AMERICAN CIVIL LIBERTIES UNION of IOWA

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November 5, 2015

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 Programs and Activities, Proposed Rule**
**RIN 0945-AA02**

For 80 years, the ACLU of Iowa has been a guardian of liberty, working in courts, with the state legislature, and communities to defend and preserve the individual rights and liberties that the Constitution and our laws guarantee everyone. With 3,222 members, activists, and supporters, the ACLU of Iowa is a statewide organization that fights tirelessly for the principle that every individual's rights must be protected equally under the law, regardless of race, religion, gender, gender identity, sexual orientation, disability, or national origin.

We write in support of the Department of Health and Human Services (HHS) Notice of Proposed Rulemaking (NPRM) to ensure nondiscrimination in federally funded healthcare programs pursuant to Section 1557 of the Affordable Care Act. The protections offered by Section 1557's nondiscrimination mandate are vitally important to advancing equality. While there are many important improvements to patient health reflected in the NPRM, we focus here on several specific issues where we believe additional improvements can be made, or where HHS has specifically asked for comment in the preamble to the NPRM. Among those issues, we believe it is critically important that:

1. HHS clarify that discrimination based on sex includes not only discrimination based on pregnancy, sex stereotypes, and gender identity, but also discrimination based on sexual orientation;

2. HHS clarify that discrimination against providers or entities that provide women's health services is sex discrimination;
3. HHS eliminate the employment discrimination exception and fully cover employer-sponsored benefit plans;
4. HHS clarify that sex-specific programs are permissible only when they are narrowly tailored and necessary to accomplish an essential health purpose; and
5. HHS not exceed its statutory authority by creating exceptions to Section 1557's prohibition on sex discrimination, including exceptions that would allow religious or moral objections to be used to justify discrimination.

Sex and Associational Discrimination Definitions

*Protection from Discrimination on the Basis of Pregnancy, Sex Stereotypes, Gender Identity and Sexual Orientation*

We commend HHS for clearly stating that discrimination based on pregnancy, sex stereotypes and gender identity constitutes discrimination on the basis of sex. Women's ability to become pregnant historically has been used to dictate their roles in the home, limit their employment options, and prevent their full civic participation.[1] In turn, women continue to face entrenched stereotypes that they are caregivers first and workers second, that they ought to look and act "feminine," and that their health needs are "extras," less deserving of coverage than more universal conditions. We further applaud the NPRM's recognition that stereotypes about gender frequently result in discrimination against non-binary identified people. Maintaining a robust definition of prohibited sex discrimination is essential to ensuring protections for people regardless of gender identity. As many federal agencies and courts have recognized, discrimination based on gender identity – including gender expression, gender transition, and transgender status – or on sex-based stereotypes is necessarily a form of sex discrimination.[2]

In contrast to the recognition that sex discrimination encompasses discrimination based on gender identity, and in contrast to the legal position taken by the Equal Employment Opportunity Commission (EEOC) and a number of courts, the NPRM fails to recognize that sex discrimination also necessarily includes discrimination based on sexual orientation. We urge

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[1] *See,e.g., Hibbs v. Nevada Department of Human Resources*, 538 U.S. 721, 736 (2003) (stereotypes about men's and women's family roles "created a self-fulfilling cycle of discrimination that forced women to continue to assume the role of primary family caregiver, and fostered employers' stereotypical views about women's commitment to work and their value as employees"); *Price Waterhouse v. Hopkins,* 490 U.S. 228, 251 (1989) (candidate's partnership denial because she needed a "course in charm school" reflected unlawful sex stereotypes under Title VII; "[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.").

[2] *See, e.g.*, Smith v. City of Salem, 378 F.3d 566, 572-75 (6th Cir. 2004); Rosa v. Park West Bank & Trust Co., 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); Schwenk v. Hartford, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act). *See also* Statement of Interest of the United States at 14, *Jamal v. Saks*, No. 4:14-cv-02782 (S.D. Tex. Jan. 26, 2015).

HHS to state explicitly in the final rule that the protections against sex discrimination in Section 1557 extend to discrimination on the basis of sexual orientation.

As the EEOC noted in its recent landmark decision in *Baldwin v. Foxx*, discrimination on the basis of sexual orientation is sex discrimination under the plain meaning of the term, because sexual orientation turns on one's sex in relation to the sex of one's partner.[3] This reasoning applies with equal force to Section 1557 as it does to Title VII, Title IX,[4] and the Equal Protection Clause.

*Protection from Discrimination for Providers or Entities Providing Women's Health Services*

We urge HHS to prohibit actions by covered entities that have the effect of denying or restricting women's timely access to providers specializing in women's healthcare. Since 2011, at least 15 states have taken actions to restrict the ability of otherwise eligible women's health providers to furnish federally supported healthcare to patients in need. Many are considering adopting analogous policies. Restrictions on the participation of women's health providers in federal health programs often place serious obstacles on women seeking timely access to care. When trusted, well-qualified women's health providers are arbitrarily eliminated from participating in federal health programs, the many women who depend on such providers for their usual care may be forced to seek federally-supported services from geographically remote providers, settle for inferior care, or forgo care altogether. HHS must carefully assess the discriminatory effects of actions that deprive women of accessible, affordable providers specializing in women's health.

*Protection from Discrimination on the Basis of Association*

We applaud the inclusion of the explicit prohibition against nondiscrimination on the basis of association. The NPRM's language mirrors that of Title I and Title III of the Americans with Disabilities Act (ADA), which have been understood to protect against discrimination based on association or relationship with a disabled person.[5] Section 1557 should, therefore, be interpreted to provide at least the same protections for both patients and healthcare providers and provider entities. In accord with the ADA, this regulation should extend its protections to providers of healthcare and other professional services who are at risk of associational discrimination due to their professional relationships with patients or clients, including those belonging to classes protected under Section 1557.[6]

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[3] EEOC Doc. 0120133080, 2015 WL 4397641, at *5 (EEOC July 15, 2015).
[4] *See Videckis v. Pepperdine Univ.*, No. CV 15-00298 DDP, 2015 WL 1735191, at *8 (C.D. Cal. 2015) ("[A] policy that female basketball players could only be in relationships with males inherently would seem to discriminate on the basis of gender.").
[5] 42 U.S.C. §§ 12112, 12182 (2012).
[6] 28 C.F.R. pt. 35, app. B (2015) (interpreting Title I and Title III of the ADA to protect "health care providers, employees of social service agencies, and others who provide professional services to persons with disabilities").

Transition-Related Health Insurance

Because transgender people have experienced and continue to experience multiple forms of discrimination in accessing care through health insurance, we strongly support the NPRM's approach of enumerating and prohibiting a range of insurance carrier and coverage program practices that discriminate against transgender individuals by arbitrarily singling them out for categorical denials of coverage for benefits provided to non-transgender people. The multifaceted nature of insurance discrimination against transgender individuals means that the provisions in the NPRM are all vital to ensuring that transgender people are able to access the health coverage and care they need. We strongly urge HHS to preserve all these provisions in the final rule.

In addition, we offer two recommendations to further strength the final rule. Many insurance carriers continue to deny medically necessary care for gender dysphoria by pointing to minor differences in the way a particular procedure is performed when used to treat gender dysphoria. By focusing on these minor differences, these insurance carriers have argued that the treatment for gender dysphoria is not "the same" as the treatment for other conditions. We urge HHS to refine the regulations to make clear that insurance carriers must provide nondiscriminatory coverage for services used to treat gender dysphoria if a substantially comparable service is covered for treating other conditions, even if the services are not identical in all respects.

Further, we are concerned about the potential misapplication of the law that might result from the proposed statement in § 92.207(d) in the NPRM that nothing in the section is intended to restrict a covered entity from determining whether a service is medically necessary or meets coverage requirements in an individual case. In determining whether a service is medically necessary, the carrier should evaluate whether the service is medically necessary to treat gender dysphoria. A procedure such as breast augmentation that is not usually considered to be medically necessary for treatment of other conditions, may nevertheless be medically necessary in the context of gender dysphoria. Insurance carriers should not be permitted to declare categorically that a particular procedure is always cosmetic or not medically necessary.

Employment Discrimination Exception

We urge HHS to rescind the draft rule's employment discrimination exception.[7] Neither the language nor the spirit of Section 1557's directive warrants such selective applicability. Section

[7] 80 Fed. Reg. 54191 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92) ("[E]mployers that receive Federal financial assistance for any purpose could be held liable for discrimination in the employee health benefit programs they provide or administer, where those employers are not otherwise engaged in a health program or activity and where the use of Federal funds for employee health benefits is merely incidental to the purpose of the assistance.

1557's nondiscrimination provision is written broadly, and further incorporates both Title IX and Section 504 of the Rehabilitation Act – both of which cover employment discrimination. Moreover, Section 1557 was intended to remedy longstanding disparities in access to critical health services, disparities not remedied by existing antidiscrimination laws. (Indeed, if those "other applicable laws" *had* been sufficient, presumably the draft rule would not extend Section 1557 to cover *any* employer.) To apply Section 1557 selectively in the employment context guarantees a patchwork of rights for individuals working for covered entities, due to a lack of unanimity among the courts interpreting antidiscrimination laws.

Sex-Specific Programs and Activities

Consistent with Section 1557's broad nondiscrimination purpose, sex-specific programs may be permissible only when they are narrowly tailored and necessary to accomplish an essential health purpose. Where such programs are necessary, however, individuals must be afforded access consistent with their gender identity and care must also be taken to ensure that comparable services are made available regardless of gender. For example, men's affliction with a medical condition typically associated with women – such as breast cancer, osteoporosis, auto-immune disorders, and Alzheimer's – should not preclude research into and coverage of treatment for such conditions.

Exceptions from the Prohibition on Sex Discrimination

The proposed rule provides critically important protections from discrimination on the basis of sex for the first time in federally funded healthcare programs, by reference to Title IX (which prohibits sex discrimination in federally funded education programs). The proposed rule appropriately does not incorporate any of the exceptions from Title IX, and nothing in the text of Section 1557 or other federal law supports adding additional exemptions into the regulation. However, the preamble to the proposed rule seeks comment as to whether any exceptions should be added.[8] HHS further asks if the rule "appropriately protects religious beliefs" and if any additional exception should be included to protect religious beliefs.[9] We strongly believe no such exceptions are appropriate or warranted.

Section 1557 does not by its terms import any exceptions from Title IX, or from any of the referenced statutes. Likewise, there is nothing in the text of Section 1557 that provides authority for HHS to create an exemption on the basis of religious or moral objection. Claims about infringements on religious liberty cannot be used to block efforts to achieve equality. For

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*We believe that claims of discrimination in such benefits, brought against employers that do not operate other health programs or activities, are better addressed under other applicable laws.*") (Emphasis added.)

[8] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54172, 54173 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

[9] *Id.*

example, individuals and institutions once claimed religious objections to racial integration as well as equal pay laws.[10] Yet, in each of these examples, when institutions tried to opt out of laws advancing equality, their claims were rejected. Just as it was not a violation of religious freedom to require segregated institutions to integrate,[11] or schools to pay their employees equally despite their gender,[12] it is not a violation of religious freedom to prohibit sex discrimination in the provision of healthcare services.[13]

Indeed, it is particularly troubling that HHS would consider adding an exception *only* with respect to sex discrimination. Women and LGBT persons deserve the same access to healthcare services as any other individual, and yet still face significant discrimination and barriers to care. Permitting discrimination only for the prohibition on sex discrimination not only is contrary to statutory intent and exceeds HHS's authority, but also wrongly creates a hierarchy of nondiscrimination protections and protected classes, thus undermining the central promise of Section 1557.

Congress drafted Section 1557 specifically to prohibit discrimination in healthcare programs and activities so that all individuals, including women and LGBT people, could have equitable access to healthcare. A new religious exemption in the context of healthcare services would undermine the spirit of the Affordable Care Act (ACA) and would put the health and well-being of vulnerable patients at risk. Indeed, pre-existing federal refusals laws already cause serious harm to women's health and well-being by permitting individuals and institutions to withhold essential healthcare, coverage, and information – such as abortion services, payment, and even referrals – from patients.[14]

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[10] *See e.g.*, Newman v. Piggie Park Enters., Inc., 256 F. Supp. 941, 944 (D. S.C. 1966), *aff'd in part and rev'd in part on other grounds*, 377 F.2d 433 (4th Cir. 1967), *aff'd and modified on other grounds*, 390 U.S. 400 (1968); Dole v. Shenandoah Baptist Church, 899 F.2d 1389, 1392 (4th Cir. 1990); Bob Jones Univ. v. United States, 461 U.S. 574, 580, 583 n.6 (1983).

[11] *Piggie Park Enters., Inc.*, 256 F. Supp. at 945.

[12] *Shenandoah Baptist Church*, 899 F.2d 1389 (holding that a religious school that gave extra payments to married male teachers, but not married women, based on the religious belief that men should be "heads of households" could be held liable under equal pay laws); *see also* E.E.O.C. v. Fremont Christian Sch., 781 F.2d 1362 (9th Cir. 1986) (holding that a religious school that gave male employees family health benefits but denied such benefits to similarly situated women because of the sincerely held belief that men are the "heads of households" violated Title VII).

[13] More recently, the majority opinion in *Burwell v. Hobby Lobby Stores, Inc.* makes it clear that religious liberty should not be used as a "shield" to escape legal sanction for discrimination in hiring on the basis of race because such prohibitions further a "compelling interest in providing an equal opportunity to participate in the workforce without regard to race" and are narrowly tailored to meet that "critical goal." *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014). The same principles apply here.

[14] *See e.g.*, 42 U.S.C. § 300a-7 (2006); Public Health Service Act § 245, 42 U.S.C. § 238n (2006); Consolidated Appropriations Act, 2010, Pub. L. No. 111-117, § 508d, 123 Stat. 3034, 3280 (2009).

To expand the reach of refusals already allowed in federal law would only further stigmatize vulnerable patients and effectively prevent patients from being able to access essential reproductive health services at all. HHS should, at a minimum, ensure that implementation of Section 1557 does not further exacerbate the discriminatory treatment of women's and LGBT people's healthcare. Given the significant negative impact of these laws, and the exemptions already provided in the ACA, it is both unnecessary and beyond the scope of the Department's regulatory authority to use Section 1557 – a provision designed to increase access to care and protect patients from discrimination – to expand these dangerous policies. We urge HHS – in the strongest possible terms – not to implement any special exemptions for providers, health plans, or other covered entities related to sex discrimination.

Disability-Based Discrimination

We strongly support the NPRM's approach of prohibiting discrimination in health-related insurance and other health-related coverage. We urge HHS to provide clear guidance on what constitutes disability-based discrimination in these contexts. One key form of discrimination is the unnecessary segregation of people with disabilities, as prohibited by Title II of the ADA and the Olmstead Decision.

In the past, states have provided higher reimbursement rates for services in segregated settings (such as nursing homes and hospitals) than for similar services in integrated settings, and health plans have offered personal care services and mental health treatment in greater amounts in segregated settings than in home and community settings. Both are strong drivers toward isolating people with disabilities in institutions instead of integrating them in home and community based services.

In addition, health plans have failed to cover core services commonly needed by people with intellectual disabilities or durable medical equipment (such as wheelchairs or ventilators) commonly needed by people with physical disabilities.

The Department should make explicit that such discrimination is prohibited by Section 1557.

Meaningful Access for Individuals with Limited English Proficiency

We strongly support the NPRM's specific requirements to ensure meaningful access to care for individuals with limited English proficiency. In particular, we support the definition of qualified interpreter, and we suggest including a definition of a qualified translator. Further, we strongly support including specific thresholds for translating written documents to ensure minimum standards exist that would directly aid evaluating compliance and enforcement. We also support requirements regarding taglines but recommend that covered entities include taglines in the top

15 languages in their state/service area rather than the proposal to only include the top 15 languages nationally. In many states, the top 15 languages nationally will not be useful for informing local limited English proficient communities.

Conclusion

We greatly appreciate the efforts by HHS to end discrimination in healthcare. Once put in place through a final rule, these protections will positively impact the health and well-being of millions of people in the United States.

Sincerely,

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