October 3, 2022

Submitted via www.regulations.gov[1]

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: 1557 NPRM (RIN 0945–AA17)
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

RE: DOCKET ID HHS-OS-2022-0012, RIN 0945-AA17, 1557 NPRM, Nondiscrimination in Health Programs and Activities

Dear Secretary Becerra, Assistant Secretary Palm, and Director Fontes Rainer,

Thank you for the opportunity to submit comments on the Department of Health and Human Services (HHS or the Department) proposed rule entitled “Nondiscrimination in Health Programs and Activities,” RIN 0945-AA17. This rule – which is designed to implement Section 1557 of the Affordable Care Act (ACA) – is vitally important, as it ensures that 1) covered entities are aware of their obligations and 2) those seeking healthcare have the ability to access the care and coverage they need. We strongly support the proposed rule and urge its swift adoption, following some minor but important suggested changes that are set forth below.

Prior to sharing these insights, we would like to offer additional information about our agency. Equitas Health is a federally designated community health center and one of the largest LGBTQ+ and HIV/AIDS serving healthcare organizations in the country. Each year, we serve tens of thousands of patients in Ohio, Texas, Kentucky, and West Virginia, and since 1984, we have been working to advance “care for all.” Our mission is to be the gateway to good health for those at risk of or affected by HIV; for the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) community; and for those seeking a welcoming healthcare home. In doing so, we offer primary and specialized medical care, pharmacy services, dentistry, mental health and recovery services, HIV/STI prevention and treatment services, Ryan White HIV case management, overall care navigation, and a number of community health initiatives. The implementation of this important rule is crucial both to our agency and our patients, because it better ensures access to care for medically underserved communities.

As noted in the preamble to the NPRM, LGBTQI+ people face both health disparities and barriers to healthcare. The National Academies of Sciences, Engineering, and Medicine reports that discrimination against people of diverse genders and sexualities – both in obtaining health insurance and in the terms of insurance coverage – has long been a barrier to accessing healthcare, which has contributed to significant health inequities. Because

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of this and other societal inequities, LGBTQI+ people report poorer health overall and increased risk factors for numerous health conditions, such as sexually transmitted infections (STIs), HIV, substance misuse, and mental health conditions including depression and suicidal ideation. They are also more likely than their cisgender and straight peers to acquire a disability or chronic illness at a younger age, which necessitates further access to culturally humble healthcare.

Much of this can be attributed to well-documented discrimination. According to a 2010 report addressing healthcare discrimination against LGBT people and people living with HIV, more than half of all respondents reported at least one of the following types of discrimination in care: being refused needed care; healthcare professionals refusing to touch them or using excessive precautions; healthcare professionals using harsh or abusive language; being blamed for their healthcare status; or healthcare professionals being physically rough or abusive. The same report found that many members of the LGBT community have a "high degree of anticipation and belief that they w[ill] face discriminatory care," which ultimately causes many people to not seek care.

More than a decade later, the situation has not much improved. The Department's Healthy People 2020 initiative recognized that "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights." This surfaces in a wide variety of contexts, including physical and mental healthcare services. In a study published in *Health Affairs*, researchers examined the intersection of gender identity, sexual orientation, race, and economic factors in healthcare access. They concluded that discrimination, as well as insensitivity or disrespect on the part of healthcare providers, were key barriers to healthcare access. In fact, a recent systematic literature review conducted by Cornell University "found robust evidence that discrimination on the basis of sexual orientation or gender identity is associated with harms to the health of LGBT people."

And unfortunately, these problems persist in 2022. Data in a new report from the Center for American Progress "reveal that LGBTQI+ communities encounter discrimination and other challenges when interacting with healthcare providers and health insurers, underscoring the importance of strengthening nondiscrimination protections through Section 1557 of the Affordable Care Act."

Other key findings from the report include the following:

- 23% of LGBTQI+ respondents – including 27% of LGBTQI+ respondents of color – reported that, in the past year, they postponed or avoided getting needed medical care when sick or injured due to disrespect or discrimination from doctors or other healthcare providers;
- Overall, 15% of LGBQ respondents – including 23% of LGBQ respondents of color – reported experiencing some form of care refusal by a doctor or other healthcare provider in the year prior;
- Overall, 32% of transgender or non-binary respondents – including 46% of transgender or non-binary respondents of color – reported that they experienced at least one kind of care refusal by a healthcare provider in the past year;
- 55% of intersex respondents reported that, in the past year, a healthcare provider refused to see them because of their sex characteristics and/or intersex variation;
- Overall, 30% of transgender or non-binary respondents – including 47% of transgender or non-binary respondents of color – reported experiencing one form of denial by a health insurance company in the past year;
- 28% of transgender or non-binary respondents – including 29% of transgender or non-binary respondents of color – reported that a health insurance company denied them coverage for gender affirming hormone replacement therapy (HRT) in the year prior; and

- 22% of transgender or non-binary respondents – including 30% of transgender or non-binary respondents of color – reported that a health insurance company denied them coverage for gender affirming surgery in the year prior.

These statistics are realities that our patients and members of the broader LGBTQI+ community know all too well. It should also be mentioned that there are also a number of alarming trends related to access to care for LGBTQI+ youth and young adults. As noted by The Trevor Project in their most recent annual survey of youth and young adults (ages 13-24), 82% of respondents wanted mental healthcare services in the past year, and of that group, "60% of LGBTQ youth who wanted mental health care in the past year were not able to get it." As previously mentioned, the stark realities of anti-LGBTQI+ discrimination in healthcare settings are exceptionally well-documented, and the protections offered under this proposed rule are crucial. While a federal rule will certainly not solve all of the problems related to access to care for medically underserved communities, this is an important step, and such regulations affirm the human rights of members of the LGBTQI+ community, as noted by the United Nations. This is especially true for protecting care for transgender, non-binary, gender expansive, and intersex people across the country.

With this important data in mind, our comments below are organized to correspond to the numbered sections in the Notice of Proposed Rulemaking (NPRM).

[Subpart A – General Provisions]

Application (§ 92.2)

We strongly support the restoration of Section 1557's application to *all health programs or activities* receiving federal funding through or administered by the Department or a Title I entity. This is consistent with the statutory language and the purpose of the ACA to ensure broad access to and coverage of healthcare.

We also support the omission of Title IX's religious exemption, which is harmful and has no place in a healthcare non-discrimination rule. Including the Title IX religious exemption would exceed HHS's authority, as the ACA referenced Title IX only to identify the ground of discrimination it addresses (on the basis of sex) and its enforcement mechanisms, not to incorporate Title IX more broadly. Most of the Title IX exemptions make no sense at all in the healthcare context. That is particularly true of Title IX's extremely broad religious exemption, which would wreak havoc if applied to the ACA by allowing healthcare providers to deny essential healthcare services based on disapproval of a particular group or for other non-medical reasons, thereby putting the health and well-being of already vulnerable individuals at risk. Particularly for urgent or emergent healthcare needs, a patient often has little to no ability to choose a particular provider in order to avoid a provider or institution that withholds care based on religious doctrine, even if the patient is aware of such restrictions (which is not typically the case). Moreover, there are already numerous federal laws that allow healthcare providers to invoke a conscience objection to providing certain kinds of care, making an additional religious exemption unnecessary. The case-by-case approach proposed in section 92.302 is far preferable to the sweeping Title IX exemption, which does not allow the Department to consider the potential harm of granting an exemption.

In the NPRM, HHS asks for comment as to whether these non-discrimination protections should be extended to other non-health programs and activities of the agency. We strongly encourage the adoption of such protections for these other programs in separate rulemaking and urge HHS to make those protections equally as robust as those proposed here for health programs and activities. As an agency, we offer a host of programs and initiatives across the community, and we firmly believe that the extension of these non-discrimination protections to other non-health programs and activities of HHS is crucial to the work of our agency and similarly

positioned health centers across the country. As such, we are strongly in favor of the extension of these non-discrimination protections *across all areas* of HHS.

Because discrimination causes significant harm and many people obtain healthcare services and coverage from other federal agencies, the protections of Section 1557 should be expressly extended to health programs and activities administered by or receiving federal funding from agencies other than HHS. We encourage HHS to work with the Department of Justice (DOJ) and other agencies that administer such programs to develop a common rule to implement Section 1557 in such a manner. Such a rule would make it clear that the ACA's non-discrimination protections do extend to health programs and activities outside of HHS, and this would assist both covered entities in addition to program participants and beneficiaries, while also promoting consistent enforcement.

Policies and Procedures (§ 92.8)

We support the requirement that covered entities develop and implement written policies and procedures to ensure compliance with this rule, and that the procedural requirements apply across all covered non-discrimination bases.

We note that the description of prohibited sex discrimination in this section differs from the language of section 92.101. While the differences are not extensive, it would be preferable to use consistent language throughout the rule; specifically, the more expansive definition in 92.101 should be used. This is especially important to ensure that the finalized rule uses a definition that *accurately* captures the lived experience of the intersex community.

Notice of Nondiscrimination (§ 92.10)

We strongly support the notice requirements in section 92.10 and the Department's attempt to strike a balance, so that covered entities are not overly burdened, but that program participants and beneficiaries are aware of their rights.

We note that the description of prohibited sex discrimination in this section differs from the language of section 92.101. While the differences are not extensive, it would be preferable to use consistent language throughout the rule; the more expansive definition in 92.101 should be used for a variety of reasons, including those related to the intersex community (as noted above).

We ask that HHS include in the notice requirement that any entity receiving a religious exemption under proposed section 92.302 include the existence and scope of such exemption in its required notices. It would be misleading and inaccurate to require entities to tell participants, beneficiaries, and the public generally that the entity does not discriminate if the entity does *in fact* discriminate in certain circumstances and has been granted permission to do so.

[Subpart B—Nondiscrimination Provisions]

Discrimination Prohibited (§ 92.101)

It is encouraging to see the Department recognize in the preamble to the NPRM that people may experience discrimination that is simultaneously related to multiple identities. However, it would strengthen the rule to

include more explicit references to intersectional discrimination within the regulatory text. As such, we propose the following change to section 92.101(a)(1):

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

Should this addition be adopted, this revised language should also then be added to sections 92.207(a), (b)(1), and (b)(2) to ensure consistency.

We applaud HHS for articulating a clear and expansive explanation of discrimination on the basis of sex, and it is important to ensure that sex discrimination captures discrimination related to sex assigned at birth, gender expression, gender identity, and sexuality (both actual and/or perceived). Our agency is particularly pleased to see this explanation in the proposed rule, given that extensive case law has demonstrated the applicability of prohibitions against sex discrimination to members of the LGBTQI+ community.

As HHS is aware, case law from the Supreme Court of the United States (SCOTUS) – including *Price Waterhouse v. Hopkins* (1989) and *Bostock v. Clayton County* (2020) – makes clear that federal non-discrimination law provides protections from both sex stereotyping and sex discrimination, including discrimination against people because of their actual and/or perceived sex assigned at birth, gender expression, gender identity, and/or sexuality. And of course, it is important to affirm that the case law established in *Bostock v. Clayton County* (2020) builds upon previous decisions from lower courts. These include *Macy v. Holder* (2012) – which held that discrimination against a transgender person [due to their gender identity and/or "transgender status"] is a form of sex discrimination that is outlawed under Title VII – and *Baldwin v. Dept. of Transportation* (2015) – which held that discrimination against someone on the basis of their sexuality necessarily involves sex discrimination [as the person has been discriminated against because of assumptions related to their sexuality based upon their sex assigned at birth and gender identity].

In relation to this point and the associated case law mentioned above, we advise HHS to incorporate the following key suggestions:

1) It is essential that this proposed rule track those decisions to provide assurance to participants, beneficiaries, and enrollees. It is also essential that HHS provides notice to covered entities, which will help to ensure that this rule's non-discrimination provisions related to access to healthcare and insurance coverage/benefits for LGBTQI+ persons are clearly and unequivocally communicated.

2) We also strongly support the clear and explicit inclusion of non-discrimination provisions based on sex characteristics, *including* intersex traits [i.e. internal, external, hormonal/secondary, and chromosomal/genetic characteristics). As an agency, we firmly find that this is an important and necessary addition to the proposed rule, as such discrimination inherently and unabashedly relies upon sex.

3) We also strongly suggest that the language in section 92.101(a)(2) be amended to explicitly include "transgender status." While the terms "gender identity" and "transgender status" are often used interchangeably, there have been documented instances in which those seeking to permit discrimination against transgender people have justified it by pressing distinctions between the

two concepts.[2] Therefore, it is preferable to enumerate both terms in the regulatory text, which further ensures statutory protections for transgender, non-binary, and gender expansive people.

[Subpart C—Specific Applications to Health Programs and Activities]

Equal Program Access of the Basis of Sex (§ 92.206)

We strongly support the inclusion of this section, which will help to address the myriad forms of harmful discrimination described above. It importantly clarifies that providers may exercise clinical judgment when determining if a particular service is appropriate for an individual patient but may *not* refuse gender affirming care based on a personal belief that such care is never clinically appropriate.
While we are in favor of the inclusion of this section, we also suggest strengthening the language pertaining to providers complying with a state or local law as a justification related to denying gender affirming care. More specifically, we would recommend that HHS states clearly and unequivocally that Section 1557 of the ACA, which is federal law, preempts *any* such state or local law that seeks to restrict access to gender affirming care. As an agency, we are strongly in favor of this addition, as it will increase protections for transgender, non-binary, and gender expansive people who may otherwise encounter additional and unnecessary barriers to culturally humble healthcare.

As with section 92.101(a)(2) above, we suggest that "transgender status" be added to sections 92.206(b)(1), (b)(2) and (b)(4). We also believe that the policy language of section (b)(2) would be clearer, if it was shortened as indicated below. In addition, we recommend deleting the indicated language in (b)(4), as it could enable a provider to engage in a discriminatory denial of care (even if a claimant cannot show that the care in question was on other occasions provided for other purposes).

In short, these suggested changes would be reflected in 92.206 as follows:

> "In providing access to health programs and activities, a covered entity must not:
>
> (1) Deny or limit health services, including those that are offered exclusively to individuals of one sex, to an individual based upon the individual's sex assigned at birth, gender identity, ***transgender status,*** or gender otherwise recorded;
>
> (2) Deny or limit a health care professional's ability to provide health services on the basis of an individual's sex assigned at birth, gender identity, ***transgender status,*** or gender otherwise recorded.
>
> (4) Deny or limit health services sought for purpose of gender transition or other gender-affirming care if the denial or limitation is based on a patient's sex assigned at birth, gender identity, ***transgender status,*** or gender otherwise recorded."

Nondiscrimination in Health Insurance Coverage and Other Health-Related Coverage (§ 92.207)

It is essential that this provision be adopted in the final rule to clarify that – pursuant to the text of the ACA – the protections of Section 1557 do apply to insurance plans and coverage.

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

Consistent with our recommendations above, we strongly suggest adding "transgender status" to section 92.207(b)(3):

> "A covered entity must not, in providing or administering health insurance coverage 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, to an individual based upon the individual's sex at birth, gender identity, ***transgender status,*** or gender otherwise recorded."

Additionally, we recommend a slight modification to section 92.207(b)(4), which bars 'categorical coverage exclusions' of services related to gender transition or other gender affirming care. As currently drafted, it could be misconstrued to *only* apply if an insurer excludes "all" health services related to gender transition or other gender affirming care services; however, we believe the true intent is to proscribe exclusions of "any" such services.

To clarify this language and to protect access to gender affirming care, we strongly propose deleting the word "all" from this paragraph such that the final text reads:

> "A covered entity must not, in providing or administering health insurance coverage or other health-related coverage: … (4) Have or implement a categorical coverage exclusion or limitation for **~~all~~** health services related to gender transition or other gender-affirming care:"

Furthermore, Section 92.207(b)(5) would be clearer if shortened:

> "A covered entity must not, in providing or administering health insurance coverage or other health-related coverage: … (5) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition or other gender-affirming care."

Nondiscrimination on the Basis of Association (§ 92.209)

We are pleased that this NPRM restores clear and explicit protections against discrimination on the basis of association. This is consistent with long-standing interpretations of other non-discrimination laws, which cover discrimination based on an individual's own characteristics or those of someone either with whom they are associated or with whom they have relationship.

As noted in the NPRM preamble, certain protected populations – including LGBTQI+ people – are particularly susceptible to discrimination based upon association. For instance, an individual in a same-gender relationship and/or marriage could be subjected to discrimination based on their own and/or their spouse or partner's sex assigned at birth and/or gender identity, whereas that same individual might not be similarly mistreated were they not in a same-gender relationship and/or marriage. Because of this, it is important that the final rule make clear that this kind of associational discrimination is within the ambit of the rule's protections.

[Subpart D—Procedures]

Notification of views regarding application of federal conscience and religious freedom laws (§ 92.302)

It is essential that the final rule include the NPRM's revised approach to religious exemptions. When providers deny medical services for religious reasons, those who require the denied care are harmed. Even if patients are able to obtain the needed medical care from another provider, the delay in receiving care may cause irreparable

harm. Moreover, the stress of being denied care – in addition to the fear of facing similar denials in the future – have very real negative impacts.

The Trump administration's 2020 version of Section 1557 implemented regulations that improperly disregarded those harms and that elevated providers' religious beliefs over the rights of individuals to receive the medical care that they need. We support the approach being proposed in the current NPRM, which contemplates a case-by-case process and expressly acknowledges that the potential harm to third parties must be considered when determining whether to grant an exemption. Such consideration is required by the Establishment Clause in the First Amendment to the Constitution, which does not permit the government to grant religious exemptions from neutral laws if doing so would shift burdens to third parties.

[Other Provisions]

Change in Interpretation - Medicare Part B Meets the Definition of Federal Financial Assistance (FFA)

We strongly support the revised definition of Federal Financial Assistance (FFA) that, at long last, include payments made under Medicare Part B. The relationship between Part B providers and HHS is not distinguishable from that of other providers who are already treated as recipients of FFA. The exclusion of Part B has historically been based on flawed reasoning; furthermore, this exclusion is rooted in a history of racism, as it developed as a way for some medical providers to exclude Black patients and other patients of color from their practices. As such, bringing Part B within the ambit of FFA and Section 1557 not only addresses this racist history, but it also furthers the core goal of the ACA to broaden and to strengthen civil rights protections in healthcare.

Centers for Medicare and Medicaid Services (CMS) Amendments

The Trump administration's 2020 version of Section 1557 implemented regulations inexplicably removed protections against sexual orientation and gender identity discrimination from a number of regulations that govern programs run by the Centers for Medicare and Medicaid Services (CMS). We are in favor of the restoration of these provisions, and we are pleased that they are being extended to additional CMS programs. However, we would like to note that the language around sex discrimination in these CMS "conforming amendments" does not match the proposed sex discrimination language in Section 1557 itself. As such, we strongly encourage HHS and CMS to adopt identical language, which will help 1) to avoid confusion, 2) to ensure a more consistent implementation for this important rule, and 3) to protect greater access to culturally humble healthcare for LGBTQI+ people across the country.