August 13, 2019

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

RE: Nondiscrimination in Health and Health Education Programs or Activities; Proposed Rule 84 Fed. Reg. 27,846 (June 14, 2019) (RIN 0945–AA11)

To Whom It May Concern:

We are grateful for the opportunity to provide comments to the Office for Civil Rights ("OCR") and the Centers for Medicare and Medicaid Services ("CMS") of the U.S. Department of Health and Human Services ("HHS") on the Notice of Proposed Rulemaking Regarding Nondiscrimination in Health and Health Education Programs or Activities (the "Proposed Rule"). The Proposed Rule aims to revise the regulation implementing Section 1557 of the Patient Protection and Affordable Care Act ("Section 1557" and "ACA," respectively), currently codified at 45 C.F.R. part 92 (2018) (the "Final Rule"), including the definition of "on the basis of sex" in the Final Rule. The Proposed Rule also proposes numerous other modifications to the Final Rule, including ones focused on notice requirements; coverage of insurance practices; and requirements to provide language assistance services to individuals with limited English proficiency. The Proposed Rule also seeks to revise numerous regulations issued by CMS that prohibit sexual orientation and gender identity discrimination in different contexts related to CMS's own implementation of the ACA (the "CMS Regulations").

The undersigned are scholars of law, public policy, public health, psychology, and economics, among other fields, with substantial expertise related to antidiscrimination law generally and discrimination against lesbian, gay, bisexual, and transgender ("LGBT") people in particular. Many of the undersigned are affiliated with the Williams Institute at the University of California at Los Angeles School of Law. The Williams Institute is a research center dedicated to conducting rigorous and independent academic research on sexual orientation and gender identity, including on health disparities facing LGBT people and legal protections against discrimination related to sexual orientation and gender identity.

The Proposed Rule is inconsistent with the weight of judicial authority; will create confusion for entities covered by Section 1557 and the CMS Regulations, health care providers, and the public; and will remove a significant source of guidance for all of them – a particular problem given that covered entities will still be able to be held liable in court under standards deleted or modified in the Proposed Rule but still applicable under Section 1557 itself. The Proposed Rule also stands to undermine access to health care and health insurance for multiple vulnerable communities, contrary to a core purpose of the ACA and the mission of HHS and OCR.

In Part I of this comment, we demonstrate that the Proposed Rule's treatment of sex stereotyping, gender identity discrimination, and sexual orientation discrimination – and consequent elimination of the Final Rule's definition of "on the basis of sex" as well as protections against sexual orientation and gender identity discrimination in the CMS Regulations – is contrary to applicable law, the intent of the ACA (including Section 1557), and HHS's and OCR's missions; it also stands to exacerbate discrimination and health disparities facing LGBT and other vulnerable populations. In Part II, we demonstrate that the Proposed Rule incorrectly seeks to incorporate the religious exemption of Title IX of the Education Amendments of 1972 into Section 1557. Section 1557's clear text does not permit such a result, and OCR's proposal to the contrary distorts the statutory language, ignores the differences between the educational and health care contexts, risks significant harm to patients, and raises serious constitutional concerns. In Part III, we demonstrate that the Proposed Rule impermissibly narrows the scope of programs and activities covered by Section 1557, impermissibly eliminates notice and tagline requirements, inappropriately weakens requirements for the provision of language access services, and ignores longstanding precedent governing the availability of private rights of action.

For all of these reasons and others explained below, the Proposed Rule fails to provide the enhanced justification needed to depart from the Final Rule and the CMS Regulations; if finalized, the Proposed Rule will raise serious concerns under the Administrative Procedure Act, 5 U.S.C. § 706(2), as well as other laws. Moreover, while we have not specifically addressed some of the provisions of the Proposed Rule – including, for example, those addressing requirements for individuals with disabilities or revising procedural requirements for health care entities – we note that similar concerns arise with regard to changes that attempt either to weaken the protections of the Final Rule or eliminate guidance provided by the Final Rule that can helpfully promote voluntary compliance.

Thus, we urge OCR and CMS to withdraw the Proposed Rule in its entirety and leave the Final Rule and CMS Regulations in place. At a minimum, OCR and CMS should suspend the rulemaking until after the U.S. Supreme Court decides *R.G. & G.R. Harris Funeral Homes v. EEOC & Aimee Stephens*, No. 18-107, *Bostock v. Clayton County*, No. 17-1618, and *Altitude Express, Inc. v. Zarda*, No. 17-1623, *cert. granted* 139 S. Ct. 1599 (2019). Engaging in this rulemaking proceeding now – using as a basis a single district court opinion that questions the validity of only a portion of the Final Rule, and upending a comprehensive rulemaking proceeding that concluded only three years ago – is an ill-advised use of agency resources and taxpayer dollars, when, as the Proposed Rule itself concedes, the Supreme Court is poised to issue rulings that will likely offer significant guidance for resolution of issues related to the scope of Section 1557's prohibition of sex discrimination. *See* 84 Fed. Reg. 27,857, 27,855. Indeed, the Proposed Rule states that "[b]ecause of the likelihood that the Supreme Court will be addressing the issue in the near future, the Department declines, at this time, to propose its own, [sic] definition of 'sex' for purposes of discrimination on the basis of sex in the regulation." *Id*. at 27,857 (footnote omitted).

I. The Proposed Rule's Treatment of Sex Stereotyping and Gender Identity Is Inconsistent With The Law and Poses Significant Risk of Harm to LGBT People

A. The Final Rule's Definition of "On the Basis of Sex" Carefully Tracks the State of the Law

Section 1557 provides that an individual shall not, on the grounds prohibited under Title VI of the Civil Rights Act of 1964 ("Title VI"), 42 U.S.C. 2000d *et seq*. (race, color, national origin), Title IX of the Education Amendments of 1972 ("Title IX"), 20 U.S.C. 1681 *et seq*. (sex), the Age Discrimination Act of 1975 ("Age Act"), 42 U.S.C. 6101 *et seq*. (age), or Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. 794 (disability), "be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under [Title I of the ACA] (or amendments)." 42 U.S.C. § 18116(a). Section 1557 states that "the enforcement mechanisms provided for and available under" Title VI, Title IX, Section 504, or the Age Act shall apply for purposes of addressing violations of Section 1557. *Id.*

OCR undertook an extensive process to develop the Final Rule, including issuing a request for information in 2013, a proposed rule in 2015, and the Final Rule in 2016. *See* 81 Fed. Reg. 31,376. OCR received 402 comments in response to the request for information and approximately 24,875 comments on the proposed rule in 2015. *Id.* at 31,376.

The Final Rule sought "to clarify the application of the nondiscrimination provision in the ACA . . . [in order to] promote understanding of and compliance with Section 1557 by covered entities and the ability of individuals to assert and protect their rights under the law." 81 Fed. Reg. 31,444. With respect to Section 1557's prohibition of sex discrimination, OCR expressly sought to conform it to "the current state of nondiscrimination law." *Id.* at 31,388. In light of the weight of legal authority and an extensive administrative record, the Final Rule defined "on the basis of sex" under Section 1557 to include "discrimination on the basis of pregnancy, termination of pregnancy, or recovery therefrom . . . sex stereotyping, and gender identity." *Id.* at 31,467; 45 C.F.R. § 92.4.

In the Preamble to the Final Rule, OCR explained that the inclusion of "pregnancy" and "termination of pregnancy" was "based upon existing regulation and previous Federal agencies' and courts' interpretations . . . ." 81 Fed. Reg. at 31,388. In particular, as Section 1557 was intended to "extend[] the grounds for discrimination found in the nondiscrimination laws cited in the statute . . . to certain health programs and activities," the Final Rule "mirror[s]" the HHS Title IX nondiscrimination regulation, which explicitly prohibits discrimination on the basis of "termination of pregnancy'" and other pregnancy-related grounds. *Id.* at 31,387 (citing 45 C.F.R. § 86.40(b) (2005)). OCR also adopted this definition in light of evidence that individuals "have experienced considerable discrimination in accessing certain health care services such as

mental health care and drug treatment services" due to pregnancy-related forms of discrimination. *Id.* at 31,428.

Similarly, OCR included both sex stereotyping and gender identity in the definition of "on the basis of sex . . . based upon existing regulation and previous Federal agencies' and courts' interpretations . . . ." *Id*. at 31,388. OCR included sex stereotyping in light of the Supreme Court's decision in *Price Waterhouse v. Hopkins* that Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq.* ("Title VII"), prohibits employment decisions based on an individual's failure to conform to gender stereotypes, 490 U.S. 228, 250-51 (1989), and "a growing body of legal precedent" that amplified the Supreme Court's decision and also applied *Price Waterhouse* to Title IX. 81 Fed. Reg. 31,387, 31,388.[1]

OCR included gender identity in the definition of "on the basis of sex" based on the clear weight of court and agency decisions interpreting Section 1557 and similar statutes, *id*. at 31,387 & nn. 56-58,[2] and distinguished older precedent narrowly construing sex-based discrimination. OCR explained:

> [*Price Waterhouse* made clear that] in prohibiting sex discrimination, Congress intended to strike at the entire spectrum of discrimination against men and women resulting from sex stereotypes. Courts after *Price Waterhouse* interpret Title VII protections against discrimination on the basis of sex as encompassing not only 'sex,' or biological differences between the sexes, but also 'gender' and its manifestations. In essence, *Price Waterhouse* thus rejects the reasoning, and vitiates the precedential value, of earlier Federal appellate court decisions that limited Title VII's coverage of ''sex'' to the anatomical and biological characteristics of sex. Moreover, courts frequently look to case law interpreting other civil rights provisions, including Title VII, for guidance in interpreting Title IX. OCR's approach accords with well accepted legal interpretations adopted by other Federal agencies and courts.

Id. at 31,388 (citations omitted); *see also id.* at 31,389.

Specifying that sex discrimination encompasses gender identity discrimination was supported by voluminous evidence that transgender people experience persistent and pervasive discrimination in health care and health insurance. For example, the Preamble to the

[1] The Final Rule correctly defined "sex stereotypes" to mean "stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics. These stereotypes can include the expectation that individuals will consistently identify with only one gender and that they will act in conformity with the gender-related expressions stereotypically associated with that gender. Sex stereotypes also include gendered expectations related to the appropriate roles of a certain sex." 81 Fed. Reg. 31,468; 45 C.F.R. § 92.4.

[2] The Final Rule correctly defined "gender identity" to mean "an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth." 81 Fed. Reg. 31,467; 45 C.F.R. § 92.4.

Final Rule explains that "[f]or transgender individuals, a major barrier to receiving care is a concern over being refused medical treatment based on bias against them. In a 2010 report, 26.7% of transgender respondents reported that they were refused needed health care. A 2011 survey revealed that 25% of transgender individuals reported being subject to harassment in medical settings." *Id*. at 31,460 (citations omitted). In addition, the administrative record before OCR contained numerous comments documenting other relevant studies and individual experiences. *Id.*

Evidencing OCR's careful attention to the weight of legal authority while interpreting Section 1557, OCR declined in the Final Rule to provide that Section 1557's prohibition of sex discrimination always includes discrimination on the basis of sexual orientation. *See id*. at 31,389. Though the Equal Employment Opportunity Commission ("EEOC") and an increasing number of district courts had by the time of the Final Rule held that sexual orientation discrimination is per se sex discrimination under Title VII, OCR observed that the state of the law on this issue was "mixed" because older decisions had previously come to the opposite conclusion. *Id*. at 31,388. Ultimately, therefore, OCR "decided not to resolve in this rule" whether "discrimination on the basis of an individual's sexual orientation status alone is a form of sex discrimination under Section 1557." *Id*. at 31,390. Rather, OCR explained that "[w]e anticipate that the law will continue to evolve on this issue, and we will continue to monitor legal developments in this area. We will enforce Section 1557 in light of those developments and will consider issuing further guidance on this subject as appropriate." *Id*.

Yet, in light of *Price Waterhouse* and consistent judicial decisions that LGB people are protected from – and may well be subject to – sex stereotyping, OCR concluded that "Section 1557's prohibition of discrimination on the basis of sex includes, at a minimum, sex discrimination related to an individual's sexual orientation where the evidence establishes that the discrimination is based on gender stereotypes." *Id*. at31,390; *see also id.* at 31,389 & nn. 74-75; *cf., e.g.*, *Prowel v. Wise Bus. Forms*, 579 F.3d 285, 291-92 (3d Cir. 2009).

B. The Proposed Rule's Treatment of "On the Basis of Sex" is Contrary to Law and Internally Inconsistent

By contrast to the clear guidance that the Final Rule provided based on the weight of judicial and agency authority, the Proposed Rule would eliminate the definition of "on the basis of sex" in the Final Rule and, instead, simply restate the statutory requirement that Section 1557 prohibits discrimination on the "ground[] prohibited under . . . Title IX." 84 Fed. Reg. 27,891. Such a regulation would bring no clarity beyond the text of Section 1557 itself.

While the proposed regulatory text would be silent as to sex stereotyping and gender identity, OCR's intent to eliminate protections on those bases is clear from the Proposed Rule's Preamble and Regulatory Impact Analysis. In the Preamble, OCR states, for example, that Section 1557 should be consistent with the views of the Department of Justice, citing to a government brief asserting that "'Title IX and Section 1557 unambiguously exclude gender-identity discrimination.'" 84 Fed. Reg. 27,856; *see also id.* (discussing other government briefs

and a memorandum from the Attorney General that assert that "sex" in Title VII means "biologically male or female" and excludes gender identity and sexual orientation). In its Regulatory Impact Analysis, OCR states, moreover, that: "under the proposed rule, covered entities would no longer have to incur certain labor costs associated with processing grievances related to sex discrimination complaints as they relate to gender identity and sex-stereotyping as defined under the Final Rule because such definitions would be repealed and no longer binding under the proposed rule." *Id*. at 27,883; *see also id.* at 27,884 ("Additionally, by virtue of rescinding the definitions from the regulatory text, the proposed rule would remove the expansive inclusion of gender identity and sex stereotyping in the definition of sex discrimination as substantive grounds for a private right of action alleging such violations by covered entities."); *id.* ("For reasons set forth above, the Department estimates that covered entities have experienced a 3% increase in grievance claims over the long term concerning gender identity and sex stereotyping claims as set forth under the Final Rule and that, under the proposed rule, they would no longer have to process such claims under the grievance procedures required under the Final Rule."). Moreover, the Proposed Rule seeks to revise the CMS Regulations to eliminate express protections against sexual orientation and gender identity discrimination, purportedly to conform the CMS Regulations to Section 1557. *Id*. at 27,871.

The Proposed Rule causes confusion by, on the one hand, stating that it is not proposing a definition of "on the basis of sex" in light of forthcoming Supreme Court decisions that OCR admits "will likely have ramifications" for Section 1557, *id*. at 27,855; *see also id.* at 27,857, but, on the other, stating in the Preamble and Regulatory Impact Analysis that sex stereotyping and gender identity are being eliminated from Section 1557's ambit, as noted above. These two positions are not consistent: either OCR is *not* proposing a definition of sex discrimination under Section 1557 at this time – meaning that "on the basis sex" in any final rule could include sex stereotyping and gender identity – or OCR *is* proposing a definition of sex that eliminates protections against sex stereotyping and gender identity as the Preamble states and on which the Regulatory Impact Analysis is based.[3] Generally throughout this comment, we assume that OCR and CMS intend any final rule – and/or through enforcement proceedings – to eliminate existing protections against sex stereotyping (including but not limited to when related to a person's gender identity or sexual orientation) and gender identity discrimination, as well as the possibility of coverage of sexual orientation discrimination as *per se* sex discrimination.

[3] Confusion also arises from OCR's deletion of the Final Rule's explicit statement, consistent with similar language in the regulations implementing Title IX, that sex discrimination includes discrimination based on pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, and childbirth and related medical conditions. 81 Fed. Reg. 31,467, 45 C.F.R. § 92.4. The Proposed Rule's silence on this point at a minimum will cause confusion and risks heightening the levels of discrimination that have historically plagued – and continue to harm – women who are pregnant, are contemplating pregnancy, have gone through childbirth, or have related medical conditions. And as to termination of pregnancy, while the Final Rule makes clear that it incorporates the protections of the provider conscience and other laws that shield providers from having to participate in an abortion, there is nothing in those laws that would authorize providers to deny care to a woman because she has had an abortion in the past or is experiencing medical conditions related to an abortion. Eliminating the definition of "on the basis of sex" is, therefore, a disservice to both individuals and the regulated community.

As we explain further below, the Proposed Rule's analysis of Section 1557's coverage of sex stereotyping and gender identity in the Preamble and the Regulatory Impact Analysis – and its consequent elimination of the definition of "on the basis of sex" – is inconsistent with the purpose of the ACA and the weight of judicial authority; stands to cause confusion among entities and individuals covered by Section 1557 and the CMS Regulations; increases the risk that covered entities will be held liable in court for discrimination against LGBT people; is likely to cause significant harm to LGBT and other vulnerable people who face widespread discrimination in health care and health coverage; and stands to violate the Administrative Procedure Act and other laws. In addition, the Proposed Rule's treatment of sexual orientation fails to take proper account of the current state of the law on whether discrimination against someone based on their sexual orientation is motivated by sex.

1. The Proposed Rule's Treatment of "On the Basis of Sex" is Inconsistent with the Purposes of the ACA and the Mission of HHS and OCR

The Proposed Rule should be withdrawn because it is inconsistent with Congressional intent in passing the ACA. "One of the central aims [of the ACA was] to expand access to health care and health coverage," as the Final Rule explained. 81 Fed. Reg. 31,444.[4] This expansion was designed to include not only low and middle-income Americans, but also minority and underrepresented groups.[5] And the ACA has, in fact, expanded health insurance coverage in the United States, including among LGBT people.[6] For example, a recent study by the Kaiser Family Foundation estimated that the rate of uninsurance among LGB adults ages 18-64 fell from 19% in 2013 to 10% in 2016, likely due to the implementation of the ACA.[7]

The purposes of Section 1557 were similarly broad. Section 1557 was passed as part of the ACA because Congress recognized that discriminatory barriers to health care and coverage remain, and it wanted to provide additional tools to combat that discrimination. As the Final Rule explained:

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[4] *See also* S.G. Stolberg & R. Pear, *Obama Signs Health Care Overhaul Bill, With a Flourish*, N.Y. TIMES, March 24, 2010, at A19.

[5] S*ee generally* 155 CONG. REC. S10265-80 (daily ed. Oct. 9, 2009), 155 CONG. REC. S11907-67 (daily ed. Nov. 21, 2009), 155 CONG. REC. S12021-31 (daily ed. Dec. 1, 2009), and 155 CONG. REC. S13558-628 (daily ed. Dec. 20, 2009); *and* 156 CONG. REC. H1854-90 (daily ed. Mar. 21, 2010); *see also* 155 CONG. REC. at S11931.

[6] *See, e.g.*, M. Karpman et al., Urban Inst., *QuickTake: Uninsurance Rate Nearly Halved for Lesbian, Gay, and Bisexual Adults since Mid-2013, Health Reform Monitoring Survey* (Apr. 2015), http://hrms.urban.org/quicktakes/Uninsurance-Rate-Nearly-Halved-for-Lesbian-Gay-and-Bisexual-Adults-since-Mid-2013.html; G. Gonzales & C. Henning-Smith, *The Affordable Care Act and Health Insurance Coverage for Lesbian, Gay, and Bisexual Adults: Analysis of the Behavioral Risk Factor Surveillance System*, 4 LGBT HEALTH 62-67 (2017).

[7] L. Dawson et al., Henry J. Kaiser Family Foundation, *The Affordable Care Act and Insurance Coverage Changes by Sexual Orientation* 2 (Jan. 2018), http://files.kff.org/attachment/Data-Note-The-Affordable-Care-Act-and-Insurance-Coverage-Changes-by-Sexual-Orientation.

> Equal access for all individuals without discrimination is essential to achieving [the goal of expanding access to health care and health coverage]. Discrimination in the health care context can often lead to poor and inadequate health care or health insurance or other coverage for individuals and exacerbate existing health disparities in underserved communities. Individuals who have experienced discrimination in the health care context often postpone or do not seek needed health care; individuals who are subject to discrimination are denied opportunities to obtain health care services provided to others, with resulting adverse effects on their health status. Moreover, discrimination in health care can lead to poor and ineffective distribution of health care resources, as needed resources fail to reach many who need them. The result is a marketplace comprised of higher medical costs due to delayed treatment, lost wages, lost productivity, and the misuse of people's talent and energy.

81 Fed. Reg. 31,444 (citations omitted).

Section 1557 was particularly transformative because it marked the first time that federally funded health care programs were prohibited from discriminating "on the basis of sex" under federal law. Section 1557 was one of a suite of tools under the ACA to broadly address sex discrimination and gender disparities in health care, and Congress intended the law to reach broadly, not narrowly, to eradicate these problems.[8] For example, Senator Max Baucus stated: "[n]o longer will insurance companies be able to discriminate based on gender or health status."[9] Senator Kay Hagan similarly stated: "one of the key points is the fact that this bill is going to eliminate discrimination based on gender and preexisting conditions."[10] According to Senator Chris Dodd: "I don't know anybody who disagrees with the statement that health care in America ought to be a right, not a privilege. And if it is a right – then, just as other rights are extended to every citizen regardless of . . . their background, their gender, certainly this right ought to be no different in that regard and available to all of our fellow citizens . . . ."[11] The Final Rule's inclusion of sex stereotyping and gender identity in the definition of "on the basis of sex" is thus faithful to Congress's intent in enacting this far-reaching legislation; the Proposed Rule is not.

Moreover, the Proposed Rule is also inconsistent with HHS's mission "to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health,

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[8] S*ee generally* 155 CONG. REC. S10265-80, S11907-67, S12021-31, and S13558-628; *and* 156 CONG. REC. H1854-90; *see also* 155 CONG. REC. at S11931.

[9] 155 CONG. REC. at S11963.

[10] 155 CONG. REC. at S11946.

[11] 155 CONG. REC. at S13608.

and social services."[12] The Proposed Rule also contravenes OCR's fundamental goals. OCR was established to remove discriminatory barriers to HHS-funded programs.[13] Since its creation, OCR has been instrumental in enhancing access to health care and health coverage by robustly enforcing civil rights laws in the context of health care and health coverage. Indeed, OCR's mission includes "[e]nsuring that recipients of HHS federal financial assistance comply with federal civil rights laws that prohibit discrimination on the basis of" sex, among other bases.[14] "OCR helps to ensure equal access to health and human services . . . advances the health and well-being of all Americans . . . and provides the tools for provider awareness and full engagement of individuals in decisions related to their health care."[15] The Proposed Rule, however, stands to erect barriers to health care and health coverage that are not required by the statutory text and that are likely to undermine health care for vulnerable communities in ways that exacerbate health disparities, as explained below.

2. The Proposed Rule's Treatment of Sex Stereotyping and Gender Identity is Incorrect as a Matter of Law

The Proposed Rule's interpretation of Section 1557's prohibition of sex discrimination not only conflicts with a central purpose of the ACA, the specific aim of Section 1557, and the missions of HHS and OCR; it is also incorrect as a matter of law and risks sowing confusion (as well as an increased risk of liability) among entities and individuals covered by Section 1557. As noted above, the Final Rule's interpretation that "on the basis of sex" includes sex stereotyping and gender identity was intended both to conform to Congressional intent and to reflect the current state of the law, as well as to bring clarity to covered entities, health care providers, and the public with respect to the application of Section 1557.

By contrast, the Proposed Rule's removal of the definition of "on the basis of sex," along with the discussion in the Preamble and Regulatory Impact Analysis supporting the elimination of protections against sex stereotyping and gender identity, reflects a rejection of the weight of legal authority that misconstrues Section 1557 and thus raises serious concerns under the APA.

a. Discrimination based on sex stereotypes is impermissible sex discrimination

The Proposed Rule's exceedingly narrow interpretation of Section 1557 is plainly inconsistent with precedent from the U.S. Supreme Court and numerous federal Courts of

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[12] U.S. Department of Health and Human Services, *Introduction: About HHS*, https://www.hhs.gov/about/strategic-plan/introduction/index.html#mission (last visited Aug. 12, 2019).

[13] *See, e.g.*, U.S. Commission on Civil Rights, *Funding Federal Civil Rights Enforcement: 2000 and Beyond* (Feb. 2001), https://www.usccr.gov/pubs/archives/crfund01/ch5.htm.

[14] U.S. Department of Health and Human Services, Office for Civil Rights, *OCR Mission and Vision*, https://www.hhs.gov/ocr/about-us/leadership/index.html (last visited Aug. 12, 2019).

[15] *Id.*

Appeals holding that federal civil rights statutes that prohibit sex discrimination forbid discrimination based on sex stereotypes. Most remarkably, the Proposed Rule fails to discuss the Supreme Court's decision in *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989), which the Preamble to the Final Rule analyzed in detail. In *Price Waterhouse*, the Supreme Court held that Title VII prohibits employers from discriminating against an employee for failing to conform to stereotypical notions of how women and men should look or behave in terms of gender. 490 U.S. at 258 (plurality). "[W]e are beyond the day when an employer could evaluate employees by assuming or insisting that they matched the stereotype associated with their group, for, in forbidding employers to discriminate against individuals because of their sex, Congress intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes." *Id.* at 251. In other words, the Court held that to demonstrate that an employer took an adverse employment action "because . . . of sex," as required by the statute, a plaintiff could rely on evidence that an employer acted based on sex or gender stereotypes, for example that a woman should "walk more femininely, talk more femininely, [or] dress more femininely." *Id.* at 235; *see also id.* at 266 (O'Connor, J., concurring) (agreeing that there had "been a strong showing that the employer has done exactly what Title VII forbids").

Courts of Appeals have explained that, under *Price Waterhouse*, "Title VII bar[s] not just discrimination based on the fact that [the employee] was a woman, but also discrimination based on the fact that she failed 'to act like a woman' – that is, to conform to socially-constructed gender expectations." *Schwenk v. Hartford*, 204 F.3d 1187, 1201-02 (9th Cir. 2000). That is because when an employee is subject to discrimination for failing to conform to sex stereotypes, "'*the discrimination would not occur but for the victim's sex*.'" *Lewis v. Heartland Inns of Am.*, 591 F.3d 1033, 1040 (8th Cir. 2010) (quoting *Smith v. City of Salem*, 378 F.3d 566, 574 (6th Cir. 2004)).

Following *Price Waterhouse*, courts have uniformly held that Title IX – like Title VII – protects individuals from discrimination based on gender stereotypes. *See Carmichael v. Galbraith*, 574 F. App'x 286, 292–93 (5th Cir. 2014) (Dennis, J., concurring) (collecting cases). Likewise, the Department of Justice's Title IX Legal Manual explains: "Since Title VII legal theories are often used by courts to evaluate Title IX claims, sex stereotyping may violate the Title IX prohibition of discrimination on the basis of sex. The fact that the harassment was based on the perception that the individual was not properly 'manly' or 'feminine' may, in appropriate circumstances, be the basis for a sex stereotyping claim filed under Title IX."[16] Just as courts have recognized sex stereotyping under Title IX, the Supreme Court has also applied concepts developed under Title VII to Title IX. *See, e.g.*, *Franklin v. Gwinnett Cty. Pub. Sch.*, 503 U.S. 60, 75 (1992) (following Title VII law to conclude that Title IX prohibits sexual harassment and permits money damages for intentional discrimination). The Proposed Rule itself states that "Title IX adopts the substantive and legal standards of the Title VII . . . ." 84 Fed. Reg. 27,855.

[16] U.S. Department of Justice, *Title IX Legal Manual*, https://www.justice.gov/crt/title-ix (last visited Aug. 12, 2019).

Section 1557, of course, incorporates the "grounds of" discrimination prohibited under Title IX. Those "grounds" – what it means to discriminate on the basis of sex – must therefore, by definition, reflect the understandings of sex discrimination applied under Title IX. Those longstanding interpretations of Title IX make clear that, as the Final Rule recognized, discrimination "on the basis of sex" includes sex stereotyping. 81 Fed. Reg. 31,387. The Proposed Rule fails to address *Price Waterhouse* and similar decisions under Title IX while seeking to eliminate protections against sex stereotyping under Section 1557. This alone is sufficient reason for OCR to withdraw the Proposed Rule.

The Northern District of Texas's analysis in *Franciscan Alliance v. Burwell* is similarly deficient and flawed. *See* 227 F. Supp. 3d 660, 689 n.28 (N.D. Tex. 2016) (rejecting coverage of sex stereotyping under Section 1557 and noting that "*Price Waterhouse* dealt with the definition of 'sex' in the Title VII context, not the incorporated statute at issue here: Title IX."). The court's analysis ignores decades of precedent and is unsupportable under longstanding principles governing the interpretation of civil rights laws generally and Title IX in particular.

OCR seems to assume that it must eliminate protections against sex stereotyping in order to create analytical consistency with its decision to eliminate coverage of gender identity discrimination. This may well be true, because it is analytically impossible to distinguish one from the other – gender identity discrimination is, by definition, a form of sex stereotyping because it rests on the view that people must present themselves in ways that are stereotypically consistent with their sex assigned at birth. But under *Franciscan Alliance*'s analysis and the approach of the Proposed Rule, *all* people – not just transgender people – would be denied protections against sex stereotyping in health programs and activities covered by Section 1557. This means that straight cisgender people who do not conform to societal expectations or norms about sex, like Ann Hopkins, will no longer be protected from denials of health care that are based on that nonconformity. This is a sweeping reversal of decades of law that holds to the contrary.

b. Gender identity discrimination is sex discrimination under the substantial weight of authority

The Final Rule's inclusion of gender identity in the definition of "on the basis of sex" reflected and conformed to the clear weight of legal authority. 81 Fed. Reg. 31,388-89. Since the Final Rule was issued in 2016, the weight of judicial authority has even more strongly tilted in favor of interpreting Section 1557 to cover gender identity discrimination, as we discuss below. The Proposed Rule, by contrast, follows a shrinking minority of court decisions – court decisions whose essential reasoning was "eviscerated" by *Price Waterhouse*. *Smith v. City of Salem*, 378 F.3d 566, 572–73 (6th Cir. 2004). As a result, the Proposed Rule is flatly inconsistent with the prevailing understanding of the scope of discrimination on the basis of sex.

To be sure, the Northern District of Texas has preliminarily enjoined OCR's enforcement of the Final Rule's coverage of gender identity discrimination; in its preliminary injunction decision, the court concluded that plaintiffs were likely to prevail in showing that Section 1557's

sex discrimination prohibition does not encompass discrimination on the basis of gender identity. *Franciscan Alliance v. Burwell*, 227 F. Supp. 3d at 688; *see also* 84 Fed. Reg. 27,848 & n.8 (noting the District of North Dakota enjoined the application of the Final Rule to two plaintiffs because the court concluded *Franciscan Alliance* was persuasive). But *Franciscan Alliance* is fundamentally flawed and should not dictate the outcome here; indeed, instead of rescinding the Final Rule, OCR should request that the Department of Justice defend this and similar lawsuits and seek appellate review of adverse rulings. As noted above, the court in *Franciscan Alliance* incorrectly held that Title IX and Section 1557 do not encompass discrimination based on sex stereotypes in accordance with *Price Waterhouse*. *See Franciscan Alliance*, 227 F. Supp. 3d at 689 n.28. Over the past two years, other district courts to consider the issue have firmly disagreed with *Franciscan Alliance's* analysis. These courts recognize that *Price Waterhouse* applies to Section 1557 and thus that discrimination against transgender individuals for their gender identity or gender transition is prohibited by the text of Section 1557.

Most recently, in *Tovar v. Essentia Health*, the District of Minnesota held that Section 1557 prohibits gender identity discrimination and denied a motion to dismiss a claim challenging a health insurance plan that categorically excluded coverage for gender reassignment surgery or services. 342 F. Supp. 3d 947, 952-53 (D. Minn. 2018). Similarly, in *Boyden v. Conlin,* the Western District of Wisconsin held that the State of Wisconsin's exclusion of "[p]rocedures, services, and supplies related to surgery and sex hormones associated with gender reassignment" from health insurance coverage provided to state employees violated Section 1557 as a form of sex discrimination under *Price Waterhouse* and Seventh Circuit precedent holding that gender identity discrimination is *per se* a form of sex discrimination. 341 F. Supp. 3d 979, 982, 988, 1005 (W.D. Wis. 2018); *see also Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 949–50 (W.D. Wis. 2018). And in *Prescott v. Rady Children's Hospital-San Diego*, the Southern District of California held that the mother of a transgender boy stated a claim under Section 1557 when she alleged that her son faced discriminatory treatment by hospital staff when the staff repeatedly and intentionally disrespected his gender identity, referring to him as "she" and calling him "a pretty girl," resulting in such severe emotional distress that the son later committed suicide. 265 F. Supp. 3d 1090, 1096-97, 1099-1100 (S.D. Cal. 2017).

The Proposed Rule contravenes each of these decisions. Moreover, because each of these decisions interpreted Section 1557 directly and did not rely on the Final Rule, they will remain in force even if OCR finalizes the Proposed Rule. Any final rule that rejects coverage of gender identity discrimination, therefore, would conflict with these decisions, cause confusion, encourage a greater number of private suits alleging gender identity discrimination (suits that might well result in findings of liability for covered entities), and engender a spate of litigation against such a new final rule. Thus, OCR's assertion that the Proposed Rule "may minimize litigation risk," 84 Fed. Reg. 27,849, is simply incorrect.

In addition to relying on the court's faulty analysis in *Franciscan Alliance*, the Proposed Rule cites HHS's Title IX regulations, various policies and guidance from the National Institutes

of Health (NIH) and other components of HHS, recent actions by the Department of Justice and Education to withdraw protections against gender identity discrimination under Title IX and Title VII, and a few other court decisions that define sex to mean "biologically male or female." *See* 84 Fed. Reg. 27,853-56. Putting to the side the irrelevance of, for example, NIH guidelines related to the importance of male and female differences in clinical research (which the Final Rule casts no doubt on), the Proposed Rule's assertion that "on the basis of sex" – as a legal concept under Section 1557 – excludes gender identity is directly contradicted by *Price Waterhouse*, the great weight of Court of Appeals and district court decisions (including those under Section 1557 itself, as discussed above), *Macy v. Holder*, EEOC Decision No. 01200120821, 2012 WL 1435995 (Apr. 20, 2012), and at least one directive from the Department of Labor.[17]

Applying *Price Waterhouse*, appellate and district courts across the country have held that discrimination based on gender identity is discrimination on the basis of sex. As these cases explain, "discrimination against a plaintiff who is a transsexual – and therefore fails to act and/or identify with his or her gender – is no different from the discrimination directed against Ann Hopkins in *Price Waterhouse*, who, in sex-stereotypical terms, did not act like a woman." *Smith*, 378 F.3d at 575. Because transgender individuals are, by definition, individuals whose gender identity does not conform to their sex assigned at birth, there is inherently "a congruence between discriminating against transgender and transsexual individuals and discrimination on the basis of gender-based behavioral norms." *Glenn v. Brumby*, 663 F.3d 1312, 1316 (11th Cir. 2011). "By definition, a transgender individual does not conform to the sex-based stereotypes of the sex that he or she was assigned at birth." *Whitaker By Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1048 (7th Cir. 2017).[18]

In this connection, it is important to note that courts have foreclosed the position that discrimination based on an individual's failure to conform to sex stereotypes violates the law only when it advantages men as a group over women as a group. For example, in *EEOC v. Boh*

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[17] U.S. Department of Labor, Office of Federal Contract Compliance Programs, *Directive 2014-02*, https://www.dol.gov/ofccp/regs/compliance/directives/dir2014_02.html.

[18] *See also, e.g.*, *Grimm v. Gloucester Cnty. Sch. Bd.*, 822 F.3d 7009, 720-23 (4th Cir. 2016), *vacated and remanded*, 137 S. Ct. 1239 (2017); *Dodds v. U.S. Dep't of Ed.*, 845 F.3d 217 (6th Cir. 2016); *Barnes v. City of Cincinnati*, 401 F.3d 729, 736-37 (6th Cir. 2005); *Smith v. City of Salem*, 378 F.3d 566, 571-75 (6th Cir. 2004); *Schwenk*, 204 F.3d at 1201-02; *Adams v. Sch. Bd. of St. Johns Cnty*, 318 F. Supp. 3d 1293 (M.D. Fla. 2018); *A.H. v. Minersville Area School District*, 290 F. Supp. 3d 321 (M.D. Pa. 2017); *Lewis v. High Point Reg'l Health Sys.*, 79 F. Supp. 3d 588 (E.D.N.C. 2015); Finkle v. Howard County, Md., 12 F. Supp. 3d 780, 788 (D. Md. 2014); *Muir v. Applied Integrated Technologies, Inc.*, No. CIV.A. DKC 13-0808, 2013 WL 6200178 (D. Md. Nov. 26, 2013); Schroer v. Billington, 577 F. Supp. 2d 293, 306-08 (D.D.C. 2008); *Lopez v. River Oaks Imaging Diagnostic Group, Inc.*, 542 F. Supp. 2d 653, 660 (S.D. Tex. 2008).

These cases make clear that, even were gender identity discrimination to be incorrectly rejected as a *per se* violation of Section 1557, transgender individuals would still be able to pursue claims based on an underlying sex stereotyping theory. *See, e.g.*, *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (analyzing the plaintiff's claim under a sex stereotyping theory without addressing whether gender identity discrimination is necessarily sex discrimination).

Bros. Const. Co., the Fifth Circuit, sitting *en banc*, sustained a jury verdict that an employer violated Title VII when the male superintendent degraded another male employee because, in the eyes of the harasser, the employee "fell outside of [a] manly-man stereotype." 731 F.3d 444, 459 (5th Cir. 2013). There was no allegation that the harassing superintendent favored women as crew workers instead of men. And the fact that the crew superintendent also expressed degrading views about women, including the employee's daughter, *see id.* at 450 n.1, did not change the fact that the harassment against the employee was because of his sex.

Furthermore, even assuming *arguendo* that sex is correctly defined as "biologically male or female," gender identity discrimination would remain sex-based. A transgender person – by definition – is identified or perceived as being transgender because their gender identity or expression does not align with their sex assigned at birth. Thus, as the Sixth Circuit has correctly observed, it is "analytically impossible to fire an employee based on that employee's status as a transgender person without being motivated, at least in part, by the employee's sex." *EEOC v. R.G. &. G.R. Harris Funeral Homes, Inc.,* 884 F.3d 560, 575 (6th Cir. 2018), *cert. granted* 139 S. Ct. 1599. Likewise, when a transgender person is in the process of transitioning or has transitioned, that relates to "sex" – both in terms of the person's perceived sex and certain biological indicators of sex that may change as part of a person's transition. For example, a person may, on the recommendation of care providers, undergo hormone therapy or surgeries that change the shape of their genitals or breasts, the amount of body fat and hair they have, or the appearance of their face. Transitioning may also involve changing one's "sex" as identified on legal documents. In those senses as well, discrimination against a transgender person for their gender identity is motivated by sex.

As laid out above, the Proposed Rule's elimination of gender identity protections is flatly inconsistent with the clear weight of judicial authority, including several rulings under Section 1557 itself. Thus, the Proposed Rule, if finalized, would at a minimum cause confusion; it would not only leave providers subject to liability for gender identity discrimination in court, but would also deprive them of the significant guidance provided by the Final Rule on the applicable standards to protect them from that liability.[19] The Proposed Rule thus undermines

[19] This guidance is particularly valuable with regard to gender identity discrimination to ensure that providers can voluntarily comply with nondiscrimination requirements that may be new to them. For example, the Preamble to Final Rule made clear that "a provider could not refuse to treat a patient for a cold or broken arm based on the patient's gender identity. Similarly, if the provider is accepting new patients, it must accept a new patient request from a transgender individual and cannot decline to accept a transgender individual in favor of a person who is not transgender." 81 Fed. Reg. 31,455. The Final Rule also provided that a covered entity providing health insurance may not "[h]ave or implement a categorical coverage exclusion or limitation for all health services related to gender transition . . . [or o]therwise 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 if such denial, limitation, or restriction results in discrimination against a transgender individual." 45 C.F.R. § 92.207(b)(4)-(5). The Preamble to the Final Rule underscored that "covered entities have justified these blanket exclusions by categorizing all transition-related treatment as cosmetic or experimental. However, such across-the-board categorization is now recognized as outdated and not based on current standards of care." 81 Fed. Reg. 31,429 (citations omitted). Further, OCR stated that it "will not second-guess a covered entity's neutral nondiscriminatory application of evidence-based criteria used to make medical necessity or coverage

prospects for voluntary compliance with the law and increases the risk of litigation. For these reasons, OCR should withdraw the Proposed Rule and leave the Final Rule in place. At a minimum, OCR should leave the Final Rule in place and suspend any rulemaking until after the Supreme Court decides *R.G. & G.R. Harris Funeral Homes v. EEOC & Aimee Stephens*, No. 18-107, *cert. granted* 139 S. Ct. 1599 (2019), which will inform interpretation of Section 1557 as it relates to gender identity discrimination.

c. The Preamble's Treatment of Sexual Orientation Discrimination Is Inconsistent with the State of the Law

The Final Rule adopted a "wait-and-see" approach on whether sexual orientation discrimination is *per se* sex discrimination under Section 1557. This approach reflected the fact that the state of the law in 2015 and 2016, when the Final Rule was under deliberation, was evolving.[20] Since then, the Second and Seventh Circuits, both sitting *en banc*, have reversed circuit precedent to hold that sexual orientation discrimination is *per se* sex discrimination under Title VII, and the Seventh Circuit has extended such reasoning to the Fair Housing Act. *Wetzel v. Glen St. Andrew Living Cmty., L.L.C.*, 901 F.3d 856 (7th Cir. 2018); *Zarda v. Altitude Express, Inc.*, 883 F.3d 100, 113 (2d Cir. 2018) (*en banc*), *cert. granted sub nom. Altitude Exp., Inc. v. Zarda*, 139 S. Ct. 1599 (2019); *Hively v. Ivy Tech Cmty. Coll. of Ind.*, 853 F.3d 339, 351–52 (7th Cir. 2017) (*en banc*). These decisions hold not only that sexual orientation discrimination is impermissible sex discrimination under *Price Waterhouse*, but also that sexual orientation discrimination is motivated at least in part by sex because sexual orientation is a function of sex. These courts also recognize that sexual orientation discrimination violates prohibitions on sex discrimination under longstanding principles applicable to civil rights laws because an individual is being penalized for their association with another individual of the same sex.

These decisions make perfect sense because, at bottom, sexual orientation cannot be understood without reference to a person's sex. According to the Institute of Medicine, "the

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determinations. Therefore, we refrain from adding any regulatory text that establishes or limits the criteria that covered entities may utilize when determining whether a health service is medically necessary or otherwise meets applicable coverage requirements." *Id*. at 31,436-37.

The Final Rule also prohibits covered entities from refusing to provide "existing services in a nondiscriminatory manner" solely based on the fact that the services are for the purpose of gender transition. *Id*. at 31,455. Thus, "[a] provider specializing in gynecological services that previously declined to provide a medically necessary hysterectomy for a transgender man would have to revise its policy to provide the procedure for transgender individuals in the same manner it provides the procedure for other individuals." *Id.* The Final Rule does not require a provider "to fundamentally change the nature of their operations to comply with the regulation. For example, the rule would not require a provider that operates a gynecological practice to add to or change the types of services offered in the practice." *Id.*

[20] *Compare, e.g.*, *In re Levenson*, 537 F.3d 925 (9th Cir. 2009) (Reinhardt, J.); *Videckis v. Pepperdine Univ.*, 100 F.Supp.3d 927, 937 (C.D. Cal. 2015); *Hall v. BNSF Railway Co.*, No. C13–2160, 2014 WL 4719007 (W.D. Wash. 2014); *Heller v. Columbia Edgewater Country Club*, 195 F. Supp. 2d 1212 (D. Or. 2002), *with, e.g., Prowel v. Wise Bus. Forms*, 579 F.3d 285 (3d Cir. 2009); *Medina v. Income Support Div.*, 413 F.3d 1131 (10th Cir. 2005); *Blum v. Gulf Oil Corp*., 597 F.2d 936 (5th Cir. 1979).

focus of sexual orientation is the biological sex of a person's actual or potential relationship partners" and "sexual orientation is inherently a relational construct [because it] depends on the biological sex of the individuals involved, relative to each other."[21] *See also, e.g.*, *Zarda*, 883 F.3d at 135 (Cabranes, J., concurring); *Baldwin v. Foxx*, Appeal No. 0120133080, 2015 WL 4397641, at *5 (E.E.O.C. July 15, 2015) (citing American Psychological Ass'n, *Definition of Terms: Sex, Gender, Gender Identity, Sexual Orientation* (Feb. 2011)).

Tellingly, in the Proposed Rule, OCR fails to engage with the reasoning of the thoughtful *en banc* majority opinions of *Zarda* and *Hively* as well as *Price Waterhouse* (as noted above) and *Oncale v. Sundowner Offshores Services*, *Inc*. In *Oncale*, the Supreme Court unanimously held that Title VII prohibits male-against-male sexual harassment because, even though such harassment was not a principal concern for Congress when it enacted Title VII, such harassment is a "comparable evil" covered by the statute's text. 523 U.S. 75, 79 (1998). As *Zarda* explained:

> *Oncale* specifically rejects reliance on "the principal concerns of our legislators," *Oncale*, 523 U.S. at 79-80 – the centerpiece of the dissent's statutory analysis. Rather, *Oncale* instructs that the text is the lodestar of statutory interpretation, emphasizing that we are governed "by the provisions of our laws." *Id.* The text before us uses broad language . . . . We give these words their full scope and conclude that, because sexual orientation discrimination is a function of sex, and is comparable to sexual harassment, gender stereotyping, and other evils long recognized as violating Title VII, the statute must prohibit it.

Zarda, 883 F.3d at 115. Title IX, of course, also prohibits same-sex harassment, consistent with *Oncale*.[22]

We acknowledge that panels of the Fifth and Eleventh Circuits have recently adhered to circuit precedent that pre-dates *Price Waterhouse* to hold that sexual orientation discrimination is not *per se* prohibited under Title VII. *Wittmer v. Phillips 66 Co.*, 915 F.3d 328, 330–31 (5th Cir. 2019) (citing *Blum v. Gulf Oil Corp.*, 597 F.2d 936, 938 (5th Cir. 1979)); *Bostock v. Clayton County Bd. of Comm'rs*, 723 Fed. Appx. 964 (11th Cir. 2018) (citing *Blum*), cert. granted, 87 U.S.L.W. 3411 (U.S. Apr. 22, 2019) (No. 17-1618); *Evans v. Georgia Reg'l Hosp.*, 850 F.3d 1248, 1255 (11th Cir. 2017) (citing *Blum*).

But even these decisions support the Final Rule's conclusion that "Section 1557's prohibition of discrimination on the basis of sex includes, at a minimum, sex discrimination related to an individual's sexual orientation where the evidence establishes that the discrimination is based on gender stereotypes." 81 Fed. Reg. 31,390; *accord, e.g.*, *Prowel v.*

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[21] INST. OF MEDICINE, THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE: BUILDING A FOUNDATION FOR BETTER UNDERSTANDING 27 (2011), http://www.ncbi.nlm.nih.gov/books/NBK64806/pdf/Bookshelf_NBK64806.pdf

[22] U.S. Department of Education, Office for Civil Rights, *Revised Sexual Harassment Guidance* (2001), https://www2.ed.gov/about/offices/list/ocr/docs/shguide.html#Guidance (last visited Aug. 12, 2019).

Wise Bus. Forms, 579 F.3d 285, 291 (3d Cir. 2009). Indeed, in *Evans v. Georgia Regional Hospital*, for example, though the Eleventh Circuit ruled that a lesbian's sexual orientation claim was not cognizable under Title VII, the court permitted her claim based on gender stereotyping to proceed. 850 F.3d at 1254-55. The Proposed Rule fails to address this precedent and its support for this part of the Final Rule.

Though we agree with the reasoning of *Zarda*, *Hively*, and similar court decisions, we also recognize that the Final Rule was purposefully designed to follow the law as it evolves, and that remains the prudent approach. Therefore, OCR should withdraw the Proposed Rule in its entirety or, at a minimum, leave the Final Rule in place and suspend any rulemaking until after the Supreme Court decides *Bostock v. Clayton County*, No. 17-1618, and *Altitude Express, Inc. v. Zarda*, No. 17-1623, *cert. granted* 139 S. Ct. 1599 (2019), which will inform interpretation of Section 1557 as it relates to sexual orientation discrimination.

C. The Proposed Rule's Elimination of Protections Against Sexual Orientation and Gender Identity Discrimination in the CMS Regulations is Unjustified

OCR and CMS also propose to rescind sexual orientation and gender identity protections in the CMS Regulations. 84 Fed. Reg. 27,871. The Proposed Rule explains that these regulations prohibit discrimination on the bases of sexual orientation and gender identity (among other bases) in: "how States and Exchanges carry out [ACA] requirements and how agents or brokers market to individuals they assist with Exchange enrollment or related applications," 45 C.F.R. § 155.120(c)(1)(ii), 45 C.F.R. § 155.120(j)(2); "marketing or benefit design practices of health insurance issuers under the [ACA]," 45 C.F.R. § 147.104(e); "the administration of qualified health plans (QHPs) by issuers and concerning marketing and other conduct by QHP issuers engaged in direct enrollment of applicants under the [ACA]," 45 C.F.R. § 156.200(e); "organizations operating Programs for All-inclusive Care of the Elderly (PACE) programs and participants receiving PACE services under Medicare," 42 C.F.R. §§ 460.98(b)(3) and 460.112(a); and "Medicaid beneficiary enrollment, and promotion and delivery of access and services," 42 C.F.R. §§ 438.3(d)(4), 438.206(c)(2), and 440.262. The Proposed Rule asserts that the sexual orientation and gender identity protections in these regulations must be rescinded to "conform them more closely to the prohibited bases for discrimination authorized by Section 1557 . . . and government policy." 84 Fed. Reg. 27,871.

But OCR and CMS have offered no reasonable explanation for why the CMS Regulations need to be "conformed" to Section 1557. Indeed, neither legal nor policy arguments suggest any such need.

From a legal perspective, the CMS Regulations' nondiscrimination protections do not stem from authority under Section 1557 or from any assessment of the appropriate scope of "sex" discrimination. They instead stem from other, independent provisions of the ACA. For example, the nondiscrimination protections of 45 C.F.R. § 155.120(c) were based on the statutory requirement that the Secretary of HHS "issue regulations setting standards for meeting the requirements under the title . . . with respect to . . . the establishment and

operation of Exchanges . . . ." 42 U.S.C. § 18041(A). Moreover, the inclusion of sexual orientation and gender identity as prohibited bases of discrimination in 45 C.F.R. § 155.120(c) did not rest on a sex discrimination analysis, as would have been required under Section 1557. *See* 79 Fed. Reg. 15808 (Mar. 21, 2014); 79 Fed. Reg. 30240 (May 27, 2014). In promulgating both its proposed and final rules, CMS did not in any way discuss case law on Title VII's, Title IX's, or Section 1557's scope as to sex stereotyping, gender identity, or sexual orientation. *See id.* [23] We understand that the other CMS Regulations were similarly based on CMS's authority independent of Section 1557.

Nothing in Section 1557 bars CMS from independently adopting these requirements. Indeed, it is clear that Section 1557 is the *floor* and not the ceiling with respect to nondiscrimination protections applicable to various components of Title I of the ACA. CMS regulations on other topics impose different requirements than Section 1557, and OCR is not proposing that those also need to be conformed. *Compare* 81 Fed. Reg. 31,377 (in Preamble to Final Rule, making clear that OCR would not automatically deem an entity's compliance with CMS requirements for QHPs, insurance benefit design, or language access standards as sufficient to demonstrate compliance with similar, but separate, requirements of Section 1557). Moreover, the CMS Regulations have, since their inception, barred discrimination based on both gender identity and sexual orientation, which, as discussed above, does not "conform" to OCR's decision, in the Final Rule, to leave open the question of whether Section 1557 bars sexual orientation discrimination. There was no need to "conform" then, and there is no need to "conform" now.

Additionally, we are unaware of any constraints on maintaining the policy positions reflected in the CMS Regulations. The Administration has taken the legal position that the prohibitions on sex discrimination under Title VII and Title IX do not include protections against sexual orientation and gender identity discrimination. *See* 84 Fed. Reg. 27,856-57. The Administration has not, to our knowledge, taken the position that imposing prohibitions on sexual orientation and gender identity discrimination is an inappropriate policy determination if there is legal authority to make it. That is precisely what the CMS Regulations have done, and they should be maintained in their current form.

Even assuming, *arguendo*, that the CMS Regulations and Section 1557 must be harmonized, OCR and CMS's proposal to eliminate sexual orientation and gender identity protections from the CMS Regulations is at best premature. The Proposed Rule explains that

[23] The only reference to Section 1557 appears to be in commenters' suggestion that the rule reference Section 1557 among the requirements for avoiding civil money penalties. Specifically, "commenters recommended that [CMS] specify the statutory and regulatory requirements with which consumer assistance entities and personnel must comply to avoid potential [civil money penalties], and various commenters suggested that these might include . . . statutory and regulatory nondiscrimination requirements at *42 U.S.C. 18116*, 45 CFR 155.105(f), and 155.120(c)," among other sources. *Id.* (emphasis added). CMS declined to "include[] in the final rule a more specific list of the requirements that could be enforced under this section." *Id.*

"[b]ecause of the likelihood that the Supreme Court will be addressing [the scope of Title VII's sex discrimination provision] in the near future, the Department declines, at this time, to propose its own, [sic] definition of 'sex' for purposes of discrimination on the basis of sex in the regulation." *Id*. at 27,857. If OCR and CMS are *not* proposing a definition of sex, then there is nothing definitive in the regulatory text that would provide that Section 1557 does *not* cover gender identity and sexual orientation. As a result, there is nothing between Section 1557 and the CMS Regulations that is out of sync.

D. The Proposed Rule, If Finalized, Would Remove Protections That Are Critical For LGBT People

Discrimination and prejudice against LGBT people remain pervasive across the United States, including in health care and health coverage. Based on a record of significant discrimination against LGBT people in health care and coverage and an understanding of the Congressional intent underlying Section 1557 and the ACA as a whole, the Final Rule expressly prohibited sex stereotyping (including when related to sexual orientation) and gender identity discrimination in order to provide clear legal protections that would both deter and remedy anti-LGBT discrimination in health care and health coverage.

Rather than helping lessen anti-LGBT discrimination in any way, the Proposed Rule seeks to withdraw critical protections not only under Section 1557 but also under the CMS Regulations cited above. In light of consistent and substantial evidence of anti-LGBT discrimination in health care and health coverage – as well as in employment, housing, public accommodations, and other areas of life that can negatively impact health and well-being – OCR should withdraw the Proposed Rule and maintain the Final Rule. Given the momentous disruption the Proposed Rule would potentially have on LGBT people's access to discrimination-free health care and coverage, and because the Proposed Rule would reverse a Final Rule adopted after a comprehensive rulemaking proceeding and issued only a short time ago, OCR should, at a minimum, suspend this rulemaking pending guidance from the U.S. Supreme Court in *Bostock*, *Zarda*, and *Harris Funeral Homes.*

1. LGBT people face pervasive discrimination in health care, health coverage, and beyond that create severe health needs

Though social acceptance of LGBT people in many parts of the United States has increased over the past few decades, discrimination and prejudice against LGBT people remain widespread. Such discrimination and prejudice occur in health care and health coverage,[24]

[24] *See, e.g.*, Testimony of Jocelyn Samuels, Executive Director of the Williams Institute, UCLA School of Law, submitted to the Committee on the Judiciary, U.S. House of Representatives, regarding the Equality Act (Apr. 10, 2019) (expert opinion and collecting sources on health care discrimination), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Samuels-Equality-Act-Testimony.pdf; Testimony of Gary Harper, Professor of Public Health at the University of Michigan, and colleagues, submitted to the Committee on the Judiciary, U.S. House of Representatives, regarding the Equality Act (Apr. 4, 2019) (expert opinion and collecting sources on health care discrimination), https://williamsinstitute.law.ucla.edu/wp-

employment,[25] and other settings.[26] Discrimination against LGBT people in health care and health coverage can take many forms, including the outright denial of care[27] and negative treatment by health care staff.[28] According to the Institute of Medicine, "LGBT individuals face

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content/uploads/Harper-Equality-Act-Testimony.pdf; NPR, Robert Wood Johnson Foundation, & Harvard T.H. Chan School of Public Health, *Discrimination in America: Experiences and Views of LGBTQ Americans* 1 (Nov. 2017), https://www.npr.org/documents/2017/nov/npr-discrimination-lgbtq-final.pdf (hereinafter "NPR Report") (showing that 16% of LGBTQ survey respondents reported being personally discriminated against because of LGBTQ status when going to the doctor or health clinic); Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf (documenting for example that, in a survey of 4,916 LGBT people, "[m]ore than half of all respondents reported that they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health status; or health care professionals being physically rough or abusive").

[25] *See, e.g.*, Testimony of Brad Sears & Christy Mallory, Senior Scholars at the Williams Institute, UCLA School of Law, submitted to the Committee on Education and Labor, U.S. House of Representatives, regarding the Equality Act (Apr. 19, 2019) (expert opinion and collecting sources on employment discrimination), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Williams-Institute-Equality-Act-Testimony.pdf; Testimony of M.V. Lee Badgett, Professor of Economics at the University of Massachusetts Amherst and Senior Scholar at the Williams Institute, submitted to the Committee on the Judiciary, U.S. House of Representatives, regarding the Equality Act (Apr. 2, 2019) (expert opinion and collecting sources on employment discrimination), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Badgett-Equality-Act-Testimony.pdf.

[26] *See, e.g.*, Ilan H. Meyer, Williams Inst., *Experiences of Discrimination among Lesbian, Gay and Bisexual People in the US* (Apr. 2019), https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGB-Discrimination-Work.pdf; NPR Report, *supra*. *See generally* INST. OF MEDICINE, *supra*, at 212-14 (discussing evidence of stigma, discrimination, and violence against LGBT people because of their sexual orientation or gender identities); Adam P. Romero, *Does the Equal Pay Act Prohibit Discrimination on the Basis of Sexual Orientation or Gender Identity?*, 10.1 ALA. C.R. & C.L. L. REV. 35, 42-58 (2019) (cataloging recent evidence, particularly in employment, on stigma and discrimination against LGBT people in the United States); Jennifer Pizer et al., *Evidence of Persistent and Pervasive Workplace Discrimination Against LGBT People: The Need for Federal Legislation Prohibiting Discrimination and Providing Equal Employment Benefits*, 45 LOY. L.A. L. REV. 715, 720-42 (2012).

[27] Human Rights Watch, *"You Don't Want Second Best": Anti-LGBT Discrimination in US Health Care* 22-23 (2018), https://www.hrw.org/report/2018/07/23/you-dont-want-second-best/anti-lgbt-discrimination-us-health-care (citing interviews where LGBTQ people described being turned away when seeking services including check-ups, fertility treatments, counseling, yeast infections, access to HIV-preventive medications, and an evaluation of a six-day-old child); INST. OF MEDICINE, *supra*, at 62; Shabab Ahmed Mirza & Caitlin Rooney, Ctr. for Am. Progress, *Discrimination Prevents LGBTQ People from Accessing Healthcare* (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/ (documenting that 8% of LGB respondents and 29% of transgender respondents who had visited a doctor or health care provider said that, in the prior year, a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation or gender identity, respectively); Lambda Legal, *supra*, at 10 ("Almost 8 percent of LGB respondents reported that they had been denied needed health care because of their sexual orientation. Over a quarter of all transgender respondents (nearly 27 percent) reported being denied care . . . .").

[28] INST. OF MEDICINE, *supra*, at 62 ("LGBT individuals have reported experiencing refusal of treatment by health care staff, verbal abuse, and disrespectful behavior, as well as many other forms of failure to provide adequate care."); Mirza & Rooney, *supra* (documenting that 9% of LGB respondents and 21% of transgender respondents said that a doctor or other health care provider used harsh or abusive language when treating them);

discrimination in the health care system that can lead to an outright denial of care or to the delivery of inadequate care. There are many examples of manifestations of enacted stigma against LGBT individuals by health care providers. LGBT individuals have reported experiencing refusal of treatment by health care staff, verbal abuse, and disrespectful behavior, as well as many other forms of failure to provide adequate care."[29]

Such discrimination and stigma lead many LGBT people to delay or avoid seeking health care[30] – or forego care entirely if no available health care alternatives exist.[31] The detrimental effect of this discrimination on LGBT health is compounded because LGBT people already face a higher risk of experiencing physical and mental health issues stemming from stigma and prejudice.[32] Indeed, denials of, or other forms of discrimination in, health care have repercussions for LGBT people's dignity, health, and well-being. Discrimination based on sexual orientation or gender identity is a "minority stressor" that can profoundly harm the health and well-being of LGBT people who are directly subject to these refusals of service.

Lambda Legal, *supra*, at 5 ("Just over 10 percent of LGB respondents reported that health care professionals used harsh language toward them; 11 percent reported that health professionals refused to touch them or used excessive precautions; and more than 12 percent of LGB respondents reported being blamed for their health status."); *id.* at 5-6 ("Nearly 21 percent of transgender and gender nonconforming respondents reported being subjected to harsh or abusive language from a health care professional, and almost 8 percent reported experiencing physically rough or abusive treatment from a health care professional. Over 20 percent of transgender and gender-nonconforming respondents reported being blamed for their own health conditions.").

[29] INST. OF MEDICINE, *supra*, at 62.

[30] Human Rights Watch, *supra,* at 20 (citing interviews with LGBTQ people who described how mistreatment by providers deterred them from seeking care); INST. OF MEDICINE, *supra* note 18, at 62 ("Fear of stigmatization or previous negative experiences with the health care system may lead LGBT individuals to delay seeking care."); *id.* at 63-64 (discussing "internalized stigma" and other personal barriers to care); Mirza & Rooney, *supra* (documenting that 8% of all LGBTQ people surveyed—and 14% of those who had experienced discrimination on the basis of their sexual orientation or gender identity in the past year—avoided or postponed needed medical care because of disrespect or discrimination from health care staff and that, among transgender people, 22% reported such avoidance); *cf.* Lambda Legal, *supra*, at 13 ("Overall, nine percent of LGB respondents are concerned about being refused medical services when they need them. Over half of transgender respondents and 20 percent of respondents living with HIV share this concern.").

[31] Mirza & Rooney, *supra* (documenting that 18% of LGBTQ people said, if they were turned away by a hospital, it would be "very difficult" or "not possible" to find the same type of service at a different hospital, and 41% of LGBTQ people living outside of a metropolitan area said it would be "very difficult" or "not possible").

[32] *See, e.g.*, Human Rights Watch, *supra*, at 5 (citing surveys showing "LGB people were at heightened risk of psychological distress, drinking, and smoking, and lesbian and bisexual women were at heightened risk of having multiple chronic conditions" and transgender people were more likely than cisgender people to "be overweight, be depressed, report cognitive difficulties, and forego treatment for health problems"); J. Kates et al., Henry J. Kaiser Family Foundation, *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.* 5 (May 2018), http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US (finding that LGB individuals are more likely to "rate their health as poor, have more chronic conditions, and have higher prevalence and earlier onset of disabilities" and "report more asthma diagnoses, headaches, allergies, osteoarthritis, and gastro-intestinal problems than heterosexual individuals.")

When a health care provider denies care or provides lesser care to an LGBT person because of their sexual orientation or gender identity, it is a prejudice event, a type of minority stress, which has both tangible and symbolic impacts on the LGBT patient. If a provider denies care to an individual patient, that denial creates harmful repercussions for the patient: An individual who is denied care must, at a minimum, experience the inconvenience of seeking alternative providers for the service. This can be especially critical for individuals who live in communities where no such alternatives are available or where reaching an alternative care provider can only be done with great cost and effort. Where delay in obtaining care has consequences for physical or mental health, those damaging repercussions are further exacerbated and could, in emergency cases, result in disability or death.

Prejudice events, such as health care denials, also carry a strong symbolic message of disapprobation. This symbolic message makes a prejudice event more damaging to the victim's psychological health than a similar event not motivated by prejudice. Research also indicates that "[f]ear of stigmatization or previous negative experiences with the health care system may lead LGBT individuals to delay seeking care."[33] Such expectations of discrimination generate a state of extra vigilance in LGBT people that is also stressful and could lead to people not finding care when it is needed.

Discrimination does not have to occur in the health care and health coverage context specifically to negatively impact health and well-being; rather discrimination in employment, housing, public accommodations, and other settings have all been connected to the health disparities facing the LGBT people.[34] Further, contrary to popular stereotypes about the affluence of the LGBT community, research also demonstrates higher rates of poverty, food insecurity, and unemployment among LGBT people compared to non-LGBT people.[35] Similarly, a larger percentage of LGBT adults are health uninsured compared to the general population.[36]

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[33] INST. OF MEDICINE, *supra* (discussing "felt stigma"); *see also id.* at 63-64 (discussing "internalized stigma" and other personal barriers to care).

[34] *See, e.g.*, Pizer et al., *supra*, at 734-42 (discussing research documenting that workplace discrimination negatively affects the income and health of LGBT people).

[35] *See, e.g.*, Williams Inst., *LGBT Demographic Data Interactive* (Jan. 2019), https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/#density; M.V. Lee Badgett et al., Williams Inst., *New Patterns of Poverty in the Lesbian, Gay, and Bisexual Community* (2013), http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGB-Poverty-Update-Jun-2013.pdf; Taylor N. T. Brown et al., Williams Inst., *Food Insecurity and SNAP Participation in the LGBT Community* 2 (July 2016), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Food-Insecurity-and-SNAP-Participation-in-the-LGBT-Community.pdf.

[36] Williams Inst., *LGBT Demographic Data Interactive* (Jan. 2019), https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/#density; *see also* Kates et al., *supra*, at 3 (explaining that "[r]acial and ethnic minorities, young people, and women are more likely than their counterparts to identify as LGBT").

2. Stigma and discrimination adversely impact LGBT people's health and well-being, resulting in population health disparities

Stress related to being part of a group that is systematically subject to stigma and discrimination affects overall health, which HHS has recognized with respect to LGBT people. For example, in stating that the LGBT population requires special public-health attention, HHS explained that "[p]ersonal, family and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBT individuals."[37] Healthy People 2020, HHS's science-based initiative setting 10-year goals and objectives for improving population health, reports that "[s]ocial determinants affecting the health of LGBT individuals largely relate to oppression and discrimination."[38] Similarly, the Centers for Disease Control and Prevention ("CDC") report that homophobia, stigma, and discrimination can negatively affect the physical and mental health of gay and bisexual men, as well as the quality of the health care they receive.[39] The CDC also reports that discrimination and social stigma may help explain the high risk for HIV infection among transgender women,[40] among other health concerns facing transgender people. HHS's Office of Women's Health has recognized that discrimination and stigma may lead lesbians and bisexual women to have higher rates of depression and anxiety than other women, as well as to be less likely than other women to get routine mammograms and clinical breast exams.[41] With respect to LGBT youth, the Institute of Medicine (now called the National Academies of Sciences, Engineering, and Medicine), which operates under a congressional charter and provides independent, objective analysis of scientific research, has observed that "the disparities in both mental and physical health that are seen between LGBT and heterosexual and non-gender-variant youth are influenced largely by their experiences of stigma and discrimination during the development of their sexual orientation and gender identity and throughout the life course."[42]

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[37] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020, *Lesbian, Gay, Bisexual, and Transgender Health*, http://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health?topicid=25 (last visited Aug. 12, 2019).

[38] *Id.*

[39] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Gay and Bisexual Men's Health, Stigma and Discrimination*, http://www.cdc.gov/msmhealth/stigma-and-discrimination.htm (last visited Aug. 12, 2019).

[40] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *HIV Among Transgender People*, http://www.cdc.gov/hiv/group/gender/transgender/index.html (last visited Aug. 12, 2019).

[41] U.S. Department of Health and Human Services, Office of Women's Health, *Lesbian and Bisexual Health*, https://www.womenshealth.gov/a-z-topics/lesbian-and-bisexual-health (last visited Nov. 20, 2017) (an archive of this webpage is available at https://web.archive.org/web/20170919061935/https://www.womenshealth.gov/a-z-topics/lesbian-and-bisexual-health).

[42] INST. OF MEDICINE, *supra*, at 142.

The disparities between health outcomes for LGBT and non-LGBT people have been well-documented. For example, in Healthy People 2010 and Healthy People 2020, which set health priorities for the country,[43] HHS found that LGBT people face these health disparities:

- LGBT youth are 2 to 3 times more likely to attempt suicide;
- LGBT youth are more likely to be homeless;
- Lesbians are less likely to get preventive services for cancer;
- Gay men are at higher risk of HIV and other STDs, especially among communities of color;
- Lesbians and bisexual females are more likely to be overweight or obese;
- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than heterosexual or LGB individuals;
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers;
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.[44]

3. The Proposed Rule stands to exacerbate the discrimination and health disparities facing the LGBT population, especially in places without state or local protections from gender identity and sexual orientation discrimination

The evidence of health care discrimination against, health disparities and barriers to health care facing, and the more general economic and social vulnerabilities of, LGBT people underscore the significance of preserving the Final Rule's prohibitions of sex stereotyping (included related to sexual orientation) and gender identity discrimination. In fact, the limited data that are available suggest that the ACA has succeeded in helping to expand access to health care and health coverage for LGBT people.[45] Such progress has been supported by the ACA's nondiscrimination mandates, including Section 1557. A recent analysis of complaints of gender identity, sex stereotyping, and sexual orientation discrimination closed by OCR between 2012 and 2016 found that many of them were resolved without enforcement actions by HHS or litigation; instead, the covered entity voluntarily took corrective action.[46] These closed

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[43] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020, *Lesbian, Gay, Bisexual, and Transgender Health*, http://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health?topicid=25 (last visited Aug. 12, 2019).

[44] *Id.*

[45] For example, between June/September 2013 and December 2014/March 2015, the decline in uninsurance rates for LGB adults ages 18-64 was larger than the decline for non-LGB adults. M. Karpman et al., *supra*. According to another study, uninsurance rates for LGB adults ages 18-64 people dropped from 19% in 2013 to 10% in 2016, likely due to the implementation of the ACA. Dawson et al., *supra.* Over the same period, these LGB adults "saw significant gains in Medicaid coverage . . . (increasing from 7% to 15%), likely due to Medicaid expansion." *Id.*

[46] *See* Sharita Gruberg & Frank J. Bewkes, Ctr. for Am. Progress, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial* (Mar. 7, 2018),

complaints indicate that OCR's treatment of Section 1557 in this time period was having a positive effect on access to nondiscriminatory health care and coverage by LGBT people.

The Proposed Rule, if finalized, stands to worsen anti-LGBT discrimination and related health disparities, because health care providers and insurers would be authorized under such a rule to discriminate on the bases of sexual orientation, gender identity, and sex stereotyping. Such a rule would have an especially devastating impact on the millions of LGBT people living in states without protections against sexual orientation and gender identity discrimination in health care.[47]

For all of the reasons discussed above, we urge OCR to withdraw the Proposed Rule and keep the Final Rule in place, or, at a minimum, suspend the rulemaking pending the Supreme Court's decisions in *Harris Funeral Homes*, *Bostock*, and *Zarda*.

II. The Proposed Rule's Creation of a Broad-Based Religious Exemption Distorts the Underlying Statutes, Raises Constitutional Concerns, and Stands to Harm Vulnerable Patients

Protecting religious liberty is a core principle of our democracy. The Final Rule states that application of the nondiscrimination standards of the regulation "shall not be required" if that application would "violate applicable Federal statutory protections for religious freedom and conscience." 45 C.F.R. § 92.2(b)(2); 81 Fed. Reg. 31,466. The Preamble to the Final Rule makes clear that this language includes the protections of provider conscience laws, the Religious Freedom Restoration Act, provisions in the ACA related to abortion services, and regulations issued under the ACA related to preventive health services. 81 Fed. Reg. 31,379. Through incorporation of these laws, the Final Rule amply protects religious liberty interests.

The Preamble to the Final Rule further demonstrates how carefully OCR considered application of Title IX's blanket religious exemption and the thoughtful reasons that OCR rejected its applicability in the health care arena. First, the nondiscrimination protections of Section 1557 explicitly apply "except as otherwise provided for in *this title* (or an amendment made by this title)." 42 U.S.C. § 18116 (emphasis added). Title I of the ACA contains no blanket religious exemption; as a result, it is simply inconsistent with the language of Section 1557 to import such an exemption and concomitant rejection of the ambit of the law's nondiscrimination protections.

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https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/. The most common complaints involved individuals being denied general care, such as mammograms, because of their gender identity or transgender status, and the next most common class of complaints involved denials of insurance coverage based on gender identity.

[47] Williams Inst., *LGBT People in the U.S. Not Protected by State Nondiscrimination Statutes* (2019), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Equality-Act-April-2019.pdf.

Second, Section 1557 incorporates the "ground[s]" for prohibited discrimination listed in other Spending Clause statutes, including Title IX. This word – "grounds" – incorporates only the statute's prohibition on discrimination on the basis of sex and the case law interpreting its meaning. By contrast, nothing in Section 1557 mentions the exemptions to Title IX. Indeed, many of those exemptions, including the membership practices of fraternities and sororities, military training institutions, and beauty pageant scholarship awards, *see* 20 U.S.C. § 1681(3), (4), (6), (9), are wholly irrelevant – and cannot be transferred – to the health care context. It is simply insupportable to assume that Congress intended to incorporate one of the Title IX exemptions (applying to educational institutions controlled by religious organizations), but not the others, all while maintaining complete silence on the issue.[48] This is particularly true because Congress *did* choose to explicitly incorporate the "enforcement mechanisms" of Title VI and the other underlying statutes. *See* 42 U.S.C. § 18116(a). Congress clearly knew how to reference specific aspects of the laws that it wanted to include, and its failure to do so with regard to Title IX's exemptions is telling.

In this regard, the Supreme Court's decision in *Consolidated Rail Corp. v. Darrone* is instructive. In that case, the Court held that the Rehabilitation Act's incorporation of the "remedies, procedure and rights" of Title VI did not incorporate Title VI's limits on those rights in the context of employment. The Rehabilitation Act was silent as to the Title VI limitations, and the Court recognized that "it would be anomalous to conclude that the section, 'designed to enhance the ability of [disabled] individuals to assure compliance with [disability nondiscrimination requirements],' . . . silently adopted a drastic limitation on the [disabled] individual's rights" in the employment context. 465 U.S. 624, 635 (1984) (internal citations omitted).[49]

There are good reasons for Congress not to have incorporated Title IX's blanket religious exemption. As the Preamble to the Final Rule explains, the educational context is different from health care in notable respects. First, while students and parents typically have a choice whether to select a religious educational institution, such choice may be absent in the health care realm, particularly in rural areas or for emergency or specialized services. 81 Fed. Reg. 31,380. In addition, the consequences of denials of health care can be truly serious and, in some instances, matters of life and death. *Id*. As a result, the "more nuanced approach" adopted in the Final Rule – applying the specific religious exemptions authorized by the ACA

[48] The Proposed Rule's approach also would create massive confusion. Proposed Section 92.6(b), 84 Fed. Reg. 27,892, bars application of any Section 1557 requirement that would violate or undermine rights or protections "provided by [Title IX]. But because the Title IX religious exemption applies only to entities covered under Title IX – and because those entities must, by the terms of Title IX, be educational institutions – any attempt to apply the Title IX exemption in the health care context would require OCR, as well as individuals and covered entities themselves, to differentiate between health care entities that are covered by Title IX (e.g., medical schools) from those that are not (e.g., religiously affiliated hospitals that are not part of a university). These questions would almost certainly increase both the risks of denials of health care by, and liability for, health care entities that misunderstood the permissible scope of the exemption.

[49] *See also* E. Sepper & J. Roberts, *Sex, Religion, and Politics, or the Future of Healthcare Antidiscrimination Law*, 19 MARQ. BENEFITS & SOC. WELFARE L. REV. 217 (2018).

and the provider conscience laws and, under the Religious Freedom Restoration Act, evaluating whether a particular application of Section 1557 substantially burdens a covered entity's exercise of religion and, if so, whether less restrictive alternatives are available, *id*., is the analysis best suited to balancing the commands of Section 1557 and the health of patients, on the one hand, and religious liberty interests, on the other.

The Proposed Rule distorts the language of Section 1557 and upends this careful balancing approach in favor of insulating religious providers from non-discrimination requirements in ways that go significantly beyond even the Title IX exemption. Under the Proposed Rule, requirements under Section 1557 may not be "imposed or required" if application of "any" of those requirements would "violate, depart from, or contradict definitions, exemptions, affirmative rights, or protections provided by" Title IX or a list of other present statutes. Section 92.6(b), 84 Fed. Reg. 27,892. The Proposed Rule further states that this prohibition applies to "any related, successor, or similar Federal laws or regulations." *Id*. None of the terms used in this section are defined; it is, for example, unclear how OCR will identify current or future laws that are "similar" to others in the list or which requirements of Section 1557 in fact "violate, depart from, or contradict" provisions of other statutes.[50]

How this broad exemption will be understood, by providers and their patients, is also unclear. While Title IX contains a religious exemption, Title VI, the Rehabilitation Act, and the Age Discrimination Act do not. But because the language of the Proposed Rule states that "application of *any* [Section 1557] requirement" is barred if it in any way conflicts with the list of statutes, Proposed Section 92.6(b), 84 Fed. Reg. 27,892 (emphasis added), covered entities could read it to authorize religious-based objections to nondiscrimination obligations based on race, disability, or age, as well as sex. Indeed, the Title IX religious exemption provision does not explicitly mention – and thus could be read out of context not to be limited to – sex discrimination at all. *See* 29 U.S.C. § 1681(a)(3) ("this section shall not apply to an educational institution which is controlled by a religious organization if the application of this subsection would not be consistent with the religious tenets of such organization"). But there is simply no civil rights law that authorizes race, national origin, disability, or age discrimination on religious grounds.

[50] In this regard, it should be noted that any reading of the Title IX exemption to apply to individual employees of health care entities – as opposed to "educational institution[s] . . . controlled by a religious organization" – would conflict with the express language of Section 1557 that dictates that nothing in the provision "shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under . . . title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.). . ." 42 U.S.C. § 18116(b). Under Title VII, employers have the right to a defense of undue hardship in cases in which employees request reasonable accommodations for their religious beliefs. See *Shelton v. University of Med. and Dentistry of N.J.*, 223 F.3d 220 (3d Cir. 2000) (holding, under Title VII, that hospital offered reasonable accommodation when it offered to transfer a nurse to a different unit after she refused on religious grounds to treat emergencies that she believed would result in abortions). OCR cannot, by regulation, eliminate an available statutory defense, much less do so under a law that HHS does not enforce.

Moreover, even if limited to sex discrimination, the Proposed Rule's incorporation of the Title IX religious exemption appears to be intended to grant a blanket exemption to a religious entity to refuse to perform any services, otherwise required under Section 1557, that the entity asserts offend its religious beliefs. The language of the Proposed Rule could, for example, lead a cardiologist to believe that he could permissibly refuse any care whatsoever to a woman suffering cardiac arrest based on the fact that she had previously had an abortion of which he disapproves on religious grounds, or to deny fertility treatments to a woman because she is unmarried.

This blanket exemption thus goes well beyond the provisions of existing provider conscience laws, such as the Church Amendments, the Coats-Snowe Amendment, or the Weldon Amendment, each of which is limited to specific services offered by particular providers who are funded under specified funding streams. Congress's decision to narrowly limit the scope of authorized exemptions under each of these provider conscience laws reflects an understanding of the damaging consequences of denials of care; to add a blanket religious exemption in the health care context would eviscerate the careful balance that Congress constructed in drafting these laws. Indeed, Federal law has never, to our knowledge, authorized the denial of health care to classes of individuals on religious grounds; the Proposed Rule thus undermines the careful and narrow approach of the provider conscience laws and unprecedentedly expands the reach of exemptions. The Proposed Rule also conflicts with the approach of the Religious Freedom Restoration Act, which applies a balancing test that enables the government to assert its compelling interest in enforcing the challenged requirement, even if the requirement substantially burdens the exercise of religion. As noted in the Preamble to the Final Rule, that balancing test is particularly appropriate in the health care context, where religious (or any) refusals of care stand to put the health and well-being of patients at risk.[51]

Indeed, it is hard to escape the conclusion that OCR's reason for incorporating the Title IX exemption into the Proposed Rule *is* to extend the levels of insulation authorized under existing laws for religiously affiliated providers to deny care; otherwise, the Proposed Rule would adopt the recognition in the Final Rule that existing laws governing religious exemptions – which are explicitly incorporated into the Final Rule – are sufficient to provide appropriate protection for religiously affiliated providers.

The Proposed Rule's approach, moreover, would exacerbate the likely health consequences of excluding sex stereotyping and gender identity discrimination from the operation of the regulation. As discussed above, LGBT people have been subject to persistent and pervasive discrimination and stigma, in health care and other arenas, and that discrimination has, among other things, created minority stressors that have had significant consequences for their mental and physical health. As noted, those consequences are likely to grow if LGBT people are deprived of opportunities to hold providers and insurers accountable

[51] *See, e.g.*, D. NeJaime & Reva Siegel, *Religious Exemptions and Antidiscrimination Law in* Masterpiece Cakeshop, 128 YALE L.J. FORUM 201, 216- (2018) (discussing the Supreme Court's concern for harms to third parties arising from Religious Freedom Restoration Act claims).

for discrimination against them, and if providers and insurers are not instructed and deterred by OCR to avoid such discrimination in the first place. But the Proposed Rule further expands the scope of the problem by endorsing the argument that religious objections to providing health care trump obligations to patients. The Proposed Rule not only fails, in either the Preamble or the Regulatory Impact Analysis, to grapple with or account for the harm to patients that refusals of care will cause; it affirmatively condones those refusals, *regardless* of the harm, when they are done for religious reasons. This position, which is inconsistent with the law for the reasons stated above, will only further stigmatize LGBT patients, among others, and chill their willingness to seek necessary medical services.[52]

The Proposed Rule's failure to adequately consider the harm to patients that may result from a religiously motivated denial of care also raises serious concerns under the Establishment Clause of the First Amendment to the Constitution. Allowing religious health care providers to deny patients health care could put those patients at grave risk and compromise the adequacy of their treatment. This is precisely the type of government action that the Supreme Court has held runs afoul of the Establishment Clause. For instance, in *Estate of Thornton v. Caldor, Inc*., the Supreme Court found that a Connecticut statute giving employees an absolute right not to work on their chosen Sabbath violated the Establishment Clause, in part because the law did not include an exception for cases where the law would impose "significant burdens" on other employees required to work in place of the Sabbath observers. 472 U.S. 703, 709–10 (1985). The Supreme Court affirmed this reasoning in *Cutter v. Wilkinson*, opining that "courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries."[53] Forcing patients to sacrifice their health, and in some cases their lives, in service of religious accommodation goes beyond even the burden the Supreme Court cited when invalidating the statute in *Caldor* – particularly where, as here, religiously affiliated providers already enjoy the protections of the provider conscience statutes and the Religious Freedom Restoration Act among other provisions incorporated by the Final Rule.

[52] The Proposed Rule's religious exemption stands to harm LGBT patients in other ways as well. If the Supreme Court decides, in the pending Title VII cases, that sexual orientation and/or gender identity discrimination are in fact covered under the law's prohibition of sex discrimination, that holding will likely powerfully dictate a finding that Section 1557 too covers these bases of discrimination. But that holding will be of cold comfort to vulnerable LGBT patients if OCR finalizes a rule that authorizes religious providers to turn such patients away if the providers have religious objections to their sexual orientation or gender identity. Because concerns about homosexuality have frequently been expressed in religious terms, it stands to reason that religious providers, insulated from liability by a sweeping religious exemption, would rely on the exemption in ways that limit access to care for the LGBT community and, in any event, create the minority stressors described above.

[53] 544 U.S. 709, 720 (2005). *See also* Otten v. Baltimore & Ohio R. Co., 205 F. 2d 58, 61 (2d Cir. 1953) (Learned Hand, J.) ("The First Amendment . . . gives no one the right to insist that in pursuit of their own interests others must conform their conduct to his own religious necessities.").

III. Other Provisions of the Proposed Rule Are Similarly Inconsistent with the Underlying Statutes and Would, if Finalized, Diminish Access to Health Care and Health Insurance

A. The Proposed Rule's Reductions in the Scope of Coverage are Inconsistent with the Statute and Stand to Harm Patients

The Final Rule applies to all health programs and activities that receive Federal financial assistance "provided or made available" by HHS (specifically including Federal financial assistance that "the Department plays a role in providing or administering, including all tax credits under Title I of the ACA", 45 C.F.R. § 92.4); health programs and activities administered by HHS; and health programs and activities administered by a Title I entity. 45 C.F.R. § 92.2(a). By contrast, the Proposed Rule would restrict application of Section 1557 to health programs or activities which receive federal financial assistance "provided by" HHS; programs or activities administered by the Department under Title I; and programs and activities administered by entities established under Title I. Proposed Section 92.2, 84 Fed. Reg. 27,891.

The language of the Proposed Rule dramatically narrows the universe of health programs and activities that will be expected to comply with Section 1557's nondiscrimination requirements – those related not just to sex but to each of the prohibited grounds. First, the Proposed Rule would exclude health programs conducted by HHS that are not administered under Title I; such programs include those administered by the Centers for Disease Control and Prevention, the Indian Health Service, and the Substance Abuse and Mental Health Services Administration, among others. Second, the Proposed Rule would "no longer cover issuers of Exchange plans solely on the basis that HHS plays a role in administering tax credits, also administered by the Internal Revenue Service." 84 Fed. Reg. 27,861. Third, the Proposed Rule ignores both the language of the statute covering health programs administered by *any* Executive branch agency and the recognition in the Final Rule that Section 1557 itself – even if not the HHS regulation implementing it – "applies to health programs and activities receiving Federal financial assistance from other [non-HHS] Departments." 81 Fed. Reg. 31,379. The Proposed Rule, as a result, takes the impermissible position that health programs funded by other federal agencies, such as the Federal Employee Health Benefit Program, or hospitals run by the Veterans Administration, are excluded from the operation of the statute.

As a corollary, the Proposed Rule narrows the application of Section 1557 to insurers and insurance in another way. The Final Rule defines "health program or activity" to mean "the provision or administration of health-related services, health-related insurance coverage, or other health-related coverage, and the provision of assistance to individuals in obtaining health-related services or health-related insurance coverage." 45 C.F.R. § 92.4. The Final Rule goes on to make explicit that "[f]or an entity principally engaged in providing or administering health services *or health insurance coverage* or other health coverage, all of its operations are considered part of the health program or activity . . ." and are thus covered by Section 1557. *Id*. (emphasis added).

In comparison, the Proposed Rule states that "an entity principally or otherwise engaged in the business of providing health insurance shall not, by virtue of such provision, be considered to be principally engaged in the business of providing health care," and will thus be accountable under Section 1557 only for discrimination in those particular programs that do receive Federal financial assistance. 45 C.F.R. § 92.3(b), (c). Even for insurers that receive Federal financial assistance from HHS (outside of the tax credits that the Proposed Rule would exclude as a form of that assistance), therefore, only those insurance products that receive HHS funds would be barred from discriminating under Section 1557; other products or lines of business would not be covered by the law.

Each of these provisions of the Proposed Rule is inconsistent with the statutory language and would create damaging repercussions for vulnerable communities that would be deprived of basic nondiscrimination protections under Section 1557.

First, the Proposed Rule would effectively read out of the statute the language making clear that Section 1557 applies not only to health programs and activities that receive Federal financial assistance, but also to "any program or activity that is administered by an Executive Agency or any entity established under this title." 42 U.S.C. § 18116(a). The Proposed Rule interprets this language as if it read that Section 1557 applies to "any program or activity that is administered . . . or . . . established under this title." But such a reading makes the statute's references to "an Executive Agency" and "any entity" mere surplusage – a clear violation of the longstanding principle that "[a] statute should be construed so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant." *Hibbs v. Winn*, 542 U.S. 88, 101 (2004). There is no permissible interpretation that would, as to programs conducted by Executive Branch agencies, restrict the operation of the statute to only those programs operated by HHS under Title I of the ACA.

In fact, the proper reading of the statutory language makes clear that Section 1557 applies to programs or activities that are administered by *any* Executive Branch agency, not just those that are administered by HHS – and certainly not only those operated by HHS under Title I. While the Final Rule recognizes the logistical difficulties of extending the HHS *regulation* to other Executive Branch agencies, 81 Fed. Reg. 31,379, it nowhere disavows the understanding that health programs and activities conducted by other federal agencies are also subject to the *statute*. Congress did not say that Section 1557 applies only to programs and activities administered by the Department of Health and Human Services, although it clearly knows how to limit language in this way if it chooses to do so, *see. e.g.*, 42 U.S.C. § 18116(c) (authorizing the Secretary of HHS to promulgate regulations under Section 1557). Instead, Section's 1557 plain text demonstrates that Congress intended to apply the law's nondiscrimination requirements to health programs conducted by any Executive Agency. The Proposed Rule's efforts to restrict Section 1557 to programs conducted by HHS under Title I is inconsistent with this clear statutory command.

Moreover, the Proposed Rule's exclusion of HHS's role with regard to tax credits as a form of Federal financial assistance sufficient to trigger application of the Rule elevates form

over substance and ignores the statutory language relevant to, and the underlying intent of, that assistance. Although advance premium and other tax credits are ultimately provided to taxpayers by the Internal Revenue Service ("IRS"), their purpose is to subsidize the purchase of insurance under the ACA, which is implemented by HHS. In addition, while OCR asserts in the Preamble that the Final Rule's treatment of tax credits as a form of Federal financial assistance "goes beyond the text of Section 1557, which, in relevant part, only covers certain programs or activities 'administered' by the Department [of Health and Human Services]," 84 Fed. Reg. 27,861, that argument misreads the relevant statutory language. Even assuming, contrary to the arguments above, that only programs administered by HHS under Title I, as opposed to HHS under other authorities or other Executive Agencies, are covered under the law, OCR here ignores that the definition of Federal financial assistance has nothing to do with the clause of the statute that addresses programs "administered" by the federal government. Instead, the entirely separate question is whether an entity that receives advance premium tax credits is "receiving Federal financial assistance." There can be no question that it is, regardless of whether the assistance comes directly from HHS or through the IRS. And because HHS is the agency that manages the process that leads to eligibility for the tax credits, it is consistent with both the statute and common sense to assign HHS the responsibility of enforcing Section 1557 against the recipients of those funds.

OCR's view that the "'business of providing . . . health care' differs substantially from the business of providing health insurance coverage (or other health coverage) for such health care," 84 Fed. Reg. 27,850, also ignores practical reality and the fundamental purpose of the ACA to promote access to health care by expanding access to health *insurance*. Insurers perform multiple functions necessary to provide a patient access to health care, including deciding on the providers a patient may see, the hospitals at which the patient may seek treatment, and the procedures that the hospital is authorized to perform or for which a patient may seek reimbursement (which, frequently, is the only way in which a patient will be able to access the service). To take the position that a health insurer is not "principally engaged" in "health care" and thus covered by Section 1557 for all of its operations obliterates Congress' recognition that the two are inextricably linked and that it was the lack of access to health insurance that was a primary barrier to adequate health care for millions of Americans. That position also undermines the basic purpose of the Civil Rights Restoration Act, which was to make clear Congress's intent that the anti-discrimination provisions of the civil rights laws tied to the receipt of Federal financial assistance typically embrace all of the operations of the recipient of that assistance. OCR's interpretation thus undermines the basic goal of the ACA to improve the health care available to those Americans who lacked health insurance before its enactment.[54]

[54] The proposed rule also disserves both insurers and individuals enrolled in insurance plans by entirely eliminating Section 92.207, 45 C.F.R. § 92.207, of the Final Rule. That section makes explicit that the statute prohibits discrimination on prohibited bases in health insurance issuance, coverage, cost-sharing, marketing, and benefit design and provides substantial guidance on how insurers can comply with the law in this regard. Eliminating this section of the Final Rule will not change the basic nature of insurers' obligations under the law; it will simply cause confusion and deprive entities of relevant information about how OCR, and courts, will apply the relevant legal standards.

In addition, OCR does not appear even to consistently apply its flawed approach. OCR states in the Preamble that "[e]xamples of recipients of Federal financial assistance from the Department for health programs or activities would include laboratories, medical schools and nursing schools." 84 Fed. Reg. 27,863. If OCR is asserting that schools for medical providers are "principally engaged" in health care because their essential purpose is to educate doctors and nurses to ultimately provide the medical services that constitute that health care, its failure to apply an analogous rationale to insurers is simply inconsistent with that approach.

OCR also ignores the goal of the Final Rule to, to the extent possible, create consistency and facilitate compliance of covered entities with multiple overlapping civil rights statutes. Title VI, Section 504, and the Age Discrimination Act all apply to all of the operations of all programs and activities that receive Federal financial assistance, whether those programs are primarily focused on health care or not; Section 504 further applies to programs conducted by the Federal government, and Title IX applies to all of the operations of federally funded education programs (including the health programs offered by educational institutions). Under the interpretations propounded in the Proposed Rule, all programs and activities that receive Federal financial assistance and are principally engaged in health care will be bound for all of their operations by prohibitions on discrimination based on race, national origin, disability, age, and sex; programs and activities that receive Federal financial assistance but are *not* principally engaged in health care (outside the context of education) will be bound by prohibitions on discrimination based on race, national origin, disability and age for all of their services but by prohibitions on sex discrimination only for particular health services that themselves receive Federal financial assistance; educational programs that receive Federal financial assistance will be bound by prohibitions on discrimination on all bases, including sex, regardless of the connection of the services to health; all programs administered by HHS will be bound by prohibitions on discrimination based on disability; and all programs administered by HHS under Title I of the ACA will be bound in addition by prohibitions on discrimination based on all of the bases included in Section 1557. This patchwork of obligations and standards will create massive confusion and significant barriers to compliance that are not required by any fair interpretation of Section 1557 and that stand to put the health and rights of vulnerable communities at considerable risk.

B. The Proposed Rule's Elimination of Notice and Tagline Requirements is Inconsistent with Longstanding Interpretations of Civil Rights Laws and Will Deprive Individuals of Knowledge of their Rights under Section 1557

The Final Rule requires covered entities to post nondiscrimination notices and taglines, in the top 15 non-English languages in the entity's state, in their offices, on their websites, and in "significant" publications. For smaller publications, entities must include an abbreviated statement and taglines in the top two non-English languages in the state. 45 C.F.R. § 92.8.

These requirements reflect the long-standing recognition that nondiscrimination notices are necessary to alert individuals to the existence of their rights and the processes available to

vindicate them. *See* 45 CFR 80.6(d) (Title VI); 45 CFR 84.8(a)-(b) (Section 504); 45 CFR 86.9(a)-(c) (Title IX); 45 CFR 91.32 (Age Act).[55] Unless covered entities are required to post nondiscrimination notices under Section 1557, individuals will be hard-pressed to learn that they have both new rights and means to hold the entities accountable for violations.

Similarly, taglines are essential for individuals who are limited English proficient to learn that they can request language assistance services – services that are often critical to ensure the adequate levels of communication necessary for medical professionals to provide competent and effective health care. Indeed, taglines are a cost-effective alternative to requiring full translations of the nondiscrimination notice and thus minimize burdens on covered entities while promoting meaningful access to health care for limited English proficient individuals.

Despite these realities, the Proposed Rule entirely rescinds the notice and tagline requirements. While OCR acknowledges that the Proposed Rule may therefore "decreas[e] access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services," it expects such an impact to be "negligible." 84 Fed. Reg. 27,882. By contrast, it estimates that the cost of the notice and taglines requirements ranges from $147 million at the low end to $1.34 billion at the high end. *Id.* at 27,873.

While we have concerns about the accuracy and validity of OCR's assumptions and calculations on the costs of compliance with these and other requirements in general, we focus here on several observations about the Regulatory Impact Analysis specific to the notice and tagline requirements. Even taking OCR's estimates at face value, its assessment of costs relates almost exclusively to those that it asserts stem from the requirement that covered entities include taglines in their significant publications. *See* 84 Fed. Reg. 27,878-80. OCR has failed to analyze the costs, if any, that arise from the nondiscrimination notice independent of the taglines, and has not estimated the cost of posting either a notice or taglines in an entity's physical location or on its website. Such costs are likely to be *de minimis*, given that the Final Rule provides a sample notice and translations and taglines in 64 languages. Moreover, covered entities are not relieved of the obligation to post notices and/or taglines under other statutes, including Title VI and Section 504; as a result, any cost/benefit analysis that rests on the notion that eliminating the notice and tagline requirements of Section 1557 will relieve entities of the associated costs is fundamentally flawed. Indeed, removing the notice requirements under Section 1557 will force covered entities to revert to the sometimes disparate notice requirements of other laws, which will, among other things, eliminate any notice to individuals that they now have rights to be free from discrimination based on sex under Section 1557.

[55] Indeed, OCR has itself recently recognized the value of nondiscrimination notices; OCR's Final Rule: Protecting Statutory Conscience Rights in Health Care, 45 C.F.R. part 88.5, states that OCR will consider an entity's posting of a notice as "non-dispositive evidence of compliance with the applicable substantive provisions of this part," and provides detailed descriptions of the factors OCR will consider, including placement and font size of notices.

OCR has similarly failed to fully evaluate the costs to *individuals* if the notice requirement is rescinded – costs that could be substantial, given that individuals may be deprived of critical information about their rights, particularly with regard to sex discrimination. OCR has failed, moreover, to consider any alternatives (including, for example, the approach under OCR's provider conscience regulations) to requiring the notice and taglines in each significant publication in order to alleviate the cost burden OCR perceives without abandoning the benefits of notices and taglines altogether.

As a result, OCR's decision to eliminate the requirements altogether is, at a minimum, overbroad. It is also inconsistent with the purposes of the ACA and Section 1557 to enhance access, and remove barriers, to health care and health insurance coverage.

C. The Proposed Rule Inappropriately Weakens Requirements for the Provision of Language Assistance Services

Under the Final Rule, covered entities must "take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities." 45 C.F.R. § 92.201(a). In assessing compliance with this requirement, OCR must give "substantial weight" to the nature and importance of the health program or activity and the particular communication at issue, and must take into account other relevant factors, including whether the covered entity has an effective written language access plan. 45 C.F.R. § 92.201(b).

The Proposed Rule appropriately recognizes that required language assistance services must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency. Section 92.101(b)(2), 84 Fed. Reg. 27,892. In the Proposed Rule, however, OCR proposes to remove the covered entity's obligation to take reasonable steps to provide meaningful access "to each individual with limited English proficiency," and instead creates a generalized obligation for covered entities to provide meaningful access to their programs or activities "by limited English proficient individuals." Section 92.101(a), 84 Fed. Reg. 27,892. In addition, the Proposed Rule substitutes a four factor test which OCR "may" use to evaluate compliance with the newly worded obligation. Section 92.101(b), 84 Fed. Reg. 27,892.

These proposed changes are inconsistent with Section 1557 and weaken the standards of the current rule in notable, and harmful, respects. First, OCR's formulation of a covered entity's basic obligation to provide language assistance services ignores the command of the statute that "an *individual* shall not" be subjected to prohibited discrimination. 42 U.S.C. § 18116(a) (emphasis added). Under the statute, it is not sufficient that a covered entity meet its nondiscrimination obligations to *some* individuals or a class of people described as "limited English proficient individuals"; the Final Rule correctly recognizes that the obligation to take reasonable steps to provide meaningful access runs to each individual with limited English proficiency. The Supreme Court's analysis in *City of L.A., Dep't of Water & Power v. Manhart*,

435 U.S. 702 (1978), is instructive. Construing Title VII's prohibition of discrimination "'against an *individual* . . . because of such *individual's* [protected characteristic],'" *id.* at 708 (quoting Title VII), the Court explained that "the statute's focus on the individual is unambiguous" and that "the basic policy of the statute requires that we focus on fairness to individuals rather than fairness to classes." *Id.* at 708-09. Like Title VII, Section 1557 prohibits discrimination against "an individual" – singular – not a class of "individuals" as the Proposed Rule would provide.

That is not to say that there is an across-the-board level of services that must be provided to each patient who is limited English proficient; a covered entity's obligation is to take "reasonable steps" as to each individual given the applicable circumstances, not to implement a prescribed regimen that applies to all communications with all patients at all times. In assessing the considerations that should inform a determination of reasonableness, the Final Rule makes clear that OCR is *required* to give substantial weight to the nature and importance of both the health program and the particular communication at issue. This requirement recognizes that the most significant factor in the analysis relates to how important it is in a particular case to ensure that a limited English proficient patient understands what is being communicated to them. Under the Final Rule, OCR is then *required* to consider other relevant factors, which may in some cases be narrower and in some cases broader than the factors listed in the Proposed Rule. These requirements of the Final Rule are necessary to ensure the individualized consideration the statute demands.

By contrast, the Proposed Rule substitutes a four-factor test that OCR "may" consider in evaluating whether a covered entity has met its obligations under this section. While the four-factor test has been used previously to assess the scope of language services obligations under Title VI, it undermines the implementation of Section 1557 to import the test into the regulation here. First, as discussed immediately above, the approach in the Final Rule focuses on the most important factor that should inform the inquiry about whether a covered entity has taken reasonable steps to provide meaningful access; the Proposed Rule gives equal valance to each of the four factors of the traditional test without providing any explanation of how they should be weighed against each other. Second, the Proposed Rule provides the OCR Director with both too much and too little discretion: while the Proposed Rule makes it optional for the Director to use the four-factor test (the Director "may assess" the factors), it simultaneously seems to deny the Director the flexibility to consider factors *other* than the ones listed in the Rule (the Director may assess how an entity "balances *the following* four factors"). Section 92.101(b), 84 Fed. Reg. 27,892 (emphasis added). The Proposed Rule thus undermines the careful, customized approach anticipated under Section 1557 and set out in the Final Rule, and eliminates the thoughtful guidance provided both in the Final Rule and in its Preamble.

Moreover, the Proposed Rule's wholesale elimination of any reference to a language access plan increases the risk that covered entities will be found to be in violation of their obligation to take reasonable steps to provide meaningful access to health care for limited English proficient individuals. As noted in the Preamble to the Final Rule, "a written language access plan has long been recognized as an essential tool to ensure adequate and timely provision of language assistance services . . . " 81 Fed. Reg. 31,414. In order to provide such

services, and to do so on a timely basis, covered entities are well advised to engage in advance planning – to, for instance, identify the languages they are likely to encounter among their patients, to identify a telephonic interpreter service or an on-site staff person who can provide competent oral interpretation, or to determine whether there are frequently used documents that ought to be translated in advance into often-encountered languages. Without this kind of advance consideration, covered entities will be ill-prepared to meet their obligations and thus more likely to be held liable for a failure to provide necessary language services on a timely basis when individuals with limited English proficiency seek medical care. It is a disservice to these entities to deprive them of the guidance provided in the current rule.

The Proposed Rule also eliminates any mention of video interpreting services and applies the requirements that the Final Rule sets for video interpreting to audio interpreting services alone. But covered entities are, of course, *allowed* to provide video, in lieu of audio, interpreting. Moreover, there may be cases in which the general standard – reasonable steps to provide meaningful access – will *require* video, rather than audio, interpreting. In both cases, the Proposed Rule would deprive covered entities of valuable guidance about the standards that must be met if video interpreting is to provide "meaningful access" to the medical service for individuals with limited English proficiency.

D. The Proposed Rule's Treatment of Private Rights of Action Would Undermine Decades of Case Law

The Final Rule explicitly states, consistent with decades of case law, that "[a]n individual or entity may bring a civil action to challenge a violation of Section 1557 or this part in a United States District Court . . ." 45 C.F.R. § 92.302(d). In the Preamble to the Final Rule, moreover, OCR made clear that it interpreted Section 1557 "as authorizing a private right of action for claims of disparate impact discrimination on the basis of any of the criteria enumerated in the legislation." 81 Fed. Reg. 31,440. The Preamble further cites the decision in *Rumble v. Fairview Health Services*, 2015 WL 1197415 (D. Minn. 2015), which recognized that:

> [i]t appears Congress intended to create a new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of plaintiff's protected class status. Reading Section 1557 otherwise would lead to an illogical result, as different enforcement mechanisms and standards would apply to a Section 1557 plaintiff depending on whether plaintiff's claim is based on her race, sex, age, or disability. For example, it would not make sense for a Section 1557 plaintiff claiming race discrimination to be barred from bringing a claim using a disparate impact theory but then allow a Section 1557 plaintiff alleging disability discrimination to do so.

Id. at *11.

Despite these precedents, the Proposed Rule entirely eliminates any reference to the availability of a private right of action. Indeed, the Proposed Rule's Regulatory Impact Analysis states explicitly that "the Department would no longer assert that a private right of action exists

for parties to sue covered entities for any and all alleged violations of the proposed rule. The Department would no longer take a position on that issue in its regulations . . ." 84 Fed. Reg. 27,883-84.

The scope of OCR's unwillingness to recognize a private right of action is unclear. But to the extent that OCR is asserting that individuals may not have a right to challenge intentional discrimination in court, its position flies in the face of four decades of precedent. The Supreme Court has stated that it has "no doubt that Congress . . . understood Title VI as authorizing an implied private cause of action for victims of illegal discrimination." *Cannon v. Univ. of Chicago*, 441 U.S. 677, 703 (1979) (holding that an individual has a private right of action under Title IX), and lower courts have routinely accepted that authorization in the hundreds of suits filed under the statutes underlying Section 1557 since that time.[56] For OCR to in any way cast doubt on the availability of a private right of action, at least for claims alleging intentional discrimination, is an unauthorized rejection of longstanding precedent and a significant disservice to vulnerable patients, who may not be aware that they have access to the judicial system to hold covered entities accountable for discriminatory actions. It may also lead covered entities to think that they cannot be held liable through private suits in court and thus to fail to take actions necessary to meet their Section 1557 obligations.

There is clearly a split in the case law on the question whether individuals have the right to file suits in court that allege violations of the law based on a disparate impact theory of discrimination. *Compare, e.g., Alexander v. Sandoval*, 532 U.S. 275, 282 (2001) (denying private right of action for disparate impact violations of Title VI) *with Rumble v. Fairview Health Services*, 2015 WL 1197415 (D. Minn. 2015) (finding that Section 1557 creates a "singular standard" for enforcement regardless of the underlying basis of plaintiffs' claims). We believe that *Rumble* – and the approach of the Final Rule -- is the better reading of Section 1557 with regard to disparate impact claims in court; that reading is consistent with the language of Section 1557 and Congress's intent to ensure effective protections against discrimination in health care, avoids the hodgepodge of procedural provisions that would otherwise apply depending on the basis for a claim of discrimination, and offers a sensible approach to adjudicating intersectional claims where a plaintiff has been subject to discrimination on the basis of both, for example, race and age.

But in any event, the Preamble to the Proposed Rule suggests that OCR may be misreading post-*Sandoval* precedents to invalidate use of a disparate impact theory of discrimination *at all*, not simply in private lawsuits in court. *See, e.g.*, 84 Fed. Reg. 27,851 (suggesting that portions of the Preamble to the Final Rule that recognize that neutral criteria, such as health status, claims experience, medical history, or immigration status, can result in "a

[56] Indeed, numerous courts have affirmed that a private right of action is available, at least for claims alleging intentional discrimination, under Section 1557 itself. *See, e.g., Audia v. Briar Place, Ltd.*, No. 17 CV 6618, 2018 WL 1920082 at *3 (N.D. Ill. Apr. 24, 2018); *Briscoe v. Health Care Serv. Corp.*, 281 F. Supp. 3d 725, 737 (N.D. Ill. 2017); *Callum v. CVS Health Corp*., 137 F. Supp. 3d 817, 845 (D.S.C. 2015).

disparate impact that results in discrimination on a basis prohibited by Section 1557" conflict with relevant precedents). There is nothing in *Sandoval* or its progeny that suggests that OCR is not free to apply disparate impact theories of discrimination in its own enforcement efforts, whatever the ability of individuals to pursue disparate impact claims in court; indeed, because judicial avenues for recourse for such claims have been cut off under Title VI and Title IX, Offices for Civil Rights across the government now offer the sole means for relief when an individual has been subjected to a disparate impact under those statutes.

IV. Conclusion

For the foregoing reasons, OCR and CMS should leave the Final Rule and CMS Regulations in place and withdraw the Proposed Rule. Indeed, the Proposed Rule raises serious concerns under the Administrative Procedure Act ("APA"), 5 U.S.C. § 706(2)(A). At a minimum, OCR and CMS should suspend the rulemaking until after the U.S. Supreme Court decides *R.G. & G.R. Harris Funeral Homes v. EEOC & Aimee Stephens*, *Bostock v. Clayton County*, and *Altitude Express v. Zarda*, which will be informative to the scope of Section 1557's prohibition of sex discrimination. In turn, the Department of Justice should request that the Northern District of Texas stay *Franciscan Alliance* pending decisions in *Harris Funeral Homes*, *Bostock*, and *Altitude Express* and any subsequent rulemaking under Section 1557.

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