October 3, 2022

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-AA17
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

VIA ELECTRONIC SUBMISSION

Re: Comments on Notice of Proposed Rulemaking on Nondiscrimination in Health Programs and Activities (RIN 0945-AA17)

The Center for Reproductive Rights respectfully submits the following comment on the Notice of Proposed Rulemaking ("the proposed rule" or "NPRM") on Nondiscrimination in Health Programs and Activities, published by the Department of Health and Human Services ("HHS" or "the Department") on August 4, 2022.

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 individuals are 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 person can make these decisions free from coercion or discrimination.

We commend the Department for proposing a strong rule that will greatly advance Section 1557's purpose of facilitating health care access, in particular reproductive health care, without discrimination. This rule would go far in repairing the damage done by the harmful 2019 rule. Below, we address many of these important provisions, and make recommendations to additionally strengthen the rule with regard to nondiscriminatory access to care, in particular to reproductive health care services, including abortion, contraception, fertility care and prenatal, birthing, and postpartum care.

I. The final rule should explicitly affirm Section 1557's nondiscrimination protections for the full spectrum of reproductive health care, including abortion care, contraceptive care, fertility care, and prenatal, birthing, and postpartum care.

A. The final rule should clearly affirm that denial of abortion care is prohibited sex discrimination under Section 1557.

1. Abortion is essential health care, and we are experiencing a public health crisis with regard to abortion access in the United States.

Abortion is a normal and common part of health care. Everybody deserves to have access to abortion, regardless of where they live and whether or how they are insured. And yet, discrimination against people who have ended or are seeking to end a pregnancy is a common occurrence. Discriminatory health care can manifest as a denial of care, incorrect or delayed diagnosis, delayed treatment resulting in the

deterioration of patient health, or a dismissal of serious medical symptoms.[1] Because "[p]atients rely on their health care providers to give them accurate information based on medical evidence and their health needs,"[2] doctors with a personal bias against abortion can cause substantial harm to patients seeking care, particularly to those who seek care in emergency circumstances. In addition, abortion stigma[3]—or discrimination against a person seeking an abortion—is experienced by the majority of people seeking abortion[4] and perpetuates a wide variety of discriminatory sex-based tropes,[5] which may vary in impact depending, in part, on the intersecting identities of the individual seeking care.[6] Discrimination based on abortion is per se sex discrimination, because it discriminates against patients based on their pregnancy and pregnancy-related care, which are protected under Section 1557.

There are serious physical and socioeconomic consequences for patients who experience discrimination when seeking abortion care, particularly for those who are denied a wanted abortion. A groundbreaking study found that participants who were denied wanted abortions and forced to give birth had statistically poorer long-term health outcomes than those who accessed abortions.[7] Participants denied abortion services were more likely to experience serious complications that generally occur at 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; and less likely to have aspirational life plans for the coming year.[8] In contrast, study participants who received a wanted abortion were not only less likely

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[1] *See* Zawn Villines, *Effects of Gender Discrimination on Health*, MEDICAL NEWS TODAY, (Jun. 23, 2021), https://www.medicalnewstoday.com/articles/effects-of-gender-discrimination#examples (providing that "doctors are more likely to view women's chronic pain as psychological, exaggerated, or even made up, in comparison with men's pain").

[2] NAT'L P'SHIP FOR WOMEN & FAMS, BAD MEDICINE: HOW POLITICAL AGENDA IS UNDERMINING ABORTION CARE AND ACCESS IN OKLAHOMA (2019), https://www.nationalpartnership.org/our-work/repro/reports/bad-medicine-oklahoma.html.

[3] Abortion stigma is rooted in sex-based tropes that women and people capable of pregnancy are inherently nurturing and maternal; expected by society to be chaste (which an unwanted pregnancy is seen as diametrically opposed to); expected to biologically desire to birth children and fulfill traditional roles of homemaker and child caretaker within the nuclear family structure. Alison Norris et al., *Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences*, 21 WOMEN'S HEALTH ISSUES 1, 6 (2011), https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/Abortion-Stigma.pdf; Anuradha Kumar et al., *Conceptualising Abortion Stigma*, 11 CULTURE, HEALTH & SEXUALITY 625, 628–29 (2009).

[4] *See* Paula Abrams, *The Scarlet Letter: The Supreme Court and the Language of Abortion Stigma*, 19 MICH. J. GENDER & L. 293, 328–29 (2013); M. Antonia Bigg et al., *Perceived Abortion Stigma and Psychological Well-Being Over Five Years After Receiving or Being Denied an Abortion*, 15 PLoS ONE 1, 2 (2020) https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0226417 (finding that most people considering abortion perceive some stigma related to their decision).

[5] *See* Alanna Vagianos, *Women Aren't the Only People Who Get Abortions*, THE HUFFINGTON POST (June 6, 2019), https://www.huffpost.com/entry/women-arent-the-only-people-whoget-abortions_n_5cf55540e4b0e346ce8286d3 (describing how people capable of pregnancy who identify at non-binary or transgender are also impacted by abortion restrictions).

[6] *Id.*

[7] *See* Lauren J. Ralph et al., *Self-reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study*, 171 ANNALS OF INTERNAL MED. 238, 238-247 (2019) https://annals.org/aim/article-abstract/2735869/self-reported-physical-health-women-who-did-did-terminate-pregnancy (finding that 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).

[8] *Turnaway Study*, ADVANCING NEW STANDARDS IN REPROD. HEALTH, https://www.ansirh.org/research/turnaway-study (last visited Oct. 1, 2022).

to experience serious health problems than those denied a wanted abortion, but were also 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, and being more financially stable—compared to participants who were denied a wanted abortion.[9]

There are also serious consequences for patients who face delays in obtaining an abortion; as delays increase, the logistical and financial burdens multiply. For example, when a patient is turned away from a doctor's office or a hospital without a referral, they must find a willing provider to access the health care they need. This costs patients significant time researching other available providers and additional time off from work for a new appointment. In areas with a limited number of health care providers, or in states that have implemented an abortion ban following the Supreme Court's overturn of *Roe v. Wade*, a patient may need to travel long distances in order to access care, requiring expenses for travel, overnight stays and childcare. The additional time and expense fall most heavily on low-income individuals and those without the job flexibility to take paid sick time.

Delays also have the effect of increasing the cost of an abortion. Abortion in the first trimester is substantially less expensive than in the second trimester: the median price of a surgical abortion at ten weeks is $508, while the cost rises to $1,195 at week 20.[10] The rising cost of abortion as gestational age increases poses a profound challenge to the affordability of the procedure for lower-income people. As one Utah woman explained: "I knew the longer it took, the more money it would cost . . . We are living paycheck to paycheck as it is, and if I [had] gone one week sooner, it would have been $100 less."[11] Moreover, delays raise the cost of each step of obtaining an abortion—not just the cost of the procedure. For example, one recent study found that Utah's mandatory waiting period caused 47 percent of patients having an abortion to miss an extra day of work.[12] More than 60 percent were negatively affected in other ways, including increased transportation costs, lost wages by a family member or friend, or being required to disclose the abortion to someone whom they otherwise would not have told.[13] And because many clinics do not offer second-trimester abortions, a person who has been delayed into the second trimester will typically be required to travel farther to obtain an abortion, thereby incurring additional travel and related costs, such as lost wages and costs for childcare.[14] As a result, health care denials that result in a delay in care can significantly drive up the cost of care for a person seeking abortion care or make it impossible altogether.

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[9] Ushma Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-year Plans*, 15 BMC WOMEN'S HEALTH 1, 1-10 (2015), https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-015-0259-1.

[10] Rachel K. Jones et al., *Differences in Abortion Service Delivery in Hostile, Middle-Ground and Supportive States in 2014,* 28 WOMEN'S HEALTH ISSUES 212, 212-218 (2018), http://www.whijournal.com/article/S1049-3867(17)30536-4/abstract.

[11] Sarah C.M. Roberts et al., *Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women*, 48 PERSPS. ON SEXUAL & REPROD. HEALTH 179, 184 (2016).

[12] Jessica N. Sanders et al., *The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion*, 26 WOMEN'S HEALTH ISSUES 483, 485 (2016).

[13] *Id.*; Deborah Karasek et al., *Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence Before Arizona's Two-Visit 24-hour Mandatory Waiting Period Law*, 26 WOMEN'S HEALTH ISSUES 60, 60-66 (2016).

[14] Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008*?, 22 J. WOMEN'S HEALTH 706, 706-13 (2013).

In another example, a patient who has a cesarean section birth and wishes to have a post-partum tubal ligation immediately following delivery cannot do so at a Catholic hospital,[15] even though having the procedure at that time is medically recommended, presents fewer risks to the patient, and is more cost-effective than delaying the procedure to a later time. If the patient cannot have the procedure immediately following delivery, they must first recover from the cesarean surgery and then schedule the tubal ligation at least six weeks later when they are busy caring for their newborn. They will be required to go to another hospital and possibly a different doctor, transfer their medical records, and endure another invasive procedure and recovery.[16]

Reproductive health care is at a crisis point in this country. Since 2011, states have passed more than 500 laws restricting access to reproductive health care, closing clinics and creating a shortage of abortion providers. Following the Supreme Court's overturn of *Roe v. Wade* in *Dobbs v. Jackson Women's Health Organization*, many states began banning abortion outright. Large swaths of the country no longer have access to abortion care.

As a result, patients who are denied abortion care may find it difficult or even impossible to find a willing and available provider in a reasonable timeframe. Even prior to the Supreme Court's decision to overturn the constitutional right to abortion in *Dobbs,* eighty-nine percent of counties in the United States did not have a single abortion clinic, and some counties that had a clinic only provided abortion services on certain days.[17] Since then, many more clinics have shuttered. Abortion bans in the U.S. have left over 78 million people across 13 states without access to abortion.[18] Thirteen states are enforcing total bans, two states are enforcing six-week bans, and six other states have tried to prohibit abortion, but are blocked by court orders as of the end of September 2022.[19] As a result, many patients must travel long distances at great expense to access care, if they are able to access care at all.[20] In addition, in some areas, the

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[15] Catholic hospitals must comply with the Ethical and Religious Directives for Catholic Health Care Services, which prohibit abortion, contraception (including sterilization) and IVF. U.S. CONF. OF CATH. BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR THE CATHOLIC HEALTH CARE SERVICES, SIXTH ED. (2016), https://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf.

[16] NAT'L WOMEN'S LAW CTR., *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; *See also*, Debra B. Stulberg et al., *Tubal Ligation in Catholic Hospitals: A Qualitative Study of Ob-Gyns' Experiences*, 90 CONTRACEPTION 422, 422-28 (2014) ("Cesarean delivery in Catholic hospitals raised frustration for obstetrician-gynecologists when the hospital prohibited a simultaneous tubal ligation and, thus, sent the patient for an unnecessary subsequent surgery. [. . .] Some obstetrician-gynecologists reported that Catholic policy posed greater barriers for low-income patients and those with insurance restrictions.").

[17] NAT'L P'SHIP FOR WOMEN & FAMS., BAD MEDICINE: HOW POLITICAL AGENDA IS UNDERMINING ABORTION CARE AND ACCESS IN OKLAHOMA (2019), https://www.nationalpartnership.org/our-work/repro/reports/bad-medicine-oklahoma.html.

[18] Calculated using the 2020 U.S. Census Apportionment Population numbers.

[19] CTR. FOR REPROD. RIGHTS, AFTER ROE FELL: ABORTION LAWS BY STATE, accessed 30 Sep. 2022. https://reproductiverights.org/after-roe-fell-abortion-laws-by-state/.

[20] NAT'L P'SHIP FOR WOMEN & FAMS., BAD MEDICINE: HOW POLITICAL AGENDA IS UNDERMINING ABORTION CARE AND ACCESS IN OKLAHOMA (2019), https://www.nationalpartnership.org/our-work/repro/reports/bad-medicine-oklahoma.html.

increased demand resulting from patients traveling from states that prohibit abortion results in significantly increased wait times[21] and, in some cases, patients may be turned away altogether.[22] Abortion opponents emboldened by these recent developments may be more likely to deny appropriate medical care to pregnant patients. In addition, state bans and restrictions that conflict with federal law mean that patients and providers are mired in uncertainty as to their rights and obligations with regards to abortion care. The final rule will be an important tool to ensure patients are not subject to discrimination on the basis of their pregnancy-related choices, particularly following the *Dobbs* decision, which has exacerbated this already pervasive form of discrimination.

2. The final rule's regulatory text should clearly state that sex discrimination on the basis of pregnancy and pregnancy-related conditions includes abortion care.

The *Dobbs* decision has unleashed chaos in our medical system. In the post-*Roe* world, discrimination against pregnant patients has become both more common and more dangerous, with hospitals and providers turning away patients even in emergency situations.[23] It is imperative that the final rule states clearly and explicitly that discrimination on the basis of pregnancy and pregnancy-related conditions includes abortion care, in order to ensure patients do not experience discrimination when accessing medically indicated care and preserve patients' trust in their providers. The final rule should also specify that providers may not discriminate against patients for having accessed such care in the past. Abortion is a type of pregnancy-related care, thus, discrimination based on abortion is a form of sex discrimination under Section 1557.

The final rule should be clear that providers may not substitute their own bias for the provision of medically indicated care. Such conduct not only denies medically necessary care to patients, but also may erode their trust in the health care system and their health care providers. For example, when patients experience abortion stigma while accessing reproductive health care, it "diminishes the trust that is

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[21] Margot Sanger-Katz, Claire Cain Miller & Josh Katz, *Interstate Abortion Travel Is Already Straining Parts of the System,* N.Y. TIMES, (Sept. 19, 2022), https://www.nytimes.com/2022/07/23/upshot/abortion-interstate-travel-appointments.html.

[22] Marty Schladen, *Affidavits: More Pregnant Minors Who Were Raped Denied Ohio Abortions,* OHIO CAPITAL JOURNAL, (Sept. 22, 2022), https://ohiocapitaljournal.com/2022/09/22/affidavits-more-pregnant-minors-who-were-raped-denied-ohio-abortions/ (quoting Allegra Pierce, a medical assistant at Preterm-Cleveland, saying that "[e]ven those patients who are able to travel out of state often have a hard time getting an appointment due to increasingly long wait times at clinics in states where abortion is still legal."); Laura Hancock, *Hamilton County Judge Immediately Halts Enforcement of Ohio's Fetal 'Heartbeat' Abortion Law for 14 Days; Abortion Now Legal Until 22 Weeks,* CLEVELAND.COM (Sept. 14, 2022), https://www.cleveland.com/news/2022/09/ohio-judge-halts-enforcement-of-fetal-heartbeat-abortion-law-for-14-days.html.

[23] *See, e.g.,* Sarah McCammon & Lauren Hodges, *Doctors' Worst Fears About the Texas Abortion Law are Coming True*, NPR, (Mar. 1, 2022), https://www.npr.org/2022/02/28/1083536401/texas-abortion-law-6-months; Kate Zernike, *Medical Impact of Roe Reversal Goes Well Beyond Abortion Clinics, Doctors Say*, NEW YORK TIMES, (Sept. 10, 2022), https://www.nytimes.com/2022/09/10/us/abortion-bans-medical-care-women.html; Christine Vestal, *Some Abortion Bans Put Patients, Doctors at Risk in Emergencies*, STATELINE, AN INITIATIVE OF THE PEW CHARITABLE TRUSTS (Sept. 7, 2022), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/09/01/some-abortion-bans-put-patients-doctors-at-risk-in-emergencies.

essential to the patient-provider relationship and undermines women's ability to make informed medical decisions."[24]

Diminished trust in health care providers is likely to increase in the wake of *Dobbs.* We expect a stark increase in prosecution for self-managed abortion; likely, other pregnancy outcomes such as miscarriage will also be the subject of prosecution.[25] With at least thirteen states where abortion is already illegal or criminalized, pregnant people are under increased surveillance and treated with heightened suspicion.[26] This growing health crisis has exacerbated unjustifiable dangers to pregnant people, as the criminalization of pregnancy outcomes harms the health and wellbeing of patients and violates their civil and human rights.[27]

The burden of abortion bans falls disproportionately on people of color and others at the intersection of marginalized identities, who already face disproportionate discrimination within the health care system as well as higher rates of poverty and policing.[28] Even prior to the overturn of Roe, people of color, especially Black pregnant people, were prosecuted for the outcomes of their pregnancies at disproportionate rates, including by using fetal assault laws, or policies that punish or penalize pregnant

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[24] NAT'L P'SHIP FOR WOMEN & FAMS., BAD MEDICINE: HOW POLITICAL AGENDA IS UNDERMINING ABORTION CARE AND ACCESS IN OKLAHOMA (2019), https://www.nationalpartnership.org/our-work/health/repro/reports/bad-medicine-oklahoma.html.

[25] There have been over 60 documented cases of people being criminally arrested or investigated for self-managing abortion or assisting someone else obtain an abortion. Laura Huss, *Self-Managed Abortion is Not Illegal in Most of the Country, but Criminalization Happens Anyway,* IF/WHEN/HOW (Aug. 9, 2022), https://www.ifwhenhow.org/abortion-criminalization-new-research/; Robert Baldwin, *Losing a Pregnancy Could Land You in Jail in Post-Roe America,* NPR (Jul. 3, 2022), https://www.npr.org/2022/07/03/1109015302/abortion-prosecuting-pregnancy-loss (interviewing legal experts from If/When/How and the National Advocates for Pregnant Women); IF/WHEN/HOW, FULFILLING ROE'S PROMISE: 2019 UPDATE 1 (2019), https://www.ifwhenhow.org/resources/roes-unfinished-promise-2019-update/ (citing Paltrow & Flavin, Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health, 38 J. Health Politics, Policy & Law 299 (2013)); Sandhya Dirks, *Criminalization of Pregnancy has Already Been Happening to the Poor and Women of Color*, NPR (Aug. 3, 2022), https://www.npr.org/2022/08/03/1114181472/criminalization-of-pregnancy-has-already-been-happening-to-the-poor-and-women-of (including expert accounts of the intersection of incarceration and pregnancy outcomes for people of color).

[26] This has already occurred while the protections of Roe were intact. Pregnant people have been investigated, penalized, and even incarcerated where there is suspicion that a person was responsible for the termination of their pregnancy. *See* Brief for If/When/How: Lawyering for Reproductive Justice et al. as Amici Curiae Supporting Petitioners, *June Medical Services L.L.C v. Russo*, 140 S. Ct. 2103 (2020) (No. 18-1323), at 3, https://www.if whenhow.org/resources/amicus-brief-june-v-gee/.

[27] Brief for Experts, Researchers, and Advocates Opposing the Criminalization of People Who Have Abortions, as Amici Curiae Supporting Respondents, *Dobbs v. Jackson Women's Health Organization, et al.*, 142 S.Ct. 2228 (2022) (No. 19-1392 at ii).

[28] Brief for If/When/How: Lawyering for Reproductive Justice et al. as Amici Curiae Supporting Petitioners, J*une Medical Services L.L.C v. Russo*, 140 S. Ct. 2103 (2020) (No. 18-1323), at 3, https://www.ifwhenhow.org/resources/amicus-brief-june-v-gee/; A Post Roe America: The Legal Consequences of the Dobbs Decision Before the Sen. Comm. on the Judiciary, 117th Cong. 11-12 (2022) (statement of Kharia M. Bridges, Professor of Law, UC Berkeley School of Law) https://www.judiciary.senate.gov/meetings/a-post-roe-america-the-legal-consequences-of-the-dobbs-decision.

people for substance use during pregnancy.[29] Often this prosecution occurred with the assistance of the pregnant person's health care provider. A study of 413 cases in which pregnant women were arrested or otherwise deprived of their liberty on the basis of harm or perceived harm to a fetus found that 58 percent were reported by hospital personnel.[30] In particular, Black pregnant people who suffered from stillbirths, miscarriages, or simply alerted their doctors to substance use, irrespective of pregnancy outcomes, have been and continue to be incarcerated with the assistance of the health care system.[31] With the rapid increase of states criminalizing abortion post-*Roe*, patients will question whether they can trust their providers with their full medical history, or trust them with their pregnancy-related care at all.[32]

The Department should also affirm in the final rule that discrimination on the basis of past medical history (including seeking, accessing, or having sought abortion, contraception or other reproductive health care) is prohibited conduct under Section 1557. Such discrimination happens when a health care provider refuses to appropriately treat a patient because the provider objects to a patient's medical history for including, among other things, abortion. Critically, the provider might object only to the patient's medical history, not object to the medical care they are currently choosing to deny. Objections to a patient's medical history are never an appropriate basis for refusing medically indicated care, and this should be expressly prohibited by the final rule where the past care objected to is care protected by Section 1557. To that end, we also recommend that the Department include examples in the final rule or preamble to clarify the discriminatory nature of refusing to provide health care based on a patient's actual or perceived medical history.

Finally, we note that clarifying in the final rule that termination of pregnancy is covered by 1557, and providing examples of prohibited conduct, would ensure that the rule aligns with international human rights standards. Discrimination against individuals seeking abortion services is a concern shared by the international human rights community, including the Committee on the Elimination of Discrimination Against Women (CEDAW Committee) [33] and the Special Rapporteur on the Right to Health. [34] Multiple treaty monitoring bodies and human rights experts have also noted the disproportionate effect of

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[29] In one instance, a South Carolina hospital serving a predominantly Black and low-income community engaged in targeted searches of pregnant women for narcotics and assisted the arrests, prosecution, and incarceration of pregnant Black women and those who recently gave birth; women were removed from their hospital beds in handcuffs and shackles. *Ferguson v. Charleston*, 532 U.S. 67 (2001).

[30] *See* Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. Health Pol., Pol'y & L. 299, 311 tbl. 1 (2013).

[31] Sandhya Dirks, *Criminalization of Pregnancy Has Already Been Happening to the Poor and Women of Color*, NPR (Aug. 3, 2022) https://www.npr.org/2022/08/03/1114181472/criminalization-of-pregnancy-has-already-been-happening-to-the-poor-and-women-of (including expert accounts of the intersection of incarceration and pregnancy outcomes for people of color); Cortney Loller, *Criminalizing Pregnancy*, 92 Indiana Law Journal 947 (2017).

[32] Making Abortion a Crime (Again), IF/WHEN/HOW (2022), https://www.ifwhenhow.org/resources/making-abortion-a-crime-again/.

[33] CEDAW Committee, Concluding observations on the eighth periodic report of Australia, para. 49(a), U.N. Doc. CEDAW/C/AUS/CO/8 (2018); CEDAW Committee, Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, Report of the Committee, para. 65, U.N. Doc. CEDAW/C/OP.8/GBR/1 (March 6, 2018) (finding that abortion restrictions in Northern Ireland constituted discrimination because they affected only women, "preventing them from exercising reproductive choice.").

[34] Anand Grover, 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, para. 34, U.N. Doc. A/66/254 (2011).

intersectional discrimination on certain communities, including people of color, people with disabilities, the LGBTQI+ community, and low-income women, in the context of sexual and reproductive health.[35] See Section IV. below for a detailed discussion of human rights in the context of sexual and reproductive health.

B. The final rule should be clear that Section 1557 prohibits discrimination against patients in the treatment of pregnancy emergencies and complications, including termination of pregnancy, miscarriage management, and other pregnancy outcomes.

1. The final rule should clarify that EMTALA and 1557 apply in all emergency situations.

We urge the Department to go further in explaining how Section 1557 and the Emergency Medical Treatment & Labor Act (EMTALA) each protect pregnant patients in emergency situations. The Rule should explain that EMTALA and Section 1557 each prohibit the denial of care, including denying termination of pregnancy.

EMTALA requires that participating entities provide stabilizing treatment to pregnant patients.[36] Under Section 1557, refusals to provide pregnant patients with emergency care that may include termination of pregnancy is patently sex discrimination. EMTALA explicitly protects patients in situations that threaten their health and life, and Section 1557 provides additional protections against discrimination on the basis of sex, including abortion.

We agree with the proposed rule's clarification that EMTALA protects emergency care for pregnancy or related conditions, including termination of pregnancy. In the preamble to the proposed rule, the Department explains that EMTALA protects the care a person needs when presenting with an "emergency medical condition."[37] Both the proposed rule's preamble and the guidance provided by the Department on July 11, 2022 ("July guidance") make clear that the EMTALA statute preempts any state laws or

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[35] Committee on Economic, Social and Cultural Rights, General Comment No. 22, para. 30; *See also, e.g.,* Committee on the Rights of the Child, General Comment No. 15 (2013) on the rights of the child to the enjoyment of the highest attainable standard of health (art. 24), paras. 8-11, U.N. Doc. CRC/C/GC/15 (Apr. 17, 2013); Committee on the Rights of People with Disabilities, General Comment No. 3 (2016) on women and girls with disabilities, para. 2, U.N. Doc. CRPD/C/GC/3 (Nov. 25, 2016); Human Rights Council, General Comment No. 28: Article 3 (The equality of rights between men and women), para. 30, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (Mar. 29, 2000); CEDAW Committee, General Recommendation No. 34 (2016) on the rights of rural women, para. 38, U.N. Doc, CEDAW/C/GC/34 (Mar. 7, 2016); Human Rights Council, Report of the Special Rapporteur on Extreme Poverty and Human Rights on his mission to the United States of America, para. 56, U.N. Doc. A/HRC/38/33/Add.1 (May 4, 2018) (noting that "low-income women['s] lack of access to abortion services traps [them] in cycles of poverty.").

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

[37] Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824 (proposed August 4, 2022) (to be codified at 42 CFR 438, 42 CFR 440, 42 CFR 457, 42 CFR 460, 45 CFR 80, 45 CFR 84, 45 CFR 86, 45 CFR 91, 45 CFR 92, 45 CFR 147, 45 CFR 155, and 45 CFR 156).

mandates that employ a more restrictive definition of an emergency medical condition.[38] In the July guidance, the Department clarified that "emergency medical conditions involving pregnant patients may include, but are not limited to, ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features."[39]

Despite the July guidance, health care providers need clarity as to when they may treat patients. Each day, physicians across the country seek guidance from the American College of Obstetricians and Gynecologists and share fears that they cannot make the best health care decisions for their patients following *Dobbs*.[40] Providers urgently need clarity on when they may treat the patients who rely on them for care.[41] Providers have been placed in an impossible situation, where providing the health care their patients need – even emergency care – could potentially expose them to prosecution and civil suit in states that ban abortion.[42]

We also recommend that the final rule clarify that denying an abortion in an emergency situation due to personal or institutional opposition to abortion violates Section 1557, because it is per se discrimination on the basis of sex. This is true regardless of any state laws that purport to ban abortion entirely. The final rule should put health care providers on notice that a failure to stabilize a patient for any reason having to do with the condition of pregnancy – including refusing to or delaying termination of pregnancy – is a violation of federal law under both EMTALA and Section 1557.

C. The proposed rule correctly declined to incorporate the Danforth Amendment.

We support the Department's decision not to incorporate Title IX's "abortion neutrality provision," also known as the Danforth Amendment and urge the Department to issue a final rule without it. We strongly agree with the Department's recognition that Section 1557 does not require the incorporation of the Danforth Amendment.[43] Inclusion of the Danforth Amendment runs counter to the congressional intent of Section 1557 and would contribute to provider confusion and health care denials related to pregnancy and pregnancy-related care.

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

[39] *Id*.

[40] A Post Roe America: The Legal Consequences of the Dobbs Decision Before the Sen. Comm. on the Judiciary, 117th Cong. (2022) (oral testimony of Collen P. McNicholas, Chief Medical Officer, Planned Parenthood of the St. Louis Region and Southwest Missouri) https://www.judiciary.senate.gov/meetings/a-post-roe-america-the-legal-consequences-of-the-dobbs-decision (sharing her experience as a leader in the American College of Obstetricians and Gynecologists).

[41] *Id*.

[42] Reese Oxner & María Méndez, *Texas Hospitals are Putting Pregnant Patients at Risk by Denying Care Out of Fear of Abortion Laws, Medical Gro Says*, TEXAS TRIBUNE (July 15, 2022), https://www.texastribune.org/2022/07/15/texas-hospitals-abortion-laws/; AP, *Letter Says Texas Hospitals Reportedly Refusing Abortion Care,* NBC DFW (Jul. 15, 2022), https://www.nbcdfw.com/news/local/texas-news/letter-says-texas-hospitals-reportedly-refusing-abortion-care/3015545/.

[43] 20 U.S.C. 1688 (''Nothing 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.'').

Section 1557 was included in the Affordable Care Act "to expand access to care and coverage and eliminate barriers to access"[44] based on the government's "compelling interest in ensuring that individuals have nondiscriminatory access to health care." Congress' silence on incorporation of the Danforth Amendment is not an oversight on the part of Congress, but rather an intentional omission. As the Department pointed out in the 2016 rule and the preamble to the 2022 proposed rule, Congress clearly chose which parts of the four statutes to incorporate, by referencing the enforcement mechanisms and the grounds for discrimination from the referenced statutes.[45] Section 1557 incorporates the bases of discrimination prohibited by Title IX; it does not incorporate the Title IX exemptions. Any conflicting interpretation runs contrary to congressional intent and would undermine the purpose of Section 1557 by prioritizing the beliefs of health care entities over the health care needs of patients.

D. The final rule should affirm that denial of contraceptive care is prohibited sex discrimination under Section 1557.

We urge the Department to affirm in the final rule that Section 1557 prohibits discrimination against those seeking contraception, generally, as well as specific types of contraception. Denial of contraceptive care is a frequent form of sex discrimination, and the *Dobbs* decision has opened the door to further attacks on contraception. It has emboldened some health care providers and entities to refuse to provide or counsel on certain types of contraceptive care and caused public confusion about the continued legality of contraception, especially as some are openly calling for reversing the constitutional right to contraception.[46] Some of these attacks are rooted in a deliberate misrepresentation of contraceptive care and how it works. For example, some forms of emergency contraception are mislabeled as abortion care, ignoring the science and medical consensus that emergency contraception prevents pregnancy and is not effective if pregnancy has already occurred.[47] Given the growing threats to contraceptive access post-*Dobbs*, the Department should clearly specify that Section 1557's sex discrimination protections for pregnancy-related care include contraceptive care.

On July 13, 2022, the Department issued guidance to retail pharmacies about Section 1557 protections in response to violations that occurred after *Dobbs*.[48] The guidance addressed certain types of discrimination that are specific to contraceptive access in the retail pharmacy setting, for example, denial of hormonal contraception to an individual when the pharmacy otherwise provides contraceptives. We urge the Department to include these examples in the final rule.

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[44] 81 Fed. Reg. 31375, 31377 (2016).

[45] Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, 47839 (proposed Aug. 4, 2022); Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31379-80 (May 18, 2016).

[46] *See, e.g.,* Oriana Gonzalez, *Post-Dobbs Birth Control Fight Heads to College Campuses*, AXIOS (Sept. 30. 2022), https://www.axios.com/2022/09/30/dobbs-roe-abortion-university-birth-control; Rebecca Boone, *Idaho Universities Disallow Abortion, Contraception Referral*, Idaho News (Sept, 28, 2022), https://idahonews.com /news/local/idaho-universities-disallow-abortion-contraception-referral.

[47] *See, e.g.*, WORLD HEALTH ORGANIZATION, Emergency Contraception Fact Sheet (Nov. 9 2021), WHO https://www.who.int/news-room/fact-sheets/detail/emergency-contraception; American College of Obstetricians and Gynecologists, FAQs on Emergency Contraception, ACOG (Nov. 2021), https://www.acog.org/womens-health/faqs/emergency-contraception.

[48] U.S. DEPT. OF HEALTH AND HUMAN SERVS., HHS ISSUES GUIDANCE TO THE NATION'S RETAIL PHARMACIES CLARIFYING THEIR OBLIGATIONS TO ENSURE ACCESS TO COMPREHENSIVE REPRODUCTIVE HEALTH CARE SERVICES, (Jul. 13, 2022), https://www.hhs.gov/about/news/2022/07/13/hhs-issues-guidance-nations-retail-pharmacies-clarifying-their-obligations-ensure-access-comprehensive-reproductive-health-care-services.html.

We also recommend that the final rule expressly list other forms of discrimination related to contraceptive access. For example, the rule should include references to prohibited discrimination such as:

- state programs that discriminate by providing coverage of contraceptives, but excluding a specific contraceptive because of an assertion that the contraception causes an abortion;
- provider networks that only include facilities that refuse to perform "female" sterilization;
- limiting access to and coverage of reproductive health services such as contraceptive services and prenatal, birthing and postpartum care to "female" beneficiaries.

The Department should also specify that items or services related to contraception are also protected. Additional medications or services are often needed to facilitate contraceptive use, such as anesthetics for insertion of long-acting reversible contraceptives, or misoprostol – a medication also used as part of the medication abortion protocol – which is used to make IUD insertion easier.

E. The final rule should affirm that discrimination on the basis of sex in fertility care is prohibited under Section 1557.

We urge the Department to explicitly clarify that Section 1557's protections against discrimination on the basis of sex include discrimination against people seeking or accessing fertility care.

While the 2020 rule sowed confusion regarding whether Section 1557 prohibits discrimination against individuals who are seeking or who have obtained fertility care, Title VII prohibits such discrimination that occurs in the context of employment.[49] Section 1557's protections against discrimination on the basis of sex include robust protections against discrimination for people who are seeking fertility care. Respectful and nondiscriminatory access to fertility care is key to fulfilling every person's right to make decisions about their reproductive life and choose if, when, and how to become a parent.

Despite Section 1557's clear prohibition of sex discrimination in health care, discrimination persists in the context of accessing infertility diagnosis, fertility treatment, and fertility services including assisted reproductive technology like in vitro fertilization (IVF). It is thus essential that the final rule explicitly name it as prohibited conduct under this provision.

Sex discrimination in the context of fertility care can take many forms. Some insurance companies refuse to cover certain types of care that are traditionally used by women (e.g., IVF).[50] Even in those states that do require insurance providers to cover IVF, some insurance providers require that patients use their "spouse's sperm" to fertilize their eggs to be eligible for IVF insurance coverage, discriminating against patients based on their sex with respect to marital status, sexual orientation, and gender identity.[51] In a recent example of discrimination on the basis of sex, sexual orientation and, marital status, OSF HealthCare, a self-insured Catholic hospital system with facilities in Illinois and Michigan, recently

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[49] *See, e.g.*, *Hall v. Nalco Co.*, 534 F.3d 644 (7th Cir. 2008), *Ciocca v. Heidrick & Struggles, Inc.*, No. CV 17-5222, 2018 WL 2298498 (E.D. Pa. May 21, 2018).

[50] Gabriela Weigel et al., *Coverage and Use of Fertility Services in the U.S.*, WOMEN'S HEALTH POLICY (September 15, 2020), https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s/.

[51] *E.g.,* Haw. Rev. Stat. § 431:10A-116.5 (1987); Ark. Code R. 054.00.1–5(B) (1991). Furthermore, Texas, which only requires insurance providers to offer IVF insurance, also includes this same eligibility requirement. *See* Tex. Ins. Code Ann. § 1366.005.

adopted an insurance policy for its employees that limits IVF coverage to "married couple[s] of opposite sex spouses."[52]

Additionally, public and private insurers often discriminate against patients based on sex by requiring that they meet outdated and heteronormative definitions of infertility before providing IVF coverage. For example, relying on a 2013 definition that has since been rescinded by the American Society for Reproductive Medicine,[53] many insurers maintain a double standard: They require that patients in different-sex relationships simply attest that they have unsuccessfully tried to become pregnant by having unprotected sex for six months or a year, depending on their age, but require same-sex couples and single individuals to undergo six to twelve unsuccessful cycles of intrauterine insemination at their own expense before deeming them eligible for IVF coverage. These patients are thereby forced to absorb exorbitant costs out of pocket and are delayed or denied access to their IVF coverage benefits solely due to their sexual orientation.

Health care providers have also refused to provide fertility care for discriminatory reasons. For example, Guadalupe Benitez underwent a year of invasive, costly treatment by the sole in-network fertility care provider on her insurance plan only to then be denied the fertility treatment she needed based on the provider's religious objections to performing the procedure because Benitez identified as a lesbian. Benitez was forced to pay for her fertility care out-of-pocket at another clinic.[54]

We urge the Department to clarify that such discrimination in health care, including in the context of seeking or accessing fertility care, is impermissible discrimination on the basis of sex under Section 1557, and to include examples of a broad range of impermissible sex discrimination in the context of seeking or accessing fertility care in the final rule.

F. The final rule should affirm that discrimination in pregnancy-related care throughout pregnancy, childbirth and the postpartum period is prohibited under Section 1557.

We urge the Department to clarify that Section 1557's prohibition of discrimination and mistreatment in the provision of pregnancy-related care includes the perinatal and postpartum period. Discrimination throughout pregnancy and the postpartum period is common, especially for Black, Indigenous, Latinx, Asian American and Pacific Islander (AAPI), and other people of color, people with disabilities, and others who live at the intersections of Section 1557's protected identities. Such discrimination includes

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[52] Shira Stein, *Hospital Chain Blocks Fertility Coverage for Its LGBTQ Employees*, BLOOMBERG LAW (July 18, 2022), https://news.bloomberglaw.com/daily-labor-report/hospital-chain-blocks-fertility-coverage-for-its-lgbt-employees.

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

[54] *Benitez v. North Coast Women's Care Medical Group, Inc.,* 106 Cal.App.4th 978 (Cal.App. 4 Dist., 2003).

mistreatment during labor and delivery.[55] A recent poll conducted by the AAMC Center for Health Justice of people in the United States who had given birth in the last five years revealed that more LGBTQ+ individuals (31%) reported having poor or worse birthing experience compared to cisgender, heterosexual individuals (18%).[56] Individuals who identified as Black, Hispanic, LGBTQ+, had lower incomes, and younger individuals were also more likely to report that they felt that their care was subject to bias or discrimination.[57] The Department should affirm the rights of pregnant patients to receive high-quality care, free from discrimination.

Experts, advocates and storytellers from the Black, Indigenous, AAPI and Latinx populations have made explicitly clear the role that discrimination and mistreatment play in the high rates of severe maternal mortality and morbidity among these most impacted communities.[58] In August of 2022, the UN Committee on the Elimination of Racial Discrimination (CERD), in reviewing the United States' progress on eliminating racial discrimination, expressed concern that "systemic racism along with intersecting factors such as gender, race, ethnicity and migration status have a profound impact on the ability of women and girls to access the full range of sexual and reproductive health services…without discrimination."[59] The Committee was also concerned about the "limited availability of culturally sensitive and respectful maternal health care, including midwifery care for low-income, rural and people of African descent and Indigenous communities."[60] It further noted that "racial and ethnic minorities are disproportionally impacted by higher rates of maternal mortality and morbidity; higher risk of unwanted pregnancies and lack of means to overcome socioeconomic and other barriers to access safe abortion."[61] We commend the Department on the actions it has taken thus far to address and eliminate these disparities in maternal and reproductive health care and urge the Department to issue a final rule that expressly affirms that discrimination in the provision of care throughout pregnancy and in the postpartum period is prohibited under Section 1557.

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[55] ABORTION CARE NETWORK ET AL., SYSTEMIC RACISM AND REPRODUCTIVE INJUSTICE IN THE UNITED STATES: A REPORT FOR THE UN COMMITTEE ON THE ELIMINATION OF RACIAL DISCRIMINATION (2022), https://reproductiverights.org/wp-content/uploads/2022/08/2022-CERD-Report_Systemic-Racism-and-Reproductive-Injustice.pdf

[56] AAMC CTR. FOR HEALTH JUSTICE, POLLING SPOTLIGHT: UNDERSTANDING THE EXPERIENCES OF LGBTQ+ BIRTHING PEOPLE (2022), https://www.aamchealthjustice.org/news/polling/lgbtq-birth.

[57] AAMC CTR. FOR HEALTH JUSTICE, FROM PREGNANCY TO POLICY (2022), https://www.aamchealthjustice.org/news/polling/pregnancy-policy.

[58] NY TIMES MAGAZINE, WHY AMERICA'S BLACK MOTHERS AND BABIES ARE IN A LIFE-OR-DEATH CRISIS (2018), https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html; CTR FOR AM. PROGRESS, AM. INDIAN AND ALASKAN NATIVE MATERNAL AND INFANT MORTALITY: CHALLENGES AND OPPORTUNITIES (2018), https://www.americanprogress.org/article/american-indian-alaska-native-maternal-infant-mortality-challenges-opportunities/; ABORTION CARE NETWORK ET AL., SYSTEMIC RACISM AND REPRODUCTIVE INJUSTICE IN THE US: A REPORT FOR THE UN COMMITTEE ON THE ELIMINATION OF RACIAL DISCRIMINATION (2022), https://reproductiverights.org/wp-content/uploads/2022/08/2022-CERD-Report_Systemic-Racism-and-Reproductive-Injustice.pdf; NAT'L P'SHIP FOR WOMEN & FAMS., *Listening to Latina Mothers in California*, (2018), https://www.nationalpartnership.org/our-work/resources/health-care/maternity/listening-to-latina-mothers-in-california.pdf; Elizabeth Chuck and Haimy Assefa, *She Hoped to Shed 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.

[59] U.N. CERD, *International Convention on the Elimination of All Forms of Racial Discrimination*: *Concluding observations on the combined tenth to twelfth reports of the United States of America*, CERD/C/USA/CO/10-12, para 35 (Sept. 21, 2022).

[60] *Id*.

[61] *Id*.

G. The final rule should enumerate these specific forms of discrimination in sections §92.206 and §92.207.

Clear nondiscrimination protections related to pregnancy or related conditions, including termination of pregnancy, fertility care, contraception, and prenatal, birthing, and postpartum care are critically necessary in this moment of crisis for reproductive health care access. We support the Department's enumeration of specific forms of sex discrimination prohibited in § 92.206(b) and § 92.207(b). We encourage the Department to strengthen these provisions by including examples related to pregnancy and pregnancy-related conditions in these sections. Accordingly, we propose the following additions to § 92.206(b):

> (5) Adopt or apply any policy or practice that subjects people to discriminatory treatment during pregnancy, childbirth, or postpartum care, including coerced or unconsented treatment, verbal or physical abuse, denied or delayed care, and violations of privacy;
>
> (6) Deny, delay or limit services, or a health care professional's ability to provide services, on the basis of pregnancy or related conditions, including termination of pregnancy, contraception, miscarriage management, fertility care, maternity care, or any health services;
>
> (7) Deny, delay or limit services based on an individual's reproductive or sexual health care decisions or history, including termination of pregnancy, miscarriage, or adverse pregnancy outcome; or
>
> (8) Deny, delay or limit services, or a health care professional's ability to provide services, that may prevent, cause complications to, or end fertility or pregnancies, including medications or treatments for disabilities or emergency medical conditions under 42 U.S.C. § 1395dd.

We also strongly support the Department's restoration of and improvements to § 92.207, including the inclusion of specific forms of prohibited discrimination. We recommend that the Department further strengthen the text of proposed § 92.207 to address sex discrimination in insurance coverage related to pregnancy or related conditions, including discrimination related to abortion, fertility care, and contraception. Accordingly, we urge the Department to amend proposed § 92.207(b) as follows:

> (4) Have or implement a categorical coverage exclusion or limitation for all services related to gender transition or other gender-affirming care, termination of pregnancy, contraception, fertility care, miscarriage management, pregnancy loss, maternity care, other reproductive and sexual health services, or any health services, if such denial, limitation, or restriction results in discrimination on the basis of sex;
>
> (5) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost-sharing or other limitations or restrictions on coverage, for specific health services related to gender transition or other gender-affirming care**,** termination of pregnancy, contraception, fertility care, miscarriage management, pregnancy loss, maternity care, other reproductive and sexual health services, or any health services, if such denial, limitation, or restriction results in discrimination on the basis of sex; or

. . .

(7) Deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations on coverage for health services that may prevent, cause complications to, or end fertility or pregnancies, if such denial, limitation, or restriction results in discrimination on the basis of sex.

We also recommend that the Department include examples of forms of discrimination on the basis of pregnancy or related care in the preamble. With the increasing attacks on abortion access, contraception, and fertility care, opponents of reproductive health care have been emboldened to deny care, and it is essential that the Department clearly state the types of conduct that are prohibited under Section 1557.

H. It is critical that the final rule prioritizes patient access to care and ensures that any religious exemptions do not lead to denials of care.

2. A blanket religious exemption to Section 1557's protections is contrary to the purpose of Section 1557

We strongly support the proposed rule's recognition that Section 1557 does not require the Department to incorporate the language of Title IX's religious exemption. Including the religious exemption from Title IX, or a new blanket religious exemption to Section 1557's protections, would run counter to the operation and purpose of a law prohibiting discrimination within the health care system.

A patient's decision to seek health care at a particular institution is frequently dependent upon geographic location, cost, insurance coverage, and the treatments sought. Allowing providers to delay or deny care based on their religious objections has a direct impact on patients and may place individuals' lives and health at risk. Religious objections to health care frequently impact LGBTQI+ patients and patients who are pregnant, seek to be pregnant or seek to avoid pregnancy. Abortion, contraception, sterilization and fertility care are essential health care services for any patient who may become pregnant, and who therefore may need one, several or all of these services in the course of their reproductive life. As discussed in detail above, denial of these services also constitutes sex discrimination under Section 1557. Accordingly, any health care entity subject to 1557 should be required to ensure that patients are able to obtain seamless access to the care they need.

The proliferation of Catholic health care system mergers has resulted in entire regions where patients do not have access to a non-religious, nondiscriminatory hospital or health care providers. Due to an acceleration of hospital mergers, people living in rural areas, people with low incomes, and communities of color often rely on the religiously affiliated health care entities which now make up a large part of the U.S. health care system.[62] In fact, women of color disproportionately give birth in Catholic hospitals, and

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[62] Susan Haigh & David Crary, *Catholic Hospitals' Growth Has an Impact Reproductive Healthcare*, AP NEWS (Jul. 24, 2022), https://apnews.com/article/abortion-health-religion-new-york-oregon-8994d9b5fd0040d40d19fd1e44c313d8; Amy Littlefield, *Women of Color More Likely to Give Birth in Hospitals Where Catholic Beliefs Hinder Care*, REWIRE NEWS GROUP (Jan. 19, 2018), https://rewirenewsgroup.com/2018/01/19/women-color-likely-give-birth-hospitals-catholic-beliefs-hinder-care/; Kira Shepherd, et al., *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, COLUMBIA LAW SCHOOL LAW, RIGHTS, AND RELIGION PROJECT (2018), https://lawrightsreligion.law.columbia.edu/bearingfaith; *See also*, U.S. CATHOLIC HEALTHCARE ASSOCIATION, CATHOLIC HEALTHCARE IN THE UNITED STATES (2022), https://www.chausa.org/docs/default-source/default-document-library/the-strategic-profile.pdf.

therefore also experience denials of care related to reproductive health care at much higher rates, including when attempting to access hormonal birth control, IUD placement, abortion, sterilization and IVF care.[63] Religious exemptions can facilitate sex discrimination against patients, and a blanket exemption would exacerbate patients' lack of access to care, especially in those areas.

To ensure alignment with international human rights norms, we also urge the Department to clarify that existing religious refusal laws do not relieve health care providers of their obligation to provide nondiscriminatory care. All countries have a human rights obligation to ensure that religious refusals do not hinder access to quality reproductive care, including abortion, a principle that has been reiterated by the World Health Organization's 2022 Abortion Care Guideline and the UN Special Rapporteur on Freedom of Religion or Belief.[64] Human rights standards are clear on the principle that where religious refusals are permitted, they cannot be allowed to infringe on a patient's access to care. The government has an obligation to ensure nondiscriminatory access to care, regardless of whether providers avail themselves of existing religious refusal laws.[65] See Section IV. below for a more detailed discussion of human rights in the context of sexual and reproductive health.

3. Religious exemptions based on other federal statutes must be weighed against their harm to patients.

The Department is correct that the potential harm to third parties must be weighed as part of any Religious Freedom Restoration Act (RFRA) analysis of whether to grant exemptions in the health care context. We urge the Department to make this element of the assessment for the application of federal refusal laws, including RFRA, clear in the final rule.

The Department has proposed that health care entities seeking an exception to the anti-discrimination provisions of Section 1557 can claim that a requirement violates RFRA or a federal refusal law and receive an individualized assessment for an exemption based on their religious objection. We agree that these exceptions, if granted at all, be assessed by the Department on a case-by-case basis. That assessment must include a fact-specific inquiry and assessment of the burden on religious exercise, in conjunction with the potential impact on a patient or potential patient seeking health care.

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[63] Amy Littlefield, *Women of Color More Likely to Give Birth in Hospitals Where Catholic Beliefs Hinder Care*, REWIRE NEWS GROUP (Jan. 19, 2018), https://rewirenewsgroup.com/2018/01/19/women-color-likely-give-birth-hospitals-catholic-beliefs-hinder-care/; Kira Shepherd, et al., *Bearing Faith: The Limits of the Catholic Health Care for Women of Color*, COLUMBIA LAW (2018), https://lawrightsreligion.law.columbia.edu/sites/default/files/content/BearingFaith.pdf.

[64] WORLD HEALTH ORGANIZATION, ABORTION CARE GUIDELINE https://www.who.int/publications/i/item/9789240039483 60 (Mar. 8, 2022); Committee on Economic, Social and Cultural Rights, General comment No. 22 (2016) on the right to sexual and reproductive health (art. 12 of the International Covenant on Economic, Social and Cultural Rights), para. 14, U.N. Doc. E/C.12/GC/22 (2016).

[65] Committee on Economic, Social and Cultural Rights, General comment No. 22 (2016) on the right to sexual and reproductive health (art. 12 of the International Covenant on Economic, Social and Cultural Rights), para. 43, U.N. Doc. E/C.12/GC/22 (2016) (noting that "where health-care providers are allowed to invoke conscientious objection, States must appropriately regulate this practice to ensure that it does not inhibit anyone's access to sexual and reproductive health care…"); 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).

In the context of discrimination in health care, the government has the strongest compelling interest to prevent longstanding discrimination in health care that has created numerous, at times insurmountable barriers to quality health care for communities of color, people with disabilities, the LGBTQI+ community, and more, but especially those who sit at the intersections of these identities. Religious exemptions have been and continue to be used to discriminate against patients in need of reproductive health care and LGBTQI+ competent care, and have actively exacerbated health disparities.[66] RFRA was intended to be a shield to protect religious minorities, not to be used as a sword to discriminate or to harm third parties such as patients attempting to access health care.

Determinations by the Department of whether an exemption should be granted should clearly explain how any exemption granted does not further discrimination, and how any denied exemption would have undermined the goals of Section 1557 if granted. Additionally, the Department should ensure that determinations of discrimination are not unduly delayed due to the time-sensitive nature of health care. Delays in care can result in increased negative health outcomes or prevent patients from accessing care entirely.

II. The NPRM's proposal to restore protections for the LGBTQI+ community are essential and align with federal law and international human rights norms.

A. The NPRM's proposed restoration of protections against discrimination for the LGBTQI+ community is essential.

We support the Department's recognition in the proposed rule that sex discrimination includes discrimination on the basis of sex stereotypes, sexual orientation, gender identity and sex characteristics, including intersex traits. LBGTQI+ people frequently experience discrimination in accessing care. In a 2016 study, 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.[67] 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.[68]

Denials of access to and coverage for gender-affirming care are among the most common forms of discrimination against the LGBTQI+ communities. Therefore, the NPRM's proposal to restore protections for gender-affirming care are essential. We support the explicit inclusion of examples in §92.206 and §92.207 of the types of discrimination that are prohibited, to ensure covered entities have clear guidance about their obligations to provide and cover this essential care. Importantly, §92.206(c) clarifies that while providers may exercise clinical judgment in determinations regarding the appropriate services for an individual patient, they may not refuse gender-affirming care to a patient based on a personal belief that such care is never clinically appropriate. We also support the clarification in §92.206(c) that a provider's compliance with a state or local law that reflects a judgment that such care is never appropriate is "not sufficient basis for a judgment that a health service is not clinically

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[66] *See, e.g.,* NAT'L WOMEN'S LAW CTR, *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide* (Feb. 18, 2022), https://nwlc.org/resource/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/.

[67] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2016), CTR FOR AMER. PROGRESS https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care.

[68] *Id.*

appropriate."[69] We recommend that the Department further strengthen this language by stating unequivocally that Section 1557, as federal law, preempts any such state or local law restricting access to gender affirming care.

Discrimination against intersex people is also inherently sex-based. For that reason, the proposed rule's explicit inclusion of discrimination on the basis of sex characteristics, including intersex traits, is essential and should be retained in the final rule. As of 2016, intersex individuals made up approximately 1.7 percent of the world population.[70] Adults with intersex conditions report facing discrimination in health care settings and denial of care once their atypical anatomy is known.[71] Studies have shown that up to 80 percent of intersex patients have changed their care based on discomfort with their medical providers.[72]

B. The proposed rule's protections against LGBTQI+ discrimination is consistent with federal law and international human rights norms.

The proposed rule's inclusion of sex stereotypes, sexual orientation, gender identity and sex characteristics is consistent with settled federal law governing sex discrimination. Supreme Court jurisprudence, including the decisions in *Price Waterhouse v. Hopkins* and *Bostock v. Clayton County*, makes clear that federal sex discrimination laws prohibit discrimination on the basis of sex stereotypes, sexual orientation and gender identity.

We also note that the proposed rule's robust interpretation of sex discrimination based on sex stereotypes, sexual orientation and gender identity is in keeping with international human rights norms.[73] The UN High Commissioner for Human Rights has affirmed that all people, including LGBT persons, are entitled to enjoy the protections provided by the right to be free from discrimination.[74] This principle has been affirmed by human rights bodies, including with respect to sexual and reproductive health. Countries have an obligation to ensure that their legal frameworks do not discriminate based on sexual orientation and

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[69] 87 Fed. Reg. 47918 (Aug. 4, 2022).

[70] 81 Fed. Reg. 31,375, 31,389 (May 18, 2016).

[71] *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.

[72] *Id.*

[73] 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, at para. 20; Convention on the Rights of Persons 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).

[74] 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. 5, U.N. Doc. A/HRC/19/41 (Nov. 17, 2011).

gender identity and to protect against discrimination by third parties.[75] See Section IV. below for a more detailed discussion of human rights in the context of sexual and reproductive health.

C. The proposed rule should include transgender status as a protected characteristic, and should use consistent language throughout the rule in reference to protected characteristics.

While the terms "gender identity" and "transgender status" are frequently used interchangeably, at times people have sought to justify discrimination against transgender people by highlighting distinctions between the two terms.[76] Therefore, we recommend that the Department use both terms in the regulatory text. We propose that this change be made in sections 92.206(b)(1), (b)(2) and (b)(4), and in section 92.207(b)(3), as well as in §92.101(a)(2) as follows:

> §92.101(a)(2) Discrimination on the basis of sex includes, but is not limited to, discrimination on the basis of sex stereotypes; sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; <u>transgender status;</u> and gender identity.

The NPRM's proposal that covered entities should develop and implement written policies and procedures to ensure compliance with this rule, and that the procedural requirements apply to all covered nondiscrimination bases, is an important addition. We also support the notice requirements in §92.10. However, the description of prohibited sex discrimination in §92.8 (Policies and Procedures) and §92.10 (Notice of nondiscrimination) differs from the language of §92.101 (Discrimination prohibited). While the differences are not extensive, we recommend the Department use consistent language throughout the rule to avoid confusion, using the more expansive definition in §92.101. Relatedly, we support the Department's proposal to restore protections for sexual orientation and gender identity that were arbitrarily and capriciously removed from §147.104, §155.120, §155.220, §156.200, and §156.1230 by the 2020 rule. However, because the proposed language of these protections differs from the language proposed under §92, we urge the Department to here, too, adopt language in the final rule consistent with the language in §92.101 to avoid confusion and ensure consistency of implementation.

III. Sex discrimination in the context of marital, parental, or family status remains a common concern in the health care context.

We support the Department's proposed new §92.208, prohibition on sex discrimination related to marital, parental, or family status. Sex discrimination in the context of marital, parental, or family status remains a common concern, particularly in the area of reproductive health care.

We note that the proposed rule limits the application of this nondiscrimination provision to prohibiting the consideration of an individual's sex in the application of "*any rule* concerning an individual's current,

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[75] 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. 41, U.N. Doc. E/C.12/GC/22 (2016) (stating that the "obligation to respect also requires States to repeal, and refrain from enacting, laws and policies that create barriers to access to sexual and reproductive health services. This includes third-party authorization requirements, such as parental, spousal and judicial authorization requirements for access to sexual and reproductive health services and information, including for abortion and contraception.").

[76] *See*, *e.g.*, "Making Admission or Placement Determinations Based on Sex in Facilities Under Community Planning and Development Housing Programs," Proposed Rule, 85 Fed Reg 44811 (July 24, 2020).

perceived, potential, or past marital, parental, or family status."[77] (Emphasis added.) This construction importantly would address some types of discrimination experienced by same-sex couples in the health care context. For example, the provision would prohibit insurance plans from denying access to IVF for same-sex married couples, where the plan requires beneficiaries to be both married and in a different-sex relationship to access the coverage benefit. (See, e.g., the example of OSF HealthCare, a self-insured Catholic hospital system with facilities in Illinois and Michigan, which recently adopted an insurance policy for its employees that limits IVF coverage to "married couple[s] of opposite sex spouses."[78] However, the proposed rule fails to address marital status discrimination that occurs outside of the application of a rule. Individual bias by health care providers against the use of birth control and sterilization for single, unmarried and/or childless patients that results in denial of this care may also be prohibited discrimination under Section 1557. For example, it is common for some health care providers to deny hormonal birth control to single and unmarried patients, or to deny IUD placement or hysterectomies to patients who are unmarried, childless, or are not in the presence of their spouse, even where they would otherwise provide that care.[79]

We urge the Department to clarify in the final rule that any conduct that denies access to or coverage for health care by considering the patient's sex in combination with marital, parental, or family status is prohibited sex discrimination under Section 1557.

IV. The proposed rule takes critical steps to align with international human rights norms and obligations.

A. International human rights law prohibits discrimination on the basis of sex, including discrimination based on termination of pregnancy, sexual orientation and gender identity.

We support the Administration's efforts to advance access to nondiscriminatory health care, which will bring U.S. policy closer into compliance with international human rights law.

Human rights are based in the principles of universality and non-discrimination, as set forth in the Universal Declaration of Human Rights (UDHR): "[A]ll human beings are born free and equal in dignity and rights."[80] Equality and non-discrimination are core principles of international human rights law, and non-discrimination is a crucial obligation for all core human rights treaties, including the International

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[77] 87 Fed. Reg. 149, p.47918 (Aug. 4, 2022).

[78] Shira Stein, *Hospital Chain Blocks Fertility Coverage for Its LGBTQ Employees*, BLOOMBERG LAW (July 18, 2022), https://www.bgov.com/core/news_articles/RF7N4HT0G1LX.

[79] *See, e.g.*, Cate Charron, *Many Struggle to Find a Doctor to Tie Their Tubes. Roe's Overturn May Make it Harder*, THE HERALD TIMES (July 12, 2022), https://www.heraldtimesonline.com/story/news/local/2022/07/12/roes-overturn-may-make-harder-those-who-want-get-tubes-tied/7765626001/ ; Meena Venkataramanan, *Post-Roe, More Americans Want Their Tubes Tied. It Isn't Easy*, WASHINGTON POST (Aug. 17, 2022), https://www.washingtonpost.com/health/2022/08/15/roe-tubal-sterilizations-barriers/.

[80] 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).

Covenant on Civil and Political Rights (ICCPR),[81] which the United States ratified in 1992,[82] and the Covenant on Economic, Social and Cultural Rights (ICESCR).[83]

The 2016 Rule's interpretation of sex-based discrimination advanced international human rights principles 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.[84] As described above, the current proposed rule has not explicitly included termination of pregnancy in its description of prohibited discrimination.[85] We urge the Department to clarify that abortion is covered by the rule and provide examples of prohibited conduct, to ensure that the rule aligns with international human rights standards.

Human rights protect against discrimination based on pregnancy-related status.[86] In fact, human rights experts have expressed particular concern over discrimination on the basis of termination of pregnancy.[87] The Special Rapporteur on the Right to Health has found that the marginalization and vulnerability of individuals resulting from abortion-related discrimination perpetuates and intensifies violations of the right to health.[88] In addition, multiple treaty monitoring bodies and human rights experts have also noted that particular communities, "such as, but not limited to, poor women, persons with disabilities, migrants, indigenous or other ethnic minorities, adolescents, lesbian, gay, bisexual, transgender and intersex

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[81] 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]. 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." This list is deliberately not exhaustive, and the Human Rights Committee and other bodies have affirmed that "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].

[82] OHCHR, *Status of Ratification Interactive Dashboard*, http://indicators.ohchr.org/ (last visited Sept. 30, 2022).

[83] 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 ICESCR, "as a signatory, we are committed to not defeating the object and purpose of the treaty").

[84] 81 FR 31387.

[85] Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824 (proposed August 4, 2022).

[86] 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); 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).

[87] Brief for United Nations Mandate Holders as Amici Curiae Supporting Respondents, *Dobbs v. Jackson Women's Health Organization*, 142 S.Ct. 2228 (2022) (No. 19-1392).

[88] Anand Grover, Special Rapporteur of the Human Rights Council, *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).

persons, [and] people living with HIV/AIDS" may be "disproportionately affected by intersectional discrimination in the context of sexual and reproductive health."[89]

The CEDAW Committee has also expressed concern over discrimination against individuals seeking abortion services.[90] 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."[91]

In its 2022 Abortion Care Guideline, the World Health Organization ("WHO") also integrates international human rights law recognizing that countries must remove all legal, practical and social barriers impeding individuals' equal and non-discriminatory access to sexual and reproductive health, including abortion.[92] The Guideline also recognizes that states have obligations to address laws, institutional arrangements, and social practices that are discriminatory and that prevent people from effective enjoyment of their right to sexual and reproductive health. Since states look to HHS for guidance interpreting Section 1557, its guidance plays a potentially pivotal role in reinforcing international human rights law.

Human rights also protect against discrimination based on sex stereotypes, and treaty bodies likewise emphasize the prohibition on such discrimination.[93] Indeed, human rights require states to ensure that

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[89] Committee on Economic, Social and Cultural Rights, General Comment No. 22, para. 30; *See also, e.g.,* Committee on the Rights of the Child, General Comment No. 15 (2013) on the rights of the child to the enjoyment of the highest attainable standard of health (art. 24), paras. 8-11, U.N. Doc. CRC/C/GC/15 (Apr. 17, 2013); Committee on the Rights of People with Disabilities, General Comment No. 3 (2016) on women and girls with disabilities, para. 2, U.N. Doc. CRPD/C/GC/3 (Nov. 25, 2016); Human Rights Council, General Comment No. 28: Article 3 (The equality of rights between men and women), para. 30, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (Mar. 29, 2000); CEDAW Committee, General Recommendation No. 34 (2016) on the rights of rural women, para. 38, U.N. Doc, CEDAW/C/GC/34 (Mar. 7, 2016); Human Rights Council, Report of the Special Rapporteur on Extreme Poverty and Human Rights on his mission to the United States of America, para. 56, U.N. Doc. A/HRC/38/33/Add.1 (May 4, 2018) (noting that "low-income women['s] lack of access to abortion services traps [them] in cycles of poverty.").

[90] CEDAW Committee, Concluding observations on the eighth periodic report of Australia, para. 49(a), U.N. Doc. CEDAW/C/AUS/CO/8 (2018); CEDAW Committee, Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, Report of the Committee, para. 65, U.N. Doc. CEDAW/C/OP.8/GBR/1 (March 6, 2018) (finding that abortion restrictions in Northern Ireland constituted discrimination because they affected only women, "preventing them from exercising reproductive choice.").

[91] 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, OHCR 7 (2017), https://www.ohchr.org/Documents/Issues/Women/WG/WomensAutonomyEqualityReproductiveHealth.pdf.

[92] WORLD HEALTH ORGANIZATION, ABORTION CARE GUIDELINE 8, (Mar. 8, 2022), https://www.who.int/publications/i/item/9789240039483.

[93] 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*

reproductive health services, in particular, are provided in a manner that does not promote or exacerbate harmful gender stereotypes and assumptions.[94]

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."[95] Human rights treaty bodies have affirmed the right to non-discrimination based on gender identity,[96] including with respect to sexual and reproductive health.[97] 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.[98]

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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*, at para. 20; Convention on the Rights of Persons 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).

[94] Convention on the Elimination of All Forms of Discrimination Against Women, *adopted* Dec. 18, 1979, art. 2(f), 5(a), 12, 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); 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), .

[95] 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. 5, U.N. Doc. A/HRC/19/41 (Nov. 17, 2011).

[96] 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); 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. 32, U.N. Doc. E/C.12/GC/20 (2009); 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 on the core obligations of states parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women, para. 18, U.N. Doc. CEDAW/C/GC/28 (Dec. 16, 2010); see also 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. 16, U.N. Doc. A/HRC/19/41 (Nov. 17, 2011) (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.").

[97] Committee on Economic, Social and Cultural Rights, General comment No. 22 (2016) on the right to sexual and reproductive health (art. 12 of the International Covenant on Economic, Social and Cultural Rights), para. 2, U.N. Doc. E/C.12/GC/22 (2016).

[98] 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. 50, 54-57, U.N. Doc. A/HRC/19/41 (Nov. 17, 2011).

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.[99] The High Commissioner recommends that governments enact comprehensive anti-discrimination legislation that includes prohibitions on discrimination based on sexual orientation and gender identity.[100] We appreciate the proposed rule's recommendation of a private right of action to enforce Section 1557, as well as a robust interpretation of prohibited sex discrimination, in keeping with human rights norms and obligations.

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.

International human rights law holds that the right of religious freedom by one individual cannot justify infringement on the human rights of others, including women and LGBTQI individuals.[101] Incorporation of federal refusal laws would encourage more provider discrimination, contrary to human rights norms.[102]

The World Health Organization's 2022 Abortion Care Guideline reiterates that "the human rights obligation to ensure conscientious objection does not hinder access to quality abortion care."[103] The Guideline also states that "[i]f it proves impossible to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible."[104] Further, 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 on women's rights,[105] and has expressed concern over the use of "religious liberty" to justify the refusal of providing goods and services to women and LGBTQI individuals.[106]

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[99] 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. 41, U.N. Doc. E/C.12/GC/22 (2016) (stating that the "obligation to respect also requires States to repeal, and refrain from enacting, laws and policies that create barriers to access to sexual and reproductive health services. This includes third-party authorization requirements, such as parental, spousal and judicial authorization requirements for access to sexual and reproductive health services and information, including for abortion and contraception.").

[100] *Id.* para. 84(e), U.N. Doc. E/C.12/GC/22 (2016); *see also* Committee on Economic, Social and Cultural Rights, Concluding Observations: Germany, para. 26, U.N. Doc. E/C.12/DEU/CO/5 (2011).

[101] Ahmed Shaheed, 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).

[102] *See* Human Rights Council, Report of the Working Group on the issue of discrimination against women in law and practice, para. 93, U.N. Doc. A/HRC/32/44 (Apr. 8, 2016) (concluding that "inadequately regulated conscientious objection may constitute a barrier for women when exercising their right to have access to reproductive and sexual health services. The jurisprudence of human rights treaty bodies states that where conscientious objections is permitted, States still have an obligation to ensure that women's access to reproductive health services is not limited and that conscientious objection is a personal, not an institutional, practice.")

[103] WORLD HEALTH ORGANIZATION, ABORTION CARE GUIDELINE 60, (Mar. 8, 2022), https://www.who.int/publications/i/item/9789240039483.

[104] *Id.*

[105] Special Rapporteur on Freedom of Religion or Belief, Interim Rep. of The Special Rapporteur on Freedom of Religion or Belief, para. 24, U.N. Doc. A/72/365 (Aug. 28, 2017).

[106] *Id.* para. 37, U.N. Doc. A/72/365 (Aug. 28, 2017).

Accordingly, human rights standards require that where a refusal of care based on religious or conscience belief is permitted, it does not infringe on others' access to health care.[107] They require the government to ensure that health care providers' refusal to provide reproductive health care, including abortion care, on grounds of conscience does not jeopardize access to reproductive health care.[108]

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.*[109]

We therefore urge the Department to explicitly delineate the limitations of religious refusal laws. Specifically, the Department should clarify that health care entities are responsible for ensuring that patients do not experience discrimination even if individual providers object to providing that care. The final rule should address the harm caused by discrimination that occurs under the guise of a religiously motivated denial of care, which does not relieve a health care provider of their obligation to provide nondiscriminatory care.

To more closely align with international human rights standards, the final rule should ensure that health care providers' religious refusals to provide sexual and reproductive health care services do not result in discrimination against their patients and do not prevent a patient's access to care.

C. The proposed regulation should be considered an important tool to prevent a retrogression of rights.

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.[110] In the context of sexual and reproductive health, in particular, the Committee on Economic, Social and Cultural Rights ("CESCR") – the Committee overseeing implementation of International Covenant on Economic, Social and Cultural Rights ("ICESCR") – has

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[107] Committee on Economic, Social and Cultural Rights, General comment No. 22 (2016) on the right to sexual and reproductive health (art. 12 of the International Covenant on Economic, Social and Cultural Rights), paras. 14, U.N. Doc. E/C.12/GC/22 (2016).

[108] *Id.* para. 43, U.N. Doc. E/C.12/GC/22 (2016) (noting that "where health-care providers are allowed to invoke conscientious objection, States must appropriately regulate this practice to ensure that it does not inhibit anyone's access to sexual and reproductive health care…"); 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).

[109] 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. 71, 95(i), U.N. Doc. A/HRC/19/41 (Nov. 17, 2011).

[110] International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 2, para. 1, 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).

provided specific examples of measures which would be retrogressive.[111] 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."[112]

The United States is currently experiencing a retrogression of reproductive rights, of which the overturn of *Roe* is just the latest and most extreme example. Over the last decade, states across the country have engaged in a retrogression of abortion rights. This has occurred within the context of a retrogression of civil rights overall, including on issues such as immigration and discrimination protections, which Section 1557 is also designed to protect.

The implications of the recent *Dobbs* decision have drawn concern from the international human rights community. Victor Madrigal-Borloz, the UN Independent Expert on Sexual Orientation and Gender Identity who visited the United States in August 2022, called the decision "a devastating action for the human rights of lesbian and bisexual women, as well as trans men and other gender diverse persons with gestational faculties."[113] Madrigal-Borloz further noted that such bans have or will lead "to the closure of clinics that are critical sources of sexual and reproductive health care for LGBT persons: contraception and abortion services, wellness services, examinations, STI testing and treatment, hormone replacement therapy and insemination services."[114] At the conclusion of its 2022 review of the United States, the Committee on the Elimination of Racial Discrimination (CERD Committee) noted deep concerns with the decision in Dobbs and recommended that the United States address the disparate impact that it will have on racial and ethnic minorities, Indigenous women, and those with low incomes.[115]

The proposed rule's renewed emphasis on protections against discrimination on the basis of sex are an important tool in holding strong against a retrogression of rights. This is critical to reenforcing core international human rights principles.

V. The proposed rule makes the vital clarification that Section 1557 applies to Medicare Part B – in keeping with the statutory intent of Section 1557 and better interpretation of the law.

We strongly support OCR's proposal to treat Medicare Part B payments as federal financial assistance and Part B providers and suppliers as recipients under Section 1557, Title VI, Title IX, Section 504, and the Age Act. This change in interpretation is well-supported by how the Part B program has evolved, the fact that most Part B providers are already receiving other forms of federal financial assistance, as well as the clear intent of the Section 1557 statute to ensure nondiscriminatory access to health care. This change will also eliminate confusion for older adults and people with disabilities and help ensure that people with

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[111] 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. 38, U.N. Doc. E/C.12/GC/22 (2016).

[112] *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.

[113] Victor Madrigal-Borloz, *Mandate of the United Nations Independent Expert on Protection from Violence and Discrimination based on Sexual Orientation and Gender Identity* 2 (2016).

[114] *Id.* at 3.

[115] U.N. CERD, International Convention on the Elimination of All Forms of Racial Discrimination: Concluding observations on the combined tenth to twelfth reports of the United States of America, CERD/C/USA/CO/10-12, para 35 (Sept. 21, 2022).

Medicare have the same protections and rights regardless of the Medicare provider they choose, the Medicare-covered service they are receiving, or whether they are in Original Medicare or Medicare Advantage. Ensuring that all Medicare providers are subject to this rule will also help increase access to quality health care for underserved communities who face the most discrimination and barriers, as many Medicare providers also serve people with other forms of insurance. These patients will benefit from their providers' compliance with Section 1557.

VI. The inclusion of new provisions that address the changing health care landscape are important to further health equity.

Clinical algorithms have the potential to be transformative tools in health care, but there is demonstrable concern about the ways in which algorithms are sensitive to the biases of their creators.[116] Recently, the WHO convened experts over the course of two years to inspect the ways that these technologies appear across the health care sector and govern various decision-making processes within health care systems. WHO's subsequent report and guiding principles urge governments and entities to center human dignity, autonomy, and principles of inclusivity, equity, and accountability in order to ensure that these systems are implemented in a way that benefits every person.[117] Therefore, we support the Department's proposed provision on nondiscrimination in the use of clinical algorithms, and appreciate that proposed §92.210 makes explicit that covered entities are prohibited from discriminating through the use of clinical algorithms on the basis of race, color, national origin, sex, age, or disability under Section 1557.

Education will be critical to prevent further discrimination and harm as a result of biases in clinical algorithms. We urge the Department and the Biden-Harris Administration to collaborate with experts to help educate stakeholders, including insurers, health care system managers, clinicians, providers, and community health care workers, on the ways that algorithms inform decision-making processes. In addition to awareness of their liability for discriminatory use of these tools, this would ensure that entities can recognize and disrupt biases in those processes. The Department should also ensure that patients can easily access information about the use of these algorithms in the provision of their care. Finally, patients should also be made aware of any mechanism to file a complaint with the Office of Civil Rights to address and remedy discrimination they experience as a result of the use of a clinical algorithm.

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[116] *See, e.g.,* AHRQ, IMPACT OF HEALTHCARE ALGORITHMS ON RACIAL AND ETHNIC DISPARITIES IN HEALTH AND HEALTHCARE, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (Jan. 25, 2022), https://effectivehealthcare.ahrq.gov/products/racial-disparities-health-healthcare/protocol; Matthew Hutson, *Even Artificial Intelligence Can Acquire Biases Against Race and Gender*, SCIENCE (Apr. 13, 2017), https://www.science.org/content/article/even-artificial-intelligence-can-acquire-biases-against-race-and-gender; Stephanie S. Gervasi, et al., *The Potential for Bias in Machine Learning and Opportunities for Insurers to Address It*, HEALTH AFFAIRS (Feb. 2022), https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01287; Ziad Obermeyer, et al., *Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations*, SCIENCE (25 Oct. 2019), https://www.science.org/doi/full/10.1126/science.aax2342; Elizabeth Edwards, Preventing Harm from Automated Decision-Making Systems in Medicaid, NATIONAL HEALTH LAW PROGRAM (Jun. 14, 2021), https://healthlaw.org/preventing-harm-from-automated-decision-making-systems-in-medicaid/.

[117] WORLD HEALTH ORG., ETHICS AND GOVERNANCE OF ARTIFICIAL INTELLIGENCE FOR HEALTH GUIDANCE, WHO (Jun. 28, 2021), https://www.who.int/publications/i/item/9789240029200; World Health Org., *WHO Issues First Global Report on Artificial Intelligence (AI) in Health and Six Guiding Principles for Its Design and Use*, WHO (Jun. 28, 2021), https://www.who.int/news/item/28-06-2021-who-issues-first-global-report-on-ai-in-health-and-six-guiding-principles-for-its-design-and-use.

VII. The proposed rule affirms key requirements for a nondiscrimination notice, as well as nondiscrimination protections for people with limited English proficiency and people with disabilities.

A. The proposed rule is correct to propose an annual nondiscrimination notice.

We strongly support the requirements related to a notice of nondiscrimination. The NPRM's proposed requirement that covered entities provide the notice on an annual basis and upon request is clearer than the prior requirement for notice in "significant" communications.[118] The proposed requirement of informing the public by prominently posting the notice in the covered entity's physical location, and on its website if applicable, is clear, specific and comes at a low cost to entities. We also agree with the Department's assessment that the 2020 Rule failed to sufficiently account for some of the harmful effects of the provisions' absence on individuals or health care systems.[119] In addition to the proposed requirements, we also recommend including a requirement that if a covered entity will deny certain services due to a religious belief that it must include that information on the notice, including in the required non-English languages.

B. The NPRM's proposed notice of language services requirement is essential for people with limited English proficiency, and should be given additional emphasis.

We strongly support the provision on notice of language assistance services and the requirements for when this notice must be made available. We also recommend that if a covered entity operates across multiple states, that the covered entity must provide the notice in not merely the top 15 languages across all the states but rather in the top 15 languages for each state. We also recommend that covered entities be required to provide the notice in large print, at least 18 point font. This will assist individuals with vision impairments to understand the importance of the notice. As the Office of Civil Rights (OCR) has previously done, we also recommend that OCR develop and provide covered entities with model notices and translated information in the relevant languages that will be needed across the country.

We also recommend a requirement that this notice must be provided at the beginning or on the first page of any document. Unfortunately, many documents in which this notice will be required can be lengthy. We do not believe a person with limited English proficiency would look through a multi-page English-language document to find the notice at the end of the document. Given the importance of this notice, we believe it should be the first page that everyone sees. This will benefit LEP individuals who will immediately see, in their language, that language assistance services are available, and will also benefit individuals with disabilities who will see information in large print up front as well.

C. The NPRM's proposed provisions for access to facilities and proposed integration provision are essential protections for people with disabilities.

We support § 92.203 and § 92.205, which preserve prior existing requirements for structural accessibility and the provision of reasonable modifications to ensure access to facilities for people with disabilities. However, we strongly recommend that the final rule incorporate existing standards relating to accessible

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[118] Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824 (proposed August 4, 2022); *See, e.g.,* Nat'l Council of Asian Pacific Ams., Comment on Section 1557 NPRM, pp. 3-7 (Aug. 13, 2019), *https://www.regulations.gov/comment/HHS-OCR-2019-0007-145953*.
[119] *Id.*

medical and diagnostic equipment that were developed by the U.S. Access Board and finalized in 2017.[120] For some people with disabilities, equipment accessibility is as necessary to equally effective health care as the accessibility of buildings and facilities, and is equally linked to requests for reasonable modifications in a covered entity's policies and procedures.

We also strongly support the proposed rule's § 92.207(b)(6), which rightly requires covered entities to provide or administer health insurance coverage or other health-related coverage in the most integrated setting appropriate to the needs of qualified individuals with disabilities. This aligns the rule with governing Supreme Court precedent in *Olmstead v. Zimring*[121] and allows patients with disabilities and disability advocates to highlight their increased risk of isolation, unmet health care needs, and lost functional capacity when public and private insurance providers and policies place arbitrary distinctions on when and where services or treatments may be provided.

VIII. The proposed rule restores the proper scope of Section 1557's nondiscrimination protections.

We support the proposed rule's restoration of the scope of application of Section 1557's nondiscrimination protections, which were severely curtailed by the 2020 rule. The 2020 Rule narrowed its scope of application of nondiscrimination protections to the narrowest possible set of entities, falling short of its statutory authority in its interpretation of Section 1557 and jeopardizing patient access to care. The Department should restore application of Section 1557's nondiscrimination protections to its original scope, ensuring that a greater number of patients will be able to benefit from Section 1557's nondiscrimination protections.

IX. The proposed rule is correct to restore a private right of action and recognize intersectional discrimination, but more can be done to clarify that intersectional discrimination is prohibited.

We agree with the Department's decision to restore an individual's private right of action to enforce Section 1557. A private right of action is essential to ensuring that individuals who experience discrimination on the basis of sex in health care are not solely reliant on the Department to enforce the law, and may be entitled to compensation for the harm they experienced.

We also support strong enforcement of Section 1557 and the Department's recognition in the preamble that the law protects people who experience intersectional discrimination. This encompasses individuals who experience health care discrimination at the intersection of two or more protected characteristics, for example some combination of sexism (e.g., people who are pregnant or capable of pregnancy or LGBTQ+), racism, xenophobia (e.g., people with limited English proficiency (LEP)), ableism, or ageism. We urge the Department to provide greater clarity in the final rule regarding the protections and enforcement mechanisms available for intersectional discrimination under Section 1557.

For example, the Department should amend the proposed regulatory text at § 92.101(a)(1) to clarify that intersectional discrimination is prohibited. Specifically, we recommend this provision to be amended as follows:

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[120] US ACCESS BOARD, *Medical Diagnostic Equipment Accessibility Standards* https://www.access-board.gov/mde/ (Last visited Oct. 3, 2022).
[121] *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).

> (a) *General.* (1) Except as prohibited in Title I of the ACA, an individual must not, on the basis of race, color, national origin, sex, age, disability**,** or any combination thereof, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any health program or activity operated by a covered entity.

In addition, §92.301 should ensure that the Department will have clear and accessible procedures for individuals to file, and the agency to investigate and remediate, discrimination complaints, including intersectional discrimination complaints. The Department should also make clear throughout the final rule that Section 1557 creates a health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff's protected class or classes.

X. Conclusion.

The proposed rule is a strong step forward in advancing Section 1557's purpose of eliminating discrimination in health care. We appreciate the opportunity to comment on this NPRM. If you require any additional information about the issues raised in this letter, please contact Freya Riedlin, Federal Policy Counsel, at friedlin@reprorights.org.

Signed,
The Center for Reproductive Rights