

**UNITED STATES OF AMERICA
BEFORE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Nondiscrimination in Health and Health) Docket No. HHS-OCR-2019-0007
Education Programs and Activities) RIN 0945-AA11**

**COMMENTS OF WHITMAN-WALKER HEALTH IN OPPOSITION
TO THE PROPOSED RULE**

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INTRODUCTION

Pursuant to the Notice of Proposed Rulemaking, 84 Fed. Reg. 27846 (June 14, 2019) (referred to in these comments as the NPRM), Whitman-Walker Health submits these comments in opposition to the Department’s proposed re-writing of regulations under Section 1557 of the Affordable Care Act, 42 U.S.C. §18116, and proposed modifications to a number of regulations issued under other statutes.

We oppose the declarations that prohibited sex discrimination does not cover discrimination based on gender identity or presentation, or sexual orientation, and the removal of references to discrimination based on sexual stereotyping and association with an individual in a protected category. The Department’s position that sex discrimination does not cover discrimination based on gender identity is inconsistent with recent case law, and the NPRM’s attempt to back away from the Final Rule’s acknowledgement of well-settled law on sexual stereotyping as sex discrimination, and from the law on associational discrimination, is

irresponsible. Although the Department's rules cannot change the statute, these provisions threaten to confuse and mislead members of the public – particularly patients, health care providers and insurers – and are likely to result in increased discrimination and substantial harm to vulnerable communities that the statute actually protects: particularly lesbian, gay, bisexual and transgender (LGBT) individuals and families.

Whitman-Walker also opposes the Department's proposed deletion of references to sexual orientation and gender identity discrimination in a number of regulations issued under statutes other than Section 1557. These changes are not authorized by the Department's (erroneous) interpretation of Section 1557 and are unsupported by any analysis or evidence – other than an intent to send a message that LGBT identity is not recognized and LGBT persons can be subjected to discrimination with impunity.

In addition, we strongly oppose the NPRM's attempts to limit Section 1557's coverage of health insurance. The Department's attempt to draw a line between "health care" and "health insurance" misses the mark: Section 1557 covers all recipients of federal financial assistance that engage in "health programs and activities," and health insurance is clearly a health-related program or activity.

The NPRM's assertion that Section 1557's nondiscrimination mandate is limited by a sweeping exemption for discrimination based on personal religious or moral belief is erroneous. The May 2016 Final Rule expressly acknowledged that federal laws protecting religious belief remain effective. The NPRM's broader declaration is likely to mislead providers, insurers and patients alike. In particular, as the May 2016 Final rule recognized, Title IX's broad exemption for religiously affiliated educational institutions is inapplicable to the health care arena.

In addition, we oppose the proposed imposition of more complex procedures for persons seeking redress for health-related discrimination based on sex, race, color, national origin or disability. By fracturing the consolidated procedures under the current regulations, the Department will make it more difficult to bring instances of discrimination to the Department's attention. Whitman-Walker also objects to the NPRM's deletion of references in the Final Rule to the private rights of action under Section 1557, and to the availability of compensatory damages under the statute. These deletions are likely to confuse members of the public and mislead some persons into not asserting their legal rights.

Moreover, Whitman-Walker objects to the proposed cutbacks in safeguards in the May 2016 Final rule for patients with Limited English Proficiency. These safeguards help to assure that LEP individuals and families receive health care unimpeded by difficulties in communication between patient, provider and other health care staff.

Finally, it is important to note that many of the changes proposed by the NPRM are flatly inconsistent with the Administration's recently announced initiative to end the HIV epidemic. That initiative focuses on engaging the communities most affected by the epidemic in HIV testing; treatment of those who are HIV-positive with the goal of viral suppression; and expanding the use of Pre-Exposure Prophylaxis and other prevention strategies among those who are HIV-negative. The communities most affected by HIV include gay and bisexual men, transgender women, and Black and Latinx people. The NPRM removes or substantially weakens safeguards against health care discrimination against LGBT individuals, and the weakening of safeguards for LEP patients will make health care for significant numbers of Latinx people less accessible and less effective. Moreover, the NPRM's attempt to exempt a substantial number of health insurance plans and programs for Section 1557's nondiscrimination provisions undercuts

the very foundation of the initiative, which depends on increasing access to and engagement with health care.

INTEREST AND EXPERTISE OF WHITMAN-WALKER HEALTH

Whitman-Walker Health is a Federally Qualified Health Center serving the greater Washington, DC metropolitan area, with a particular mission to the LGBT community and to persons living with HIV of every sexual orientation and gender. Our more than 280 medical, behavioral health and dental professionals, lawyers and paralegals, support staff and administrators provide comprehensive primary and specialty HIV, Hepatitis C, and LGBT care, including medical, dental, mental health, substance use disorder treatment, community health, legal and insurance navigation services, and youth and family health and wellness-related support services. In 2018, Whitman-Walker provided health care services to more than 20,700 individuals.

Whitman-Walker's patient population is quite diverse and reflects Whitman-Walker's commitment to being a health care home for individuals and families that have experienced stigma and discrimination, or have otherwise encountered challenges in obtaining affordable, high-quality health care. We are nationally known as experts in HIV and Hepatitis C specialty care and in gender-affirming care for transgender and gender nonconforming persons. In calendar year 2018, 58% percent of our health care patients and clients who provided their sexual orientation identified as lesbian, gay, bisexual, or otherwise non-heterosexual, and 9% of our patients and clients—more than 1,800 individuals—identified as transgender or gender nonconforming. Our patients reflect the diversity of the Washington, DC metropolitan area: they include a wide range of races and ethnicities, ages and income levels.

Our commitment to high-quality, welcoming, culturally competent care for the LGBT community has made us a “go-to” health center for LGBT people in the surrounding states – not only from Virginia and Maryland, but also from Pennsylvania, West Virginia and Delaware. Many of these patients are unable to find nondiscriminatory, welcoming and competent care in their own communities.

Our patients and legal clients include a wide range of nationalities and cultures. Significant numbers of them have limited English proficiency. We have a number of staff who are proficient or fluent in Spanish as well as English, and also staff who are proficient in Amharic, French, Portuguese and other languages spoken by patients. Our LEP services have benefitted very significantly from the guidance provided in the Department’s current rule under ACA Section 1557, issued in 2016.

Since the mid-1980s, Whitman-Walker has had an in-house Legal Services Department. Our attorneys and legal assistants provide information, counseling, and representation to Whitman-Walker patients, and to others in the community who are LGBT or living with HIV, on a wide range of civil legal matters that relate directly or indirectly to health and wellness – including access to health care and discrimination based on HIV, sexual orientation, or gender identity. Our legal staff includes nationally recognized experts in Medicaid, Medicare, the Affordable Care Act and health insurance law generally, HIV law, and LGBT law. In 2018, 52% of our legal clients who provided their sexual orientation identified as lesbian, gay, bisexual or otherwise non-heterosexual; 20% of our legal clients identified as transgender or gender nonconforming; and 50% were diagnosed with HIV.

Over the years, Whitman-Walker health care providers, lawyers and paralegals have encountered many instances of discrimination against our patients and legal clients by health

care providers and staff outside of Whitman-Walker, based on sexual orientation, gender identity or HIV status. Our lawyers, paralegals and health care providers also have many years of experience advocating for patients with health insurance plans that discriminate against gender-affirming care, same-sex couples, and patients living with HIV or Hepatitis C who need specialized care. Whitman-Walker was extensively involved in the proceedings that resulted in the ACA Section 1557 rule in May 2016: the Request for Information in 2013 and the Notice of Proposed Rulemaking in 2015-2016.

COMMENTS ON THE PROPOSED RULE

I. The Proposed Elimination of Protections Against Gender Identity and Sexual Orientation Discrimination Are Legally Unsupported and Arbitrary, and Threaten Substantial Harm to Vulnerable Populations

A. The Department's Position That Sex Discrimination Does Not Include Discrimination Based on Gender Identity or Presentation, and Discrimination Based on Sexual Orientation, is Unsupported by Current Case Law

Relying primarily on one District Court case, *Franciscan Alliance, Inc., et al. v. Burwell, et al.*, 227 F. Supp. 3d 660 (N.D. Tex. 2016), the NPRM declares that the prohibition of sex discrimination in Section 1557 does not include discrimination based on gender identity or presentation. This position is contrary to the weight of current case law. The overwhelming majority of courts that have been presented with the question of whether federal sex discrimination laws such as Section 1557 cover anti-transgender discrimination have ruled that they do. Those courts have relied on the undeniable fact that discrimination against someone because they are transgender, or have transitioned from sex assigned at birth to their true gender, is discrimination because of their sex, or discrimination because they do not conform to sex stereotypes or gender norms. *See, e.g., Boyden v. Conlin*, 341 F. Supp. 3d 979 (W.D. Wis. 2018); *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018);

Flack v. Wis. Dep't of Health Servs., No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090 (S.D. Cal. Sept. 27, 2017); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. 2016); *Rumble v. Fairview Health Servs.*, No. 14-cv-2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (Section 1557); *Whitaker v. Kenosha Unified School District*, 858 F.3d 1034 (7th Cir. 2017), *cert. denied*, 138 S. Ct. 1260 (2018); *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217 (6th Cir. 2016); *M.A.B. v. Board of Education of Talbot County*, 286 F. Supp. 3d 704 (D. Md. March 12, 2018); *Grimm v. Gloucester County School Board*, No. 4:15-cv-54 (E.D. Va. May 22, 2018); *Adams v. School Board of St. Johns County*, 318 F.Supp.3d 1293 (M.D. Fla. Jul. 26, 2018) (Title IX). *See also EEOC v. R.G.*, 884 F.3d 560 (6th Cir. 2018), *cert. granted*, *R.G. & G.R. Harris Funeral Homes, Inc. v. EEOC, et al.*, No. 18-107 (U.S. April 22, 2019); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005); *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII);¹ *Smith v. Avanti*, 249 F. Supp. 3d 1149 (D. Colo. 2017) (Fair Housing Act); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act). *And see Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011) (Equal Protection Clause).

A number of courts also have concluded in Title VII cases that discrimination based on an individual's sexual orientation is discrimination because of sex. Such discrimination is because of the sex of the plaintiff/complainant him- or herself; because of the sex of the person(s) with whom the plaintiff/complainant is associated; and/or because of sex-based stereotypes. *Zarda v. Altitude Express, Inc.*, 883 F.3d 100 (2d Cir. 2018) (en banc), *cert.*

¹ Case law under Title IX, which is incorporated in Section 1557, relies on case law under Title VII. *E.g.*, *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1047 (7th Cir. 2017); *Wolfe v. Fayetteville, Ark. Schl. Dist.*, 648 F.3d 860 (8th Cir. 2011).

granted, Altitude Express, Inc. v. Zarda, No. 17-1623 (U.S. April 22, 2019); *Hively v. Ivy Tech Cmty. Coll. of Ind.*, 853 F.3d 339 (7th Cir. 2017) (en banc); *EEOC v. Scott Med. Health Ctr., P.C.*, 217 F. Supp. 3d 834 (W.D. Pa. Nov. 4, 2016); *Winstead v. Lafayette Cty. Bd. of Cty. Comm'rs*, 197 F. Supp. 3d 1334 (N.D. Fla. 2016); *Videckis v. Pepperdine Univ.*, 150 F. Supp. 3d 1151 (C.D. Cal. 2015); *Isaacs v. Felder*, 143 F. Supp. 3d 1190 (M.D. Ala. 2015); *Hall v. BNSF Ry. Co.*, 2014 WL 4719007 (W.D. Wash. Sept. 22, 2014); *Terveer v. Billington*, 34 F. Supp. 3d 100 (D.D.C. 2014); *Koren v. Ohio Bell Tel. Co.*, 894 F. Supp. 2d 1032 (N.D. Ohio 2012); *Heller v. Columbia Edgewater Country Club*, 195 F. Supp. 2d 1212, 1224 (D. Or. 2002); *Centola v. Potter*, 183 F. Supp. 2d 403 (D. Mass. 2002).

As the Department is well aware, the U.S. Equal Opportunity Commission has concluded, based on careful analysis, that sex discrimination under Title VII includes discrimination based on gender identity or sexual orientation. *Macy v. Holder*, 2012 EEOPUB LEXIS 1181, 112 FEOR (LRP) 257, (2012) (gender identity); *Baldwin v. Foxx*, 2015 EEOPUB LEXIS 1905; 116 FEOR (LRP) 2 (2015) (sexual orientation).

The NPRM fails to even mention the Supreme Court's ground-breaking decision in *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989), which established that decisions based on stereotypes about appropriate behavior for men or women constitute sex discrimination under Title VII. There is no justification for deleting all references to this important principle of sex discrimination law – acknowledged in § 92.4 of the current rule (Definitions – “Sex stereotypes” and “On the basis of sex”), and throughout the May 2016 order promulgating the current regulations.

The NPRM argues that Congress did not contemplate covering transgender persons, or homosexuals or bisexuals, when the sex discrimination statutes were initially enacted, and that

Congress to date has failed to enact legislation explicitly naming gender identity and sexual orientation as protected categories. These arguments fail in light of the Supreme Court's declaration, in ruling that Title VII applies to same-sex sexual harassment, that the meaning of the statutory text, not the subjective intent of members of Congress, must control:

As some courts have observed, male-on-male sexual harassment in the workplace was assuredly not the principal evil Congress was concerned with when it enacted Title VII. But statutory prohibitions often go beyond the principal evil to cover reasonably comparable evils, and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed.

Oncale v. Sundowner Offshore Services, Inc., 523 U.S. 75, 79 (1998).

As the NPRM acknowledges, the Supreme Court will hear cases in the October 2019 Term addressing sex discrimination under Title VII and discrimination based on gender identity and sexual orientation.² How the Court will rule, and the implications for Title IX or for Section 1557, cannot be reliably predicted at this time. At least until the Court rules in the pending cases, there is no reasonable basis for the Department to attempt to upend the developing case law, in reliance on the District Court's preliminary ruling in the *Franciscan Alliance* case – which in many respects is an outlier. As noted in the following section of these comments, this premature, ill-founded move by the Department threatens considerable harm by sending a message that discrimination against LGBT people in health care is permitted under federal law.

We have a particular concern that while the Department declares that “[its] position will not bar covered entities from choosing to grant protections for sexual orientation and gender identity that are not required by, but do not conflict with, any other federal law,” it then adds the following qualification in a footnote:

Policies of covered entities that result in unwelcome exposure to, or by, persons of the opposite biological sex where either party may be in a state of undress – such as in

² *R.G. & G.R. Harris Funeral Homes, Inc. v. EEOC, et al.*, No. 18-107; *Bostock v. Clayton County*, No. 17-1618; *Altitude Express, Inc. v. Zarda*, No. 17-1623.

changing rooms, shared living quarters, showers, or other shared intimate facilities – may trigger hostile environment concerns under Title IX. *United States v. Virginia*, 518 U.S. 515, 550 n.19 (1996) (“Admitting women to [an all-male school] would undoubtedly require alterations necessary to afford members of each sex privacy from the other sex in living arrangements”); *Fortner v. Thomas*, 983 F.2d 1024, 1030 (11th Cir. 1993) (“[M]ost people have a special sense of privacy in their genitals, and involuntary exposure of them in the presence of people of the other sex may be especially demeaning or humiliating.”).

84 Fed. Reg. 27846, 27874 n.179. This assertion is both completely outside the scope of Section 1557 and the issues in this rulemaking, and completely off-base as a statement of law. The cases cited did not address questions of making “shared intimate facilities” available to a patient or other individual in a health care settings on the basis of their gender identity. The quote from *U.S. v. Virginia* simply noted that Virginia Military Institute would likely need to make accommodations to transition from an (unconstitutional) all-male school; *Fortner v. Thomas* involved the asserted rights of (presumably cisgender) male inmates not to have their naked bodies and intimate bodily functions intrusively and regularly exposed to (presumably cisgender) female correctional officers. Simply being in a restroom, changing room or other “intimate facility” with a transgender individual does not raise any cognizable issue of privacy or sexual harassment. *E.g.*, *Doe v. Boyertown Area Sch. Dist.*, 897 F.3d 518, 526-36 (3d Cir. 2018), *cert. denied*, 139 S. Ct. 2636 (2019); *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. Of Educ.*, 858 F.3d 1034, 1052-1053 (7th Cir. 2017); *Cruzan v. Special Sch. Dist. No. 1*, 294 F.2d 981, 984 (8th Cir. 2002). For the Department to suggest otherwise, in a gratuitous footnote apparently intended to “warn” institutions that want to accommodate transgender people, is irresponsible and will only heighten alarm among LGBT people and embolden those who attack them with frivolous assertions.

B. The NPRM’s Ill-Conceived Statements Regarding Gender Identity and Sexual Orientation Discrimination Under Section 1557 Threaten to Exacerbate Discrimination Against LGBT Individuals and Families, With Substantial Harm to Them and to the Public Health

If enacted as proposed, the Department’s new rule will not change the actual meaning of Section 1557; the statute’s meaning and effect will be determined by the courts. However, the Department’s rules have substantial impact on health care providers and institutions, and on the public. For the Department to apparently give a “go-ahead” to LGBT discrimination in health care will, at best, mislead many patients and providers and result in substantial confusion. Moreover, the Department’s Office for Civil Rights serves a critical function in restraining, and providing relief from, discriminatory incidents and practices. Few individuals have the resources to seek relief through litigation in the courts, and legal service providers and law reform organizations can bring only a small fraction of the cases that come to their attention. The NPRM acknowledges that eliminating the current rule’s expansive interpretation of sex discrimination is likely to result in more discrimination, particularly against transgender persons (84 Fed. Reg. at 27876, footnote omitted):

The Section 1557 Regulation likely induced many covered entities to conform their policies and operations to reflect gender identity as protected classes under Title IX. The Department anticipates that, as a result of the proposed rule, some – but not all – covered entities may revert to the policies and practices they had in place before the [May 2016 Final Rule].

1. The NPRM Will Likely Increase LGBT Discrimination By Health Care Providers and Staff

Whitman-Walker physicians, nurses and other medical providers, therapists and counselors, attorneys and paralegals, hear many accounts from LGBT patients and legal clients of discriminatory experiences in hospitals, clinics, doctors’ offices and other health care settings. These experiences are not only offensive and upsetting to our patients and clients; they also are

damaging to health. Discriminatory incidents delay or deny needed health care, and discourage LGBT individuals from seeking care and from fully disclosing personal information that health care providers need for proper diagnosis and treatment. Patients come to Whitman-Walker sicker than they would otherwise be; their negative experiences outside Whitman-Walker make them distrustful of health care providers and reluctant to fully engage in treatment; and also make it more challenging for Whitman-Walker providers to make appropriate referrals for specialty care that we do not provide.

Among the many recent incidents reported by our medical, behavioral health and legal services providers are the following:

- Whitman-Walker was recently contacted by a transgender woman suffering from tonsillitis. She wanted treatment but knew of no hospital or facility other than Whitman-Walker where she could go. The caller reported that in her suburban area, she and other transgender individuals she knows are routinely disrespected and poorly treated when they seek medical care, and asked for advice on where transgender patients can receive good care.
- A gay man reported that he consulted a cardiologist for a heart issue. The cardiologist reviewed his medications and saw that one was Truvada – an antiretroviral medication that is used for “Pre-Exposure Prophylaxis” or “PrEP” – taken by persons who are not HIV-infected to avoid contracting HIV during sex. The cardiologist was startled and disapproving, and began lecturing the patient about what the cardiologist considered his inappropriate sex life.
- A transgender man, together with his girlfriend, consulted a fertility clinic about their options for pregnancy. Clinic staff told them that they would not help people like them.
- A transgender patient of Whitman-Walker attempted to fill a prescription at a non-Whitman-Walker pharmacy for a hormone prescribed to assist in their gender transition, and was refused by the pharmacist.
- Our patients seeking to fill prescriptions for Truvada for PrEP have also been refused by some pharmacies.
- A gay man who is a long-term HIV survivor went to a local hospital emergency room after an accident that occurred during sex. He was treated with contempt by ER staff and was lectured about his sex life.

- A transgender individual went to a local hospital emergency room suffering from acute abdominal pain. The individual was subjected to intrusive, hostile questioning by ER personnel, loudly and in public, about their anatomy and gender identity.
- A transgender woman was scheduled to receive an ultrasound for cancer. The first radiological technician she encountered refused to perform the ultrasound. When she protested, a second technician performed the procedure, but mocked her openly.
- Transgender patients have reported to us that they have been in medical or mental-health crisis and called for an ambulance, and that the Emergency Medical Service personnel who have arrived on the scene have intentionally used pronouns inconsistent with their gender identity, even when the patients have asked them to stop and told them that their language was increasing their distress.
- A gay man who was engaged in sex, while under the influence of drugs, experienced a physical episode and was fearful he was having a heart attack. He called an ambulance, but the Emergency Medical Service personnel who arrived belittled him and his situation and refused to take him to an emergency room.
- Local hospitals and surgeons have refused to perform gender-transition-related surgeries on Whitman-Walker transgender patients, even when they routinely perform the procedures in question on non-transgender patients, including in situations where the patient's insurance would cover the procedure or when the patient was able to pay for the procedure. This has happened with orchiectomies, breast augmentations, and breast reductions - procedures which are all routinely performed for treatment of cancer or for other reasons, not related to gender identity.
- A number of primary care physicians in our area have refused to prescribe hormone therapy for transgender patients seeking to transition from the sex they were assigned at birth to their actual gender identity. Many of these doctors have stated that they are not "comfortable" with such hormone therapy.
- Our providers have seen situations in which teenagers who are transgender or gender-nonconforming have presented at local hospitals with symptoms for which hospitalization was indicated, but their hospitalization was delayed and even denied because hospital personnel took them less seriously than they took other young people with similar presentations who were not transgender.
- Our transgender patients frequently report instances of being treated with disrespect and hostility by staff in doctors' offices, hospitals, and clinics. Frequently, staff at these facilities will refuse to address patients by their chosen names and gender pronouns, if these are not the same as the patients' legal names and sex assigned at birth, or if patients appear to be transgender. The persistent use of names and pronouns other than what the patients have requested appears intentional and intended to communicate strong disapproval of the patients.

- A transgender teenager was hospitalized after a suicide attempt. Hospital staff refused to address the teenager by the young person's preferred pronouns and gender throughout the teenager's hospital stay. This was experienced by the teenager as disapproval and contempt for the young person's gender identity. This discrimination exacerbated the teenager's acutely fragile state when the teenager was so desperately in need of health care providers' support and health care services free of judgment.
- A facility that specializes in inpatient mental health and substance-use disorder treatment, and which has explicit non-discrimination policies, nonetheless has significant trouble from nurses on weekend shifts (when the facility uses pool nurses rather than regular employees), who express strong disapproval of LGBT patients based on their religious beliefs or cultural upbringing. Despite the facility's non-discrimination policies, LGBT patients encounter hostility, expressions of disapproval, and lack of responsiveness to their needs or requests from these nurses. For patients hospitalized for mental or substance-use disorders, these experiences can activate their disorders.
- Whitman-Walker behavioral health staff often receive calls or other communications from LGBT persons expressing desperation about finding a therapist or substance use professional who will not discriminate against them because of their sexual orientation or gender identity.
- Our behavioral-health providers who regularly interview our transgender patients to assess their stage of gender transition and readiness for gender-affirming surgical procedures, or who provide psychotherapy for these patients, report that the large majority of the patients they meet with – as many as four out of every five – report incidents of mistreatment or discrimination by health care providers and staff at hospitals, other clinics, doctor's offices, and other facilities.
- A transgender woman who was about to have surgery at an area hospital for an inner ear condition (unrelated in any way to her transgender-related health care) was confronted and harassed by hospital staff objecting to her gender identity. She was repeatedly and intentionally referred to as “he” and as “a man” by staff in the radiology department when she went for a pre-surgical scan; by desk staff at the surgery center; and by the nurse preparing her for surgery. Several nurses talked about her with each other and laughed. One staff person refused to talk with the patient when she addressed them. Even the anesthesiologist, who she was expected to entrust with her life in one of her most vulnerable moments before surgery, mocked her and intentionally referred to her as a man. Health care providers are supposed to provide comfort to patients when they seek health care. Instead, the staff increased her fear just before her surgery because they showed complete disrespect and lack of care for the patient’s health and well-being.
- A transgender woman went to the office of an ophthalmologist at a local medical center for an eye exam. She arrived on time, filled out the initial paperwork, and then waited for about 45 minutes without being called for her appointment. The patient went to the desk to inquire, and was treated rudely by the staff. The staff then arbitrarily called a security guard to eject her from the office. As the patient spoke to the security guard, one of the

clinic staff came to her and said, loudly and offensively, “Sir, your kind needs to go away. We’re not serving your kind.” She complained to the Office of the Chief Medical Officer and was eventually seen by the ophthalmologist on another day, after considerable effort by her and Whitman-Walker staff.

- A transgender woman was seen by a medical provider at Whitman-Walker, who examined her and determined she might have broken her ankle. She was sent to the Emergency Room at a Washington, DC hospital. She identified herself to the ER check-in staff as a woman and presented a driver’s license that contained a female gender marker. She then waited for a number of hours (she remembers five or six) without being examined. When she inquired about the delay, she was treated rudely and mis-gendered by ER staff. She was finally called from the waiting area, but was taken to the men’s dressing room, rather than the area for women patients, to undress and put on a gown for a scan. During the four or more hours before she received the scan, examination and treatment, she suffered very significant physical pain.
- A gay male patient with end-stage renal disease was confronted by a staff person at the dialysis clinic the patient attends regularly for care. The employee expressed a strong dislike for LGBT people and objected to being involved in the patient’s care at the clinic.

Some of these incidents appear to constitute discriminatory denials of care. In other incidents, care was ultimately provided, but providers or staff expressed dislike, even hostility, towards the patients. By proposing to re-write the Section 1557 nondiscrimination rule to eliminate any discussion of gender identity, sexual orientation or sex stereotyping, the Department is sending a message to the health care industry and to the LGBT community that discrimination against LGBT patients is permitted under federal law. We are greatly concerned that as a result, discrimination will increase, and with it harms to the health of LGBT individuals and families, and to the public health generally.

2. The NPRM Will Likely Result in Increased Discrimination By Health Plans, Particularly Against Persons Seeking Gender-Affirming Care

Whitman-Walker medical and behavioral health providers, care navigators and attorneys assist hundreds of transgender patients every year to navigate private health plans, Medicaid, and Medicare to obtain the gender-affirming services that they need – including a wide range of surgical procedures and hormone therapy. Many private and public plans continue to resist

coverage of medically necessary procedures – if not through blanket exclusions of “sex change” or “sex transition” procedures, then through denials of coverage of specific procedures. For instance, many plans that do not contain blanket exclusions of all “sex reassignment” procedures still exclude many essential types of surgeries related to gender transition, including facial or chest surgery, and plans that are more inclusive commonly exclude revision work (labiaplasty and glans reconstruction). In addition, many insurers deny coverage of other specific treatments needed to complete an individual’s transition on grounds that the procedure is “cosmetic” – either by relying on general plan language excluding cosmetic procedures or concluding that a procedure is not medically necessary. In many cases, plans specifically exclude procedures that are routinely considered cosmetic for most cisgender persons, but may be part of a medically recognized course of treatment for a transgender person. Examples of such procedures, which are categorically excluded as “cosmetic” in many plans and by many utilization reviewers, include:

- Surgeries of the head and face, such as hair transplant, scalp advancement, brow reduction, lip reduction or augmentation, rhinoplasty, cheek and chin contouring, jawline modification, blepharoplasty, and other facial feminization techniques for transgender women.
- Laser hair removal and electrolysis, on the face and elsewhere on the body.
- Surgeries involving the neck, such as cartilage reduction (modification of the Adam’s Apple) and vocal feminization surgery.
- Breast augmentation and reduction.
- Other body contouring procedures, such as waist reduction, hip/buttocks implants, fat transfer, pectoral implants.
- Lessons/training to modify the vocal range.

Although District of Columbia law provides valuable support for our advocacy efforts,³ the Department’s current Section 1557 regulations have been very valuable in persuading Medicaid administrators, insurance company personnel, and employee health plan sponsors to eliminate outdated exclusions and to agree to cover procedures when supported by evidence of medical necessity.⁴ The NPRM threatens to return us to days when health plans routinely excluded all gender-affirming procedures, which in turn threatens many of our patients who suffer from crippling gender dysphoria.

The harm threatened by the NPRM’s erroneous interpretation of sex discrimination is exacerbated by its plainly unreasonable conclusions about the scope of Section 1557’s coverage of health insurance. As discussed in Section III, below, the Department’s assertion that health insurance is not a “health program or activity” within the meaning of Section 1557 is plainly erroneous. Under this interpretation, many health insurance plans – including many on which transgender and gender nonconforming persons depend to access critically needed care – would be exempt from Section 1557’s nondiscrimination mandate altogether. Also as noted in Section III, the NPRM further compounds the harm by deleting from the regulations the important specification of discriminatory insurance practices (current § 92.207).

C. The Proposed Modifications to HHS Regulations Outside the Scope of Section 1557 Are Legally Unsupported, Arbitrary and Harmful

The Department proposes “conforming amendments” to a number of HHS regulations, pertaining to Medicaid State Plans; Programs for All-Inclusive Care for the Elderly (PACE); and ACA State health insurance exchanges and plans issued under an exchange. These regulations

³ D.C. Department of Insurance, Securities and Banking, Bulletin 13-IB-01-30/15 Revised: *Prohibition of Discrimination in Health Insurance Based on Gender Identity or Expression* (Feb. 27, 2014), available at <https://disb.dc.gov/publication/disb-bulletin-13-ib-01-3015-revised-prohibition-discrimination-health-insurance-based>; D.C. Department of Health Care Finance, *Non-Discrimination in the District's State Medicaid Program Based on Gender Identity or Expression* (Feb. 27, 2014), available at <https://dhcf.dc.gov/publication/MedicaidPolicy-GenderIdentity>.

⁴ The impact of the Department’s May 2016 final rule on Section 1557 on health insurance exclusions of transgender care is demonstrated by, e.g., a recent study of 37 states in the federal marketplace, showing that 94% of plans analyzed did not have blanket exclusions of transition-related care in 2019. Out2Enroll, *Summary of Findings: 2019 Marketplace Plan Compliance with Section 1557*, <https://out2enroll.org/out2enroll/wp-content/uploads/2018/11/Report-on-Trans-Exclusions-in-2019-Marketplace-Plans.pdf> (visited August 5, 2019).

are outside the scope of Section 1557 and were not issued pursuant to that provision; they are not relevant to the Department's (erroneous) interpretation of sex discrimination under Title IX and, therefore, Section 1557. They are unsupported by any analysis or evidence – other than an intent to send a message that LGBT persons can be subjected to discrimination with impunity.

42 CFR §§ 438.3(d)(4), 438.206 (c)(2), 440.262 – Medicaid State plans and Medicaid contractors. These regulations were issued pursuant to HHS authority under Section 1902 of the Social Security Act, to implement Section 1902(a)(19), which directs HHS to “provide such safeguards as may be necessary to assure that eligibility for care and services under the [Medicaid] plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients.” 42 U.S.C. § 1396a(a)(19). *See Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability: Final Rule*, 81 Fed. Reg. 27498, 27538-39, 27666 (May 6, 2016).

42 CFR §§ 460.98 and 460.112 – PACE (Program of All-Inclusive Care for the Elderly). This is a program for services for frail community-dwelling elderly persons, most of whom are Medicaid and Medicare dual eligible, to keep them in the community rather than moving to nursing homes. HHS added sexual orientation to the list of protected categories of persons eligible for PACE services in 2006, explaining that “we do not believe anyone should be denied enrollment in PACE because of discrimination of any kind.” *Medicare and Medicaid Programs; Programs of All-Inclusive Care for the Elderly (PACE); Program Revisions: Final Rule*, 71 Fed. Reg. 71244, 71295 (Dec. 8, 2006). *See also id.* at 71283, 71299, 71328-29.

45 CFR § 147.104(e) – requirements for group and individual market health

insurance plans subject to the ACA. Prohibition of sexual orientation and gender identity

discrimination was added in 2013 with this explanation:

[D]iscriminatory marketing practices or benefit designs represent a failure by issuers to comply with the guaranteed availability requirements. In response to comments, we revise § 147.104(e) of this final rule to make clear that a health insurance issuer and its officials, employees, agents and representatives must not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals in health insurance coverage based on these factors. This standard will ensure consistency with the prohibition on discrimination with respect to [Essential Health Benefits] in § 156.125, the non-discrimination standards applicable to [Qualified Health Plans] under § 156.200(e), and the marketing standards in § 156.225.

Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review: Final Rule, 78 Fed. Reg. 13406, 13417 (Feb. 27, 2013).

45 CFR §§ 155.120(c)(ii) and 155.220(j)(2)(i) – requirements of ACA-created health insurance exchanges; 45 CFR §§ 156.200(e) and 156.1230(b)(2)⁵ – requirements for

qualified health plans under the ACA. The prohibitions of gender identity and sexual orientation discrimination were promulgated to further the ACA’s aim of expanding insurance coverage, which is thwarted by discriminatory marketing practices and benefit designs. *See, e.g.,*

Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers: Final Rule, Interim Final Rule, 77 Fed. Reg. 18310, 18319, 18415 (March 27, 2012); *Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond: Final Rule*, 79 Fed. Reg. 30240, 30261 (May 27, 2014); *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program: Final Rule*, 81 Fed. Reg. 94058, 94152 (Dec. 22, 2016).

⁵ The NPRM identifies the regulation to be amended as 45 CFR § 156.1230(b)(3), but this appears to be a typographical error.

The Department's analysis of sex discrimination under Title IX, even if it were well-founded – which it is not – would provide no justification for amending these regulations, which were promulgated to advance the goals of other statutory provisions.

II. The Proposed Deletion of Discrimination Based on Association With Someone in a Protected Category is Unsupported by Case Law

Without any discussion, much less analysis, the Department proposes to delete Section 92.209 of the current regulations, which prohibits discrimination against a person on the basis of the race, color, national origin, sex, disability or age of an individual with whom they are associated. This provision accurately reflects the law; it should be retained.

A number of Courts of Appeals have recognized, in cases brought under Title VII, that actionable race discrimination includes discrimination based on the race of an individual with whom the plaintiff has a relationship or is associated. *E.g.*, *Floyd v. Amite County School Dist.*, 581 F.3d 244, 249 (5th Cir. 2009); *Holcomb v. Iona Coll.*, 521 F.3d 130, 138 (2d Cir. 2008); *McGinest v. GTE Service Corp.*, 360 F. 3d 1103, 1118 (9th Cir. 2004), *cert. denied*, 552 U.S. 1180 (2008); *Tetro v. Elliot Popham Pontiac, Oldsmobile, Buick & GMC Trucks Inc.*, 173 F.3d 988, 993–96 (6th Cir. 1999); *Parr v. Woodmen of the World Life Ins.*, 791 F.2d 888, 892 (11th Cir. 1986). A number of District Courts have reached similar conclusions when the discrimination was based on association with persons of a different national origin or sex. *E.g.*, *Montes v. Cicero Pub. Sch. Dist. No. 99*, 141 F. Supp. 3d 885,900 (N.D. Ill. 2015) (national origin); *Morales v. NYS Dep't of Labor*, 865 F. Supp. 2d 220, 242-43 (N.D.N.Y. 2012), *aff'd summarily*, 530 F. App'x 13 (2d Cir. 2013) (race and national origin); *Kauffman v. Maxim Healthcare Servs., Inc.*, No. 04-CV-2869, 2006 U.S. Dist. LEXIS 47514, 2006 WL 1983196, at *4 (E.D.N.Y. July 13, 2006) (sex and race); *Reiter v. Ctr. Consol. Sch. Dist. No. 26-JT*, 618 F. Supp. 1458, 1460 (D. Colo. 1985) (race and national origin). Courts have also recognized claims

of associational discrimination under Section 504 of the Rehabilitation Act. *E.g.*, *Loeffler v. Staten Island Univ. Hosp.*, 582 F.3d 268, 277 (2d Cir. 2009); *Falls v. Prince George's Hosp. Ctr.*, No. Civ. A 97–1545, 1999 U.S. Dist. LEXIS 22551, 1999 WL 33485550 at * 11 (D. Md. Mar. 16, 1999).

These cases have recognized that the civil rights laws apply not only to discrimination based on an individual's own protected status, but also discrimination based on a disfavored association involving any enumerated protected status. The same concept of prohibited associational discrimination applies to sex; Title VII treats all protected categories the same regarding standards for determining discrimination, including sex as well as race, color and national origin,⁶ and Title IX, incorporated into Section 1557, is guided by Title VII sex discrimination law.

III. The NPRM's Cutbacks on Coverage of Health Insurance Are Inconsistent with the Statute and Threaten Drastic Reductions in Protections for Vulnerable Communities

A. The NPRM Excludes From Section 1557 Health-Related Programs and Activities, Including Health Insurance Plans and Programs, That the Statute Plainly Covers

Section 1557 applies to:

Discrimination [] under [1] any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or

⁶ As observed by the EEOC in *Baldwin v. Foxx*, 2015 EEOPUB LEXIS 1905, *19:

Title VII “on its face treats each of the enumerated categories” — race, color, religion, sex, and national origin — “exactly the same.” *Price Waterhouse*, 490 U.S. at 243 n.9 (“[O]ur specific references to gender throughout this opinion, and the principles we announce, apply with equal force to discrimination based on race, religion, or national origin.”); see also *Whidbee v. Garzarelli Food Specialties, Inc.*, 223 F.3d 62, 69 n.6 (2d Cir. 2000) (“[T]he same standards apply to both race-based and sex-based hostile environment claims.”); *Williams v. Owens-Illinois, Inc.*, 665 F.2d 918, 929 (9th Cir. 1982) (“[T]he standard for proving sex discrimination and race discrimination is the same.”); *Horace v. City of Pontiac*, 624 F.2d 765, 768 (6th Cir. 1980) (“Both cases concern Title VII cases of race discrimination, but the same standards and order of proof are generally applicable to cases of sex discrimination.”).

under [2] any program or activity that is administered by an Executive Agency or [3] any entity established under [Title I of the ACA}

42 U.S.C. § 18116(a). The current rule correctly concluded that this language covers all health-related operations and programs of any health care or health insurance provider, if any part of its operations receives Federal financial assistance (clause 1 of the statute); any other health program or activity administered by HHS (clause 2 of the statute); or any health insurance exchange or other entity established under ACA Title I, or health insurance-exchange-related insurance plan (clause 3 of the statute). The NPRM, however, proposes to limit dramatically the scope of Section 1557, in two major ways.

First, the NPRM would limit Section 1557 to just those health programs of HHS that are established or administered under ACA Title I – excluding other HHS health-related programs and activities. This limitation would affect numerous health-related Department programs and activities, including those of the Centers for Medicare and Medicaid Services – and, arguably, the Department’s operation of the entire Medicare program.⁷ It would also exclude from Section 1557 health-related programs and activities of the Centers for Disease Control and Prevention, the National Institutes of Health, and the Substance Abuse and Mental Health Services Administration. This result is nonsensical as well as inconsistent with the statutory language, which provides that Section 1557 applies to “any program or activity that is administered by an Executive Agency.”⁸

⁷ Even though Section 1557 would, presumably, still cover health care providers who participate in Medicare Parts A, C or D (since only Medicare Part B payments are not considered Federal financial assistance).

⁸ Whitman-Walker does not contest the Department’s conclusion that its regulations under Section 1557 should apply only to health-related programs and activities of HHS itself, and to entities receiving health-related financial assistance from HHS.

Second, and of even greater concern, the NPRM erroneously declares that health insurance is not a “health program or activity” under Section 1557. Proposed § 92.3 states:

§ 92.3 Scope of application.

(a) Except as otherwise provided in this part, this part applies to

(1) Any health program or activity, any part of which is receiving Federal financial assistance (including credits, subsidies, or contracts of insurance) provided by the Department;

(2) Any program or activity administered by the Department under Title I of the Patient Protection and Affordable Care Act; or

(3) Any program or activity administered by any entity established under such Title.

(b) As used in this part, “health program or activity” encompasses all of the operations of entities principally engaged in the business of providing health care that receive Federal financial assistance as described in paragraph (a)(1). For any entity not principally engaged in the business of providing health care, the requirements applicable to a “health program or activity” under this part shall apply to such entity’s operations only to the extent any such operation receives Federal financial assistance as described in paragraph (a)(1).

(c) For purposes of this part, 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.

84 Fed. Reg. at 27891. It is unclear, from this language and from the discussion in the NPRM, 84 Fed. Reg. at 27850, 27862-63, whether the Department is proposing to exclude from Section 1557’s nondiscrimination mandate (1) *all* health insurance plans, programs and activities *except* for those that operate under ACA Title I; *or* (2) *all* health insurance plans, programs and activities *except* for Title I plans and exchanges *and* insurance plans outside of Title I that receive Federal financial assistance. Either way, the NPRM would exempt many forms of health

insurance from Section 1557, subjecting individuals and families who rely on those forms of insurance to discrimination based on race, color, national origin, disability, sex or age.⁹

The Department’s argument that “health insurance” is different from “health care” (84 Fed. Reg. at 27862) is irrelevant; Section 1557 covers “health programs and activities,” not just direct health care. Clearly, health insurance is health-related: it is what enables the vast majority of Americans to access health care. The NPRM’s contrast of two unrelated statutes, which define “health care” and “health insurance” for other purposes,¹⁰ is similarly off-point. Indeed, one of the statutes cited by the Department, 42 U.S.C. § 300gg–91, notes that health insurance is one way of providing health care.¹¹

The Department’s appeal to language in the Civil Rights Restoration Act, which amended Title VI, Title IX, Section 504 of the Rehabilitation Act, and the Age Act to specify that those laws apply to all operations of an entity that receives federal financial assistance, also misses the mark. The Department argues:

The CRRA ... defined “program or activity” under Title VI, the Rehabilitation Act, the Age Act, and Title IX to cover all the operations of entities only when they are “principally engaged in the business of providing education, *health care*, housing, social services, or parks and recreation.” Pub. L. 100-259, 102 Stat. 28 (Mar. 22, 1988) (emphasis added).

⁹ Interpretation #1, above, would seem to exclude Medicaid programs from Section 1557. Clearly, an interpretation under which the programs in every state on which millions of particularly vulnerable persons depend would be exempt from Section 1557 would have disastrous results.

¹⁰ 5 U.S.C. § 5371, which addresses pay and other terms of employment for certain federal employees in certain “health care” positions; and 42 U.S.C. § 300gg–91, which defines terms for purposes of federal laws regulating health insurance.

¹¹ 42 U.S.C. § 300gg–91(a)(1) (emphasis supplied):

The term “group health plan” means an employee welfare benefit plan ... to the extent that the plan *provides medical care* (... *including items and services paid for as medical care*) to employees or their dependents (as defined under the terms of the plan) *directly or through insurance*, reimbursement, or otherwise.

84 Fed. Reg. at 27862. The CRRA’s general language amended all four statutes, including Title IX, which applied to education, in 1988. More than two decades later, Congress enacted ACA Section 1557, to impose nondiscrimination requirements in Title IX and four other statutes to “health programs and activities” receiving federal financial assistance. The CRRA language was not addressing at all the question of whether health insurance is a “health program or activity.”

The NPRM’s assertion that health insurance is not a “health program or activity” within the meaning of Section 1557 (unless falling under ACA Title I) also cannot be squared with the court decisions that have found that state Medicaid plans, and other health insurance plans, violate Section 1557’s sex discrimination when they exclude coverage of medical procedures for transgender persons. *Boyden v. Conlin*, 341 F. Supp. 3d 979 (W.D. Wis. 2018) (state employee health plan); *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018) (employer-based health insurance plan); *Flack v. Wis. Dep’t of Health Servs.*, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018) (state Medicaid program); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. 2016) (state Medicaid program).

The current regulatory provisions regarding Section 1557’s applicability to health insurance, and to HHS-administered programs outside the scope of ACA Title I, should be restored.

B. The NPRM Eliminates Specific Guidance for Health Insurance Plans That Is Needed by the Industry and the Public

The current regulations include provisions that specify insurance practices and plan features that constitute forms of unlawful discrimination:

§ 92.207 Nondiscrimination in health-related insurance and other health-related coverage.

* * *

(b) Discriminatory actions prohibited. A covered entity shall not, in providing or administering health-related insurance or other health-related coverage:

(1) Deny, cancel, limit, or refuse to issue or renew a health-related insurance plan or policy or other health-related coverage, or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, or disability;

(2) Have or implement marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age, or disability in a health-related insurance plan or policy, or other health-related coverage;

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

(4) Have or implement a categorical coverage exclusion or limitation for all health services related to gender transition; or

(5) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

(c) The enumeration of specific forms of discrimination in paragraph (b) does not limit the general applicability of the prohibition [against discrimination based on race, color, national origin, sex, disability or age] in paragraph (a) of this section.

(d) Nothing in this section is intended to determine, or restrict a covered entity from determining, whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case.

These provisions provide useful guidance, not only for consumers and others advocating on their behalf – including health care providers who assist patients in determining coverage of health care being provided or contemplated – but also for health insurance companies and plan administrators. This guidance is important not only for transgender individuals seeking gender-

affirming surgery or other medical care, but also to assessing insurance practices regarding the “tiering” of certain drugs, e.g., to determine co-pays or cost-sharing ratios. Such practices are of great concern to persons living with HIV or other medical conditions or disabilities that require expensive treatments.¹² Regulatory guidance in this area is needed by the industry as well as by patients and health care providers. The omitted regulatory provisions should be restored.

IV. The Proposed Inclusion of Sweeping Religious Exemption Language is Unnecessary and Sends Misleading Signals to Covered Entities and the Public

Section 92.2(b)(2) of the existing regulations provides: “Insofar as the application of any requirement under this part would violate applicable Federal statutory protections for religious freedom and conscience, such application shall not be required.” The Department’s sweeping enumeration of laws that might justify a religious- or conscience-based refusal to provide care in specific circumstances – 84 Fed. Reg. at 27890 (proposed § 86.18(c)), 27892 (proposed § 92.6(b)) is unnecessary and overly broad. The broad language in the NPRM is likely to confuse providers, health plan administrators, and patients alike, and contribute to inaccurate impressions that religious beliefs, or an individual provider’s personal religious or moral feelings, are a legitimate reason to limit or deny needed health care.

In particular, the NPRM errs in declaring that Section 1557’s nondiscrimination mandate is limited by the exemption in Title IX for “[an] educational institution controlled by a religious organization if the application of [Title IX nondiscrimination requirements] would not be consistent with the religious tenets of such organization.”¹³ By its express terms, the religious exemption in the text of Title IX applies only to educational institutions and educational

¹² See, e.g., Douglas B. Jacobs and Benjamin D. Sommers, *Using Drugs to Discriminate – Adverse Selection in the Insurance Marketplace*, N. Engl. J. Med. 372 (5) (January 29): 399-402, available at <https://dash.harvard.edu/bitstream/handle/1/14008379/nejmp1411376.pdf?sequence=3&isAllowed=y>.

¹³ 20 USC § 1681(a)(3).

programs, not to health care providers or health plans. The intent of the Title IX exemption is to protect religiously-controlled *educational* institutions and programs from requirements that violate their religious tenets: for instance, religious schools that believe that only men can be priests, rabbis or ministers are not required to admit women to training programs for the priesthood, rabbinate or ministry; a religious school whose tenets oppose sex outside of marriage can discriminate against unmarried pregnant students; religious schools based on certain tenets can limit female-male interactions in athletic programs, gymnasiums and swimming pools; and several religious schools have obtained exemptions under Title IX from requirements not to discriminate against transgender students in student housing, locker rooms and restroom facilities. Such exemptions are very different from an exemption that would allow a health care provider, health care center or hospital, or health plan to discriminate against patients or plan members on the basis of sex.

Moreover, Section 1557's express incorporation of "[t]he enforcement mechanisms provided for and available under ... title IX," 42 U.S.C. § 18116(a), reinforces the conclusion that Congress did not intend to incorporate the Title IX religious exemption, which is not mentioned. Both Title IX and Section 504 of the Rehabilitation Act expressly incorporate the enforcement mechanisms of Title VI. However, the Supreme Court rejected arguments that this language incorporated Title VI's limitations on coverage of employment discrimination into Title IX and Section 504, because such incorporation would have been inconsistent with the intent of those statutes. *North Haven Board of Education v. Bell*, 456 U.S. 512 (1982) (Title IX); *Consolidated Rail Corp. v. Darrone*, 465 U.S. 624 (1984) (Section 504).

Religiously affiliated hospitals and health care systems occupy a large and growing percentage of health care markets, and providing a broad exemption from Section 1557's

proscription of sex discrimination by such institutions would threaten the health of increasing numbers of Americans.¹⁴

In addition, incorporating Title IX's exemption for religiously controlled institutions and programs into Section 1557 would result in a strikingly imbalanced rule, since Title VI, the Age Discrimination Act, and Section 504 of the Rehabilitation Act contain no such exemption. Such an interpretation of Section 1557 would allow for discrimination in the case of sex that would be prohibited for race, color, national origin, disability and age.

V. The NPRM Imposes Unwarranted Complications on Administrative Enforcement Mechanisms and Limitations on Remedies

The current rule provides that administrative complaints alleging discrimination by a recipient of Federal financial assistance, complaints alleging race, color, national origin, sex or disability discrimination are handled pursuant to the regulations promulgated by the Department under Title VI, and complaints alleging age discrimination are handled pursuant to the Department's regulations under the Age Act. § 92.302. Complaints alleging discrimination on any covered basis by programs administered by HHS are handled pursuant to the Department's regulations under Section 504 of the Rehabilitation Act. § 92.303. The NPRM appears to complicate the handling of administrative complaints by implying that an allegation of discrimination based on race, color or national origin is determined by Department regulations under Title VI; sex discrimination by regulations under Title IX; disability discrimination by regulations under Section 504 of the Rehabilitation Act; and age discrimination by regulations

¹⁴ The Department recently issued a wide-ranging final rule that empowers health care providers and staff, and even persons working for health insurance companies and health plans, to refuse even very indirect participation in health care based on their personal religious and moral views. *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority: Final Rule*, 84 Fed. Reg. 23170 (May 21, 2019). Whitman-Walker, along with many other health care providers and institutions, and state and local governments, have filed suits challenging this rule. As of the date of these comments, the rule's effective date has been suspended until at least November 22, 2019, while the courts are considering motions for summary judgment.

under the Age Act. *See* 84 Fed. Reg. at 27850-51, 27860, 27863. The lack of clarity and apparent complication of enforcement mechanisms in the NPRM is a recipe for confusion and traps for the unwary – particularly since many administrative complaints are lodged by individuals without legal representation or legal training. The enforcement procedures enumerated in the current regulations appear substantially more efficient and fairer.

The NPRM also deletes the statement in the current regulations that compensatory damages are available in administrative enforcement actions under Section 1557 (current § 92.301((b))). If the Department’s intent is to exclude compensatory damages as an available remedy when discrimination is established and resulting harm is demonstrated, this action is arbitrary and inconsistent with Congressional intent. The Department clearly has the legal authority to award such damages, and to fail to do so in appropriate cases is to abrogate its duty under the civil rights laws.

The NPRM also deletes the references, in the current regulations, to the right to bring a private action in court (current § 92.302(d)) and to the availability of compensatory damages in judicial actions (current § 92.301(b)). Although the Department’s statements regarding a private right of action, or availability of compensatory damages in such an action, have no legal effect, omitting this information may deprive aggrieved individuals of valuable information, and is inconsistent with the Department’s obligation to provide the public with accurate statements of their legal rights.¹⁵

¹⁵ Although the current case law is mixed regarding private lawsuits alleging disparate impacts, under Section 1557 and some of the statutes it incorporates, it is clear, at a minimum, that a private right of action is available under Section 1557 alleging disparate treatment.

VI. The Proposed Weakening of Safeguards for LEP Patients is Ill-Advised and Likely to Deprive Some Individuals and Families of Adequate Care

Whitman-Walker serves a substantial number of patients with limited English proficiency. While acknowledging that Section 1557 requires that LEP persons receive nondiscriminatory, adequate care, the NPRM weakens provisions in the existing regulations that are important to achieving that goal. Perhaps most fundamentally, the current regulations provide that compliance with the obligation to provide nondiscriminatory services to LEP patients is determined by:

- (1) Evaluat[ing], and giv[ing] substantial weight to, the nature and importance of the health program or activity and the particular communication at issue, to the individual with limited English proficiency; and
- (2) Tak[ing] into account other relevant factors, including whether a covered entity has developed and implemented an effective written language access plan, that is appropriate to its particular circumstances

Current § 92.201(b). By contrast, the NPRM proposes that covered entities balance the following factors:

- (i) The number or proportion of limited English proficient individuals eligible to be served or likely to be encountered in the eligible service population;
- (ii) The frequency with which LEP individuals come in contact with the entity's health program, activity, or service;
- (iii) The nature and importance of the entity's health program, activity, or service; and
- (iv) The resources available to the entity and costs.

84 Fed. Reg. at 27892 (proposed § 92.101(b)(1)). Replacing a balancing test focused on the individual LEP patient, with a balancing test focusing on the number or proportion of LEP patients, appears to be an invitation to downplay the needs of LEP patients when they are relatively few in number as an absolute or relative matter.

The NPRM also proposes to eliminate any reference to the importance of a written language access plan. Whitman-Walker has found that developing such a plan was a critical aid in our efforts to improve our services to LEP patients. Developing the plan helped us to formulate specific guidance for our staff and to ensure that the guidance was well understood and fully implemented. We believe that the Department should continue to encourage covered entities to develop and adhere to written language access plans.

The NPRM also proposes to eliminate certain requirements that we believe are essential to ensuring that LEP patients understand their rights – and, most importantly, that LEP patients are able to communicate fully and effectively with their providers and other health care staff.

The provisions in the current regulations that, in our experience, are particularly important are:

- The notice requirements in the current § 92.8.
- The requirement that a covered entity with at least 15 employees designate a specific individual or individuals with responsibility to oversee LEP efforts and investigate complaints and concerns – current § 92.7(a).
- The requirement that a covered entity with at least 15 employees establish and adhere to a specific grievance procedure – current § 92.7(b).

The NPRM appears to acknowledge that the weakening of notice and related requirements may result in some LEP patients failing to understand or assert their rights. 84 Fed. Reg. at 27883.

Even more important, we are concerned that the loosening of requirements is likely to result in some LEP patients failing to receive adequate care, because of difficulties patients may have in understanding their providers or other staff, or difficulties that providers and other staff may have in understanding their patients.

Whitman-Walker urges the Department to adhere to current regulatory standards for LEP patients.

VII. The Proposed Changes to Section 1557 Safeguards Against Health Discrimination Would Undercut the Administration’s End the HIV Epidemic Initiative

In his State of the Union Address on February 5, 2019, President Trump announced an ambitious initiative to end the HIV epidemic in the United States in 10 years. The initiative initially will target specific communities – 48 counties, seven states, the District of Columbia and San Juan, Puerto Rico – where HIV incidence and prevalence are particularly high – and subsequently expand across the nation. The initiative’s announced strategies are:

- Diagnose all individuals with HIV as early as possible.
- Treat people with HIV rapidly and effectively to reach sustained viral suppression.
- Prevent new HIV transmissions by using proven interventions, including PrEP and syringe services programs (SSPs).
- Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

What is “Ending the HIV Epidemic: A Plan for America”? <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview> (visited Aug. 9, 2019).

The Department has correctly noted that the initiative must concentrate on the populations most heavily impacted by HIV, including “men who have sex with men [and] minorities, especially African Americans, Hispanics/Latinos, and American Indians and Alaska Natives.” *Id.* HIV prevalence and incidence also are very high among transgender people, particularly transgender women. Anthony S. Fauci, Robert R. Redfield, George Sigounas, et al., *Ending the HIV Epidemic: A Plan for the United States*, J. Am. Med. Assn. 321(9): 844-845 (2019); CDC. *HIV and Transgender People*, <https://www.cdc.gov/hiv/group/gender/transgender/index.html> (visited Aug. 9, 2019). The stigma and discrimination these populations face present substantial challenges to the Ending the Epidemic’s plan to engage them more deeply and broadly in HIV testing, treatment and prevention. For Latinx people, the CDC has acknowledged that “language barriers may make it

harder for some Hispanics/Latinos to get HIV testing and care.” CDC, *HIV and Hispanics/Latinos*, <https://www.cdc.gov/hiv/group/raciaethnic/hispaniclatinos/index.html> (visited Aug. 9, 2019). The NPRM’s proposed curtailment of protections against health care discrimination on the basis of gender identity, sexual stereotyping and association, and weakening of safeguards for LEP patients, fly in the face of the agenda of the Ending the Epidemic initiative – and threaten the Department’s overall goals of improving health care and controlling costs. The proposed exemption of many health insurance plans and programs from Section 1557’s protections against discrimination, and LEP requirements, would further undercut the Administration’s goals by making adequate, affordable, nondiscriminatory health care less available to the very communities that must be at the heart of any initiative to end the HIV epidemic.

CONCLUSION

The proposed rule is inconsistent with the law, is arbitrary and capricious, and threatens substantial harm to vulnerable communities. It should be withdrawn.

Respectfully submitted,

A handwritten signature in cursive script that reads "Daniel Bruner".

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