed rule's unnecessary integration of religious and moral refusal laws, since it will likely operate to deny access to care. When implemented without balancing against the best interest of patients, religious and moral refusal laws can be and have been exploited to limit access or deny care, particularly in the field of reproductive health care.[102] Services that health care providers and entities have refused to provide include access to safe pregnancy termination, miscarriage management, and contraception, which are all necessary to ensure women's health and wellbeing.

Recently, HHS finalized a regulation that would vastly expand the scope of a number of denial of care laws, including the Church, Coats-Snowe and Weldon amendments, which are incorporated here.[103] That new final rule could empower health care workers to deny medical care from any patient based on personal beliefs, and incentivize facilities to cease offering contraception, abortion and LGBTQI-focused care for fear of losing federal funding.

While an objecting provider presents an obstacle to any patient, it may impose a particularly challenging burden on marginalized individuals. Economically disadvantaged women, rural women, and LGBTQI individuals already face barriers to care, including limited financial means, language and cultural differences, medical providers' unconscious biases, historic discrimination, and geography.[104] A health care provider's religiously motivated refusal to provide care may force a patient to choose between foregoing health care or taking on the often substantial and sometimes insurmountable burden of locating and traveling to a non-refusing provider.

Explicitly incorporating the statutes that the Denial of Care Rule purports to interpret will, we fear, be taken to incorporate the Denial of Care Rule. This dangerous regulation would further encourage providers who wish to discriminate to do so, contrary to the intent of Section 1557, which intends to eliminate, not encourage or tolerate, discrimination.

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[99] *Providing Ethical and Compassionate Health Care to Intersex Patients: Intersex-Affirming Hospital Policies*, INTERACT & LAMBDA LEGAL (2018), https://www.lambdalegal.org/sites/default/files/publications/downloads/resource20180731hospital-policies-intersex.pdf.
[100] *Id.*
[101] 84 Fed. Reg. 27,855 (June 14, 2019).
[102] *See, e.g.*, Julia Kaye et al., *Health Care Denied: Patients and physicians speak out about Catholic hospitals and the threat to women's health and lives*, ACLU (May 2016), https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied.
[103] Implementation of the Denial of Care Rule, 84 Fed. Reg. 23,170 (May 21, 2019), is enjoined until November 22, 2019. *See County of Santa Clara v. U.S. Dep't of Public Health and Human Services*, No. 3:19-cv-02916 (N.D. Cal. July 2, 2019).
[104] *Committee Opinion No. 516: Health Care Systems for Underserved Women*, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (Jan. 2012), http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-Systems-for-Underserved-Women.

D. The Proposed Rule Will Create Confusion in Implementation.

The proposed rule acknowledges that there is little clarity as to implementation of the proposed rule. The preamble to the NPRM anticipates that "50 percent of covered entities would modify their policies and procedures" to reflect the proposed clarification of the application of Section 1557, but provides no basis for that estimation nor analysis as to which entities are likely to adopt modifications.[105] Because the proposed rule affects a "wide range of types and sizes of covered entities, from complex multi-divisional hospitals to small neighborhood clinics and physician offices," the impact of this rule has the potential to dramatically destabilize health care access across the country, depending on the entities electing to modify their policies. It is premature and inappropriate for HHS to propose such a change without a significantly improved understanding of the impact of the proposed rule's implementation.

Further, patients will likely struggle to determine whether their health care providers and insurers will continue to offer access to needed services—and, in some cases, whether their providers will continue to treat them without discriminating. Access could well differ within states and from provider to provider, further complicating patient access.

The rule fails to provide any clear guidance as to how the agency plans to interpret and enforce the law with regards to sex discrimination. Without additional clarity about how the agency intends to enforce the law and lacking clear benchmarks for compliance, provider liability will be broadly unknown and variable. Providers and other entities unclear on implementation requirements and compliance best practices may thus be perversely incentivized to err on the side of permitting restricted care at the expense of patient health.

III. Narrowing the Scope of Section 1557's Anti-Discrimination Protections Is Counter to Human Rights Principles.

A. International Human Rights Law Prohibits Discrimination On the Basis of Sex, Including Discrimination Based on Termination of Pregnancy, Sex Stereotyping, and Gender Identity.

Human rights are based in the principles of universality and non-discrimination, as set forth in the Universal Declaration of Human Rights (UDHR): "all human beings are born free and equal in dignity and rights."[106] Equality and non-discrimination are core principles of international human rights law. Non-discrimination is a crucial obligation for all core human rights treaties, including the International Covenant on Civil and Political Rights (ICCPR),[107] which the United

[105] 84 Fed. Reg. 27,885 (June 14, 2019).
[106] Universal Declaration of Human Rights, *adopted* Dec. 10, 1948, art. 1, 2, G.A. Res. 217A (III), U.N. Doc. A/810 at 71 (1948).
[107] International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, art. 2, 26, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter ICCPR].

States ratified in 1992,[108] and the Covenant on Economic, Social and Cultural Rights (ICESCR).[109]

By incorporating a broad definition of "on the basis of sex" to include prohibitions on discrimination based on pregnancy, false pregnancy, termination of pregnancy, gender identity, and sex stereotyping, the Final Rule's interpretation of sex-based discrimination advanced international human rights principles. The proposed rule attempts to roll back these critical protections.

First, human rights protect against discrimination based on pregnancy-related status.[110] Human rights experts have expressed particular concern over discrimination on the basis of termination of pregnancy. The Special Rapporteur on the right to health has found that marginalization and vulnerability of individuals resulting from abortion-related discrimination perpetuates and intensifies violations of the right to health.[111] The Committee on the Elimination of Discrimination Against Women (CEDAW Committee) has also expressed concern over discrimination against individuals seeking abortion services.[112] And the UN Working Group on the issue of discrimination against women in law and practice has called on states to ensure the right of pregnant women to access abortion services by "provid[ing] nondiscriminatory health insurance coverage for women" and "exercis[ing] due diligence to ensure that the diverse actors and corporate and individual health providers who provide health services or produce medications do so in a non-discriminatory way."[113]

Human rights also protect against discrimination based on sex stereotypes, and treaty bodies likewise emphasize the prohibition on such discrimination.[114] Indeed, human rights require states

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[108] *Status of Ratification Interactive Dashboard*, OHCHR, http://indicators.ohchr.org/ (last visited July 31, 2019). Article 26 of the ICCPR establishes equality before the law and forbids discrimination "on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status." ICCPR, *supra* note 69, art. 26. This list is deliberately not exhaustive, and the Human Rights Committee and other bodies have affirmed "other status" encompasses sexual orientation and gender identity. United Nations High Commissioner for Human Rights, *Discriminatory Laws and Practices and Acts of Violence Against Individuals Based on Their Sexual Orientation and Gender Identity*, para. 7, U.N. Doc. A/HRC/19/41 (Nov. 17, 2011) [hereinafter UNHCHR, *Discriminatory Laws and Practices*].

[109] International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 2, para 2, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3 (*entered into force* Jan. 3, 1976) [hereinafter ICESCR]. While the U.S. has not ratified ICESCR, it is a signatory and therefore has an obligation to refrain from acting against the intent of the treaty. Vienna Convention on the Law of Treaties, *adopted* May 23, 1969, art. 18, 1155 U.N.T.S. 331, 8 I.L.M. 679 (*entered into force* Jan. 27, 1980). *See also* Michael H. Posner, Assistant Secretary, Bureau of Democracy, Human Rights, and Labor, Address to the American Society of International Law (Mar. 24, 2011), https://2009-2017.state.gov/j/drl/rls/rm/2011/159195.htm (noting that while the United States is not a party to the International Covenant on Economic, Social and Cultural Rights, "as a signatory, we are committed to not defeating the object and purpose of the treaty").

[110] Committee on Economic, Social and Cultural Rights, *General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, para. 5, U.N. Doc. E/C.12/GC/22 (2016) [hereinafter ESCR Committee, *Gen. Comment No. 22*]; Committee on Economic, Social and Cultural Rights, *General Comment No. 20 Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights)*, para. 10(a), U.N. Doc. E/C.12/GC/20 (2009) [hereinafter ESCR Committee, *Gen. Comment No. 20*].

[111] Special Rapporteur of the Human Rights Council on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, para. 34, U.N. Doc. A/66/254 (2011) (by Anand Grover).

[112] CEDAW Committee, *Concluding observations on the eighth periodic report of Australia*, para. 49(a), U.N. Doc. CEDAW/C/AUS/CO/8 (2018).

[113] Working Group on the issue of discrimination against women in law and in practice, *Women's Autonomy, Equality and Reproductive Health in International Human Rights: Between Recognition, Backlash and Regressive Trends*, OHCHR 7 (2017), https://www.ohchr.org/Documents/Issues/Women/WG/WomensAutonomyEqualityReproductiveHealth.pdf.

[114] Convention on the Elimination of All Forms of Discrimination Against Women, *adopted* Dec. 18, 1979, art. 5(a), G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1980), U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW]; CEDAW Committee, *General recommendation No.28 on the core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women*, para. 9, U.N. Doc. CEDAW/C/GC/28 (2010) [hereinafter CEDAW Committee, *Gen. Recommendation No. 28*]; CEDAW Committee, *General Recommendation No. 33 on women's access to justice*, para. 7, U.N. Doc. CEDAW/C/GC/33 (2015); *see also* ESCR Committee, *General comment No. 20*, *supra* note 72 at para. 20; Convention on the Rights of Persons

to ensure that reproductive health services, in particular, are provided in a manner that does not promote or exacerbate harmful gender stereotypes and assumptions.[115]

Finally, human rights protect against discrimination on the basis of gender identity. As the UN High Commissioner for Human Rights has affirmed, "[a]ll people, including lesbian, gay, bisexual and transgender (LGBT) persons are entitled to enjoy the protections provided for by international human rights law, including . . . the right to be free from discrimination."[116] Human rights treaty bodies have affirmed the right to non-discrimination based on gender identity,[117] including with respect to sexual and reproductive health.[118] The UN High Commissioner for Human Rights has identified discrimination in health care as an area in which individuals are particularly susceptible to discriminatory treatment, marginalization, and restriction in their enjoyment of rights because of sexual orientation or gender identity.[119]

Countries have an obligation to both ensure that their own laws and policies do not discriminate against people based on sexual orientation and gender identity and also ensure that legal frameworks provide protection against discrimination by third parties. The High Commissioner recommends that governments enact comprehensive anti-discrimination legislation that includes prohibitions on discrimination based on sexual orientation and gender identity.[120]

B. International Human Rights Law Requires the Government to Ensure That Health Care Personnel's Refusals to Provide Health Care on Grounds of Religious or Moral Objection Do Not Jeopardize Access to Reproductive Health Care.

The proposed rule's incorporation of federal refusal laws will encourage more provider discrimination, contrary to human rights norms. Under international human rights law, religious freedom cannot justify infringement on the human rights of others, including women and LGBTQI individuals. [121]

The UN Special Rapporteur on Freedom of Religion or Belief has specifically mentioned "the denial of access to reproductive health services" as an example of an impermissible infringement

with Disabilities, *adopted* Dec. 13, 2006, art. 8, para. 1(b), G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611 (1980) (*entered into force* May 3, 2008).

[115] CEDAW, *supra* note 76, art. 2(f), 5(a), 12; L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, 9, U.N. Doc. CEDAW/C/50/D/22/2009 (2011). *See also* Simone Cusack, *Gender Stereotyping as a Human Rights Violation*, OHCHR Women's Rts & Gender 51-53 (2013), https://www.ohchr.org/Documents/Issues/Women/WRGS/2013-Gender-Stereotyping-as-HR-Violation.docx.

[116] UNHCHR, *Discriminatory Laws and Practices*, *supra* note 70, para. 5.

[117] Human Rights Committee, *General comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life*, para. 61, U.N. Doc. CCPR/C/GC/36 (2018); ESCR Committee, *Gen. Comment No. 20*, *supra* note 72, para. 32; Committee on the Rights of the Child, *General Comment No. 13 The right of the child to freedom from all forms of violence*, para. 60, 72(g), U.N. Doc. CRC/C/GC/13 (2011); Committee against Torture, *General Comment No. 2 Implementation of article 2 by States parties*, para. 21, U.N. Doc. CAT/C/GC/2 (2008); CEDAW Committee, *Gen. Recommendation No. 28*, *supra* note 76, para. 18; *see also* UNHCHR, *Discriminatory Laws and Practices*, *supra* note 70, para. 16 (noting that "[i]n their general comments, concluding observations and views on communications, human rights treaty bodies have confirmed that States have an obligation to protect everyone from discrimination on grounds of sexual orientation or gender identity").

[118] ESCR Committee, *Gen. Comment. No.* 22, *supra* note 72, para. 2.

[119] UNHCHR, *Discriminatory Laws and Practices*, *supra* note 70, para. 50, 54-57.

[120] *Id.* at para. 84(e); *see also* ESCR Committee, *Concluding Observations: Germany*, para. 26, U.N. Doc. E/C.12/DEU/CO/5 (2011).

[121] Special Rapporteur on Freedom of Religion or Belief**,** *Interim Rep. of The Special Rapporteur on Freedom of Religion or Belief*, para. 46, U.N. Doc. A/72/365 (Aug. 28, 2017) (by Ahmed Shaheed).

on women's rights,[122] and has expressed concern over the use of "religious liberty" being used to justify the refusal of providing goods and services to women and LGBTQI individuals.[123]

Human rights requires that where refusal of care based on religious or conscience belief is permitted, it does not infringe on others' access to health care.[124] They require the government to ensure that health care personnel's refusal to provide reproductive health care, including abortion care, on grounds of conscience does not jeopardize women's access to reproductive health care.[125]

UN human rights experts have noted the United States' particular obligations in this regard. At the conclusion of its 2015 fact-finding visit to the United States, the UN Working Group on Discrimination Against Women reiterated that:

> Refusal to provide sexual and reproductive health services on the grounds of religious freedom should not be permitted where such refusal would effectively deny women immediate access to the highest attainable standard of reproductive health care and affect the implementation of rights to which they are entitled under both international human rights standards and domestic law.[126]

C. The Proposed Regulation Represents a Retrogression of Rights.

By narrowing the scope of protections against discrimination on the basis of sex, the proposed rule will result in a retrogression of rights. This is contrary to core international human rights principles.

Retrogression is a backwards step in law or policy that impedes or restricts the enjoyment of a right. The principle against retrogression is premised on the obligation of governments to ensure constant forward progress in realizing rights.[127] In the context of sexual and reproductive health, in particular, the Committee on Economic, Social and Cultural Rights (the Committee overseeing implementation of International Covenant on Economic, Social and Cultural Rights, ICESCR) has provided specific examples of measures which would be retrogressive.[128] These include "legal and policy changes that reduce oversight by States of the obligation of private actors to respect the right of individuals to access sexual and reproductive health services."[129]

IV. Conclusion

For the aforementioned reasons, HHS should immediately withdraw the proposed rule.

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[122] *Id.* at para. 24.
[123] *Id.* at para. 37.
[124] ESCR Committee, *Gen. Comment. No.* 22, *supra* note 72, para. 14.
[125] *Id.* at para. 43, 45; CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, para. 11, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008); *see also* CEDAW Committee, *Concluding Observations: Croatia*, para. 31(a), U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015); Human Rights Committee, *Concluding Observations: Poland*, para. 23-24, U.N. Doc. CCPR/C/POL/CO/7 (2016).
[126] UNHCHR, *Discriminatory Laws and Practices*, *supra* note 70, para. 71, 95(i).
[127] ICESCR, *supra* note 71, art. 2, para. 1.
[128] ESCR Committee, *Gen. Comment No. 22*, *supra* note 72, para. 38.
[129] *Id.* Other examples of retrogressive measures include the removal of sexual and reproductive health medications from national drug registries; laws or policies revoking public health funding for sexual and reproductive health services; imposition of barriers to information, goods and services relating to sexual and reproductive health; and enacting laws criminalizing certain sexual and reproductive health conduct and decisions.

We appreciate the opportunity to comment on this NPRM. If you require any additional information about the issues raised in this letter, please contact Katherine Gillespie, Senior Federal Policy Counsel, at kgillespie@reprorights.org.

Signed,

The Center for Reproductive Rights