

November 8, 2015

U.S. Department of Health and Human Services  
Office for Civil Rights  
Attention: 1557 NPRM (RIN 0945-AA02)  
Hubert H. Humphrey Building, Room 509F  
200 Independence Avenue SW.  
Washington, DC 20201.

Subject: Healthcare and Equality Experts' Comments on 1557 NPRM (RIN 0945-AA02)

Dear Secretary Burwell:

As legal experts in healthcare and equality, we respectfully submit the following comments in response to the Notice of Proposed Rulemaking on Nondiscrimination in Health Programs and Activities, published in the Federal Register on September 8, 2015 (the "Nondiscrimination Rule"). We applaud the U.S. Department of Health and Human Services ("HHS") for developing a comprehensive Nondiscrimination Rule. We especially wish to commend the Department for its efforts to ensure that the final rule reflects the most current and robust understanding of nondiscrimination law.

A fundamental purpose of the Affordable Care Act is to root out discrimination in healthcare and to eliminate health disparities. Accordingly, HHS should adopt the interpretation of the statute that most broadly protects against discrimination on the basis of sex, race, color, national origin, age, and disability. With this in mind, we recommend that HHS revise the proposed Nondiscrimination Rule to: 1) Provide uniform mechanisms and legal standards for the private enforcement of Section 1557 across categories of race, sex, disability, and age; 2) Adopt a comprehensive definition of sex discrimination that includes sexual orientation and allows sex segregation only where medically necessary; 3) Include Medicare Part B within the definition of "federal financial assistance" as the statute requires; and 4) Refrain from expanding religious exemptions to sex nondiscrimination obligations, contrary to statute.

**HHS should interpret Section 1557 to provide uniform mechanisms and legal standards for private enforcement of nondiscrimination requirements across race, sex, disability, and age.**

Section 1557 provides an explicit private right of action, as the proposed rule recognizes. The rule, however, fails to give adequate guidance as to mechanisms and legal standards that govern private rights of action. Because the text of Section 1557 is ambiguous as to the legal standards required for a private cause of action, courts have already divided on this question.<sup>1</sup> Under such circumstances, HHS should provide the courts and the public with guidance.<sup>2</sup>

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<sup>1</sup> Compare *Se. Pennsylvania Transp. Auth. v. Gilead Sciences, Inc.*, No. CIV.A. 14-6978, 2015 WL 1963588 (E.D. Pa. May 4, 2015) (holding that disparate standards and scope apply to different protected classes), with *Rumble v. Fairview*

We strongly recommend that HHS interpret Section 1557 liberally to provide uniform enforcement mechanisms and legal standards across race, sex, disability, and age discrimination. First, HHS should specify that the full range of enforcement mechanisms—that is, agency enforcement, administrative complaints, and private rights of action—are available for violations of Section 1557. The mechanisms of enforcement do not vary across prohibited grounds of discrimination. Second, HHS should set out a single, uniform standard that allows any private party bringing suit under Section 1557 to proceed on disparate treatment and disparate impact claims and to receive any equitable and legal remedies those claims typically allow.

As we explain below, a single, uniform standard for all violations of 1557 constitutes the best reading of the statutory text. It reflects the statutory context and the overarching purpose of the nondiscrimination requirements. Adopting a uniform standard also avoids the perverse consequences that flow from a contrary interpretation.

***The Text of 1557 Refers to Civil Rights Statutes But Does Not Import Their Limitations.***

We begin with the text of Section 1557 (a), which provides that

(a) In general

Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance . . . . The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

(b) Continued application of laws

Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.), or to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).<sup>3</sup>

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Health Servs., No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at \*10-12 (D. Minn. Mar. 16, 2015) (holding that Section 1557 requires uniform standards and scope across protected classes).

<sup>2</sup> Section 1557 contains an express Congressional delegation to HHS to resolve any ambiguities. 42 U.S.C.A. § 18116 (c) (“The Secretary may promulgate regulations to implement this section.”).

<sup>3</sup> 42 U.S.C.A. § 18116(a) (emphasis added).

The first sentence of Section 1557(a) refers to several long-standing civil rights statutes to list the prohibited grounds of discrimination. Section 1557 thus encompasses discrimination on the basis of race, color, or national origin (Title VI); sex (Title IX); age (Age Discrimination Act); and disability (Rehab Act). In listing the four civil rights statutes, the statute incorporates by reference their definitions of prohibited grounds for discrimination, which have been extensively developed in case law and agency interpretations. As a result, as HHS has recognized, like these long-standing statutes Section 1557 prohibits disparate treatment and disparate impact.<sup>4</sup>

The final sentence of Section 1557(a) establishes the availability of the enforcement mechanisms provided for and available under each of the referenced civil rights acts. As district courts have agreed, by the phrase “enforcement mechanisms” the statute refers to both private rights of action and agency enforcement.<sup>5</sup> Thus, unlike many of the civil rights statutes to which it refers, Section 1557 provides an explicit private right of action.

While 1557(a) makes explicit the prohibited grounds of discrimination and the availability of a range of “enforcement mechanisms,” the standards for private enforcement are left ambiguous.<sup>6</sup> The term “enforcement mechanisms” does not import the “rights, remedies, procedures, or legal standards” available under other civil rights statutes and their limitations. This is apparent from a reading of Section 1557 as a whole.<sup>7</sup> While Section 1557(a) refers to “enforcement mechanisms,” Section 1557(b) uses “rights, remedies, procedures, or legal standards,” indicating that Congress regarded these two phrases as having different meanings. If Congress had meant for Section 1557(a) to import the “rights, remedies, procedures, or legal standards” under Title VI, Title IX, the Age Discrimination Act, or the Rehab Act with all their limitations, it would have used the term “rights, remedies, procedures, or legal standards” in Section 1557(a), rather than “enforcement mechanisms.”

The Supreme Court’s decision in *In Consolidated Rail Corp. v. Darrone* is instructive.<sup>8</sup> There, the Court was called upon to determine whether the Rehabilitation Act—which made available the “remedies, procedure, and rights set forth in Title VI of the Civil Rights Acts of 1964”—also

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<sup>4</sup> Department of Health and Human Services, 80 Fed. Reg., 54172, 54218 (Sept. 8, 2015) (proposing to prohibit discrimination in intent and effect through the incorporation by reference of existing regulations addressing race, disability, sex, and age discrimination).

<sup>5</sup> See *Gilead Sciences, Inc.*, 2015 WL 1963588, at \*6 (“Congress intended to create a private right of action for alleged violations of Section 1557”); *Rumble*, 2015 WL 1197415, at \*7 n.3 (Section 1557 provides Plaintiff with a private right of action to sue Defendants.”). The term “enforcement mechanisms” is often used to refer to administrative procedures or private rights of action. See, e.g., *Fitzgerald v. Barnstable Sch. Comm.*, 555 U.S. 246, 255 (2009) (“[Title IX’s] only express enforcement mechanism, § 1682, is an administrative procedure resulting in the withdrawal of federal funding from institutions that are not in compliance. In addition, this Court has recognized an implied private right of action.”).

<sup>6</sup> In *Gilead Sciences*, the district court rejected this straightforward interpretation of the statute, reasoning that, “Had Congress intended, ‘that the same standard and burden of proof apply to a Section 1557 plaintiff, regardless of the plaintiff’s protected class status,’ Congress could have listed the six protected classes without reference to those statutes and expressly provided for a single enforcement mechanism instead of incorporating mechanisms from all four statutes.” 2015 WL 1963588, at \*6 n.3 (citation omitted). The *Gilead Sciences* decision thus confuses enforcement mechanisms with legal standards. The reason Congress referenced the four statutes was to incorporate their protected classes and their public and private enforcement mechanisms.

<sup>7</sup> *Util. Air Regulatory Grp. v. E.P.A.*, 134 S. Ct. 2427, 2442 (2014) (“[R]easonable statutory interpretation must account for both “the specific context in which . . . language is used” and “the broader context of the statute as a whole” (quoting *Robinson v. Shell Oil Co.*, 519 U.S. 337, 341 (1997)).

<sup>8</sup> *In Consolidated Rail Corp. v. Darrone*, 465 U.S. 624 (1984).

incorporated Title VI’s limits on remedies and rights in the employment setting.<sup>9</sup> The Court held that referring to Title VI did not import its limitations into the Rehabilitation Act.<sup>10</sup> The text of the Rehabilitation Act contains no explicit limitation or reference to Title VI’s limiting language, but “instead prohibits discrimination against the handicapped under ‘any program or activity receiving Federal financial assistance.’”<sup>11</sup> Looking to legislative history and the Act’s broad nondiscrimination purpose, the Court determined that “it would be anomalous to conclude that the section, “designed to enhance the ability of handicapped individuals to assure compliance with [disability nondiscrimination requirements],” silently adopted a drastic limitation on the handicapped individual’s right to sue federal grant recipients for employment discrimination.”<sup>12</sup>

With regard to Section 1557, there is an even stronger argument for an expansive reading of the rights and remedies available under the statute than there was in *Darrone*. As the foregoing makes clear, Section 1557’s text refers to other civil rights acts, but only for the ground on which they prohibit discrimination, which is race, sex, disability, and age, and for their enforcement mechanisms. By its own terms, Section 1557 does not include the limitations from the civil rights statutes to which it refers. For example, whereas Title VI has been understood not to include a private right of action for disparate impact claims,<sup>13</sup> Section 1557 includes no such restriction. As in *Darrone*, the text does not import restrictions on its reach through its reference to existing civil rights statutes. Congressional debates show an intent to create broad protections against discrimination, as we explain below. Indeed, Congress was careful to distinguish between mechanisms to enforce nondiscrimination under Section 1557 and the “rights, remedies, procedures, or legal standards” of Title VI, Title IX, the Age Discrimination Act, and the Rehab Act.

Section 1557’s statutory text thus should be read to indicate that individual litigants—whether they allege race, sex, disability, or age discrimination—should be able to avail themselves of the same enforcement mechanisms with uniform legal standards and remedies. Plaintiffs may choose to follow an administrative process, file a complaint with the agency, or proceed directly to court as these statutes read together allow. Private parties alleging violations of Section 1557—whether on the basis of race, disability, sex, or age—equally should be able to proceed with claims of disparate treatment and disparate impact. Remedies should be uniform across all protected statuses, instead of importing limitations from referenced civil rights acts depending on the plaintiff’s status.

### ***Uniform Standards Reflect Section 1557’s Context and the Affordable Care Act’s Goals***

This interpretation is consistent with Section 1557’s statutory context and the Affordable Care Act’s cross-cutting purpose of eliminating discrimination. Statutory interpretation “must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law,

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<sup>9</sup> *Id.* at 626.

<sup>10</sup> *Darrone*, 465 U.S. at 626.

<sup>11</sup> *Id.* at 631-32.

<sup>12</sup> *Id.* at 635.

<sup>13</sup> *Alexander v. Sandoval*, 532 U.S. 275, 293 (2001).

and to its object and policy.”<sup>14</sup> Fundamentally, only a uniform, liberal construction of Section 1557’s private right of act reflects the ACA’s purpose of ensuring nondiscrimination across healthcare.<sup>15</sup>

Beyond the explicit nondiscrimination protections of Section 1557, the ACA manifests a policy goal of universal, nondiscriminatory healthcare access regardless of disability, race, sex, and health. The law includes protections targeted to ensuring the equality of people with disabilities.<sup>16</sup> The ACA also seeks to foster the health of racial and ethnic minorities, including through the creation of an Office for Minority Health to evaluate and eliminate racial and ethnic health disparities.<sup>17</sup> The ACA’s focus on nondiscriminatory access to healthcare on the basis of sex appears in the numerous provisions designed to improve women’s health generally<sup>18</sup> and their reproductive health in particular.<sup>19</sup> More broadly, the goal of eradicating discrimination is represented by one of the ACA’s central reforms—prohibiting health insurers from discriminating based on health-related statuses in making eligibility decisions and in setting premium rates, a phenomenon one of us has dubbed “healthism.”<sup>20</sup>

While the legislative history of the ACA is limited, Congress unmistakably manifested the intent to eradicate health disparities. Members of Congress discussed reforming the healthcare system in antidiscrimination terms.<sup>21</sup> According to Representative James Clyburn, for example,

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<sup>14</sup> *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 51 (1987); *see also Util. Air Regulatory Grp. v. E.P.A.*, 134 S. Ct. 2427, 2441 (2014) (noting “fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme.”).

<sup>15</sup> *See New York State Dept. of Social Servs. v. Dublino*, 413 U.S. 405, 419–420 (1973) (“We cannot interpret federal statutes to negate their own stated purposes.”).

<sup>16</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (hereinafter, “Affordable Care Act”), § 1302(C) (requiring that the healthcare needs of people with disabilities be considered in defining essential health benefits); § 4203 (amending the Rehabilitation Act to include standards for accessible medical and diagnostic equipment); § 2405; § 3306 (both designating additional federal funding for aging and disability resource centers).

<sup>17</sup> § 10334.

<sup>18</sup> § 1302(C) stating that in defining essential health benefits, the Secretary should “take into account the health care needs of . . . women”). Other provisions further equalize coverage and treatment. *See* § 2713 (requiring all new insurance plans to cover any preventative care and screening for women without cost-sharing); § 10413 (providing support for breast health awareness for young women); § 3509 (creating an Office for Women’s Health within the Department of Health and Human Services).

<sup>19</sup> § 2303(a)(2) (designating non-pregnant individuals with an income up to the highest level for pregnant women as an optional categorically-needy eligibility group to facilitate access to family planning services); § 4102(a) (including pregnant women among target populations for oral healthcare prevention education provision); § 2952 (providing support for post-partum depression education and research); § 4107 (requiring states to provide Medicaid coverage for tobacco cessation programs for pregnant women without cost-sharing); § 10212 (creating a Pregnancy Assistance Fund to award grants to States for offering support to pregnant and parenting teenagers and women).

<sup>20</sup> Jessica L. Roberts, “*Healthism*”: *A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform*, 2012 UNIV. ILL. L. REV. 1159; Jessica L. Roberts & Elizabeth Weeks Leonard, *What Is (& Isn’t) Healthism?*, 50 Ga. L. Rev. --- (forthcoming 2016).

<sup>21</sup> 145 CONG. REC. H3447 (daily ed. March 17, 2009) (statement of Rep. Steven Kagen) (“[D]iscrimination is alive and well all across America. . . . 40 years after the civil rights movement has established that all citizens of any color shall be able to drink from the same water fountain, sit on the same bus, and attend the same medical clinic, our Nation still remains divided, not by skin color but by skin chemistry. Mr. Speaker, it’s time we bring an end to discrimination in health care.”); Senator Patrick Leahy, Statement on H.R. 3590, The ‘Patient Protection and Affordable Care Act,’ Press Release (Dec. 24, 2009), available at [http://leahy.senate.gov/press/press\\_releases/release/?id=065cc6a9-4284-4da6-bc38-a5aabfdb0a44](http://leahy.senate.gov/press/press_releases/release/?id=065cc6a9-4284-4da6-bc38-a5aabfdb0a44) (“Insurance companies can and do discriminate against sick people.”).

healthcare reform was “the Civil Rights Act of the 21st century.”<sup>22</sup> Legislators frequently linked issues of discrimination against the sick in health insurance to protected statuses under civil rights laws.<sup>23</sup> For example, Senator Richard Durbin described insurers as engaging in “discrimination against some people—women, certain age groups, people living in certain places—when it comes to premiums.”<sup>24</sup> Representative Sheila Jackson Lee noted that healthcare reform would “[b]ar[] insurance companies from discriminating based on pre-existing conditions, health status, and gender.”<sup>25</sup> In particular, members of Congress emphasized the ACA’s goal of eradicating discrimination against women.<sup>26</sup> They also underscored the ways in which healthcare reform could benefit historically disadvantaged racial and ethnic communities.<sup>27</sup>

Based on 1557’s context and purpose, in *Rumble v. Fairview Health Services*, one of the two district courts to consider the issue held that Section 1557 required a singular standard that applied to private causes of action across protected classes.<sup>28</sup> The court read the statute as “list[ing] ‘the ground[s]’ on which discrimination is prohibited in a health care setting.” It then said, “Although the four civil rights statutes provide the separate and distinct grounds or bases on which discrimination is prohibited, the court finds that the language of Section 1557 is ambiguous, insofar as each of the four statutes utilize different standards for determining

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<sup>22</sup> 145 CONG. REC. H1886 (Mar. 21, 2010) (statement Rep. James Clyburn); see also Robert K. Ross, *The Health Reform You Haven’t Heard About*, CAL. ENDOWMENT (Mar. 30, 2010, 10:20 AM), <http://tcenews.calendow.org/pr/tce/blog-post.aspx?id=3952> (“This reform is the civil rights bill for the sick. And make no mistake about it: this is a civil rights issue on par with racism.”).

<sup>23</sup> See, e.g., 145 CONG. REC. S11946 (Nov. 21, 2009) (statement of Sen. Kay Hagan) (“I think one of the key points is the fact that this bill is going to eliminate discrimination based on gender and preexisting conditions.”); 145 CONG. REC. S11963 (Nov. 21, 2009) (statement of Sen. Maxwell Baucus) (“No longer will insurance companies be able to discriminate based on gender or health status. No longer will insurance companies be able to charge more for women or for people who are sick.”); 145 CONG. REC. H1873 (Mar. 21, 2010) (statement of Rep. Lynn Woolsey) (“the whole Nation desperately needs health care reform, but no group of Americans needs it more than women who face discrimination and insult at the hand of the broken status quo every single day. . . . we will make history by passing a health care bill that will correct these injustices, and no longer will female be considered a preexisting condition.”); see also 145 CONG. REC. S12026 (Dec. 1, 2009) (statement of Sen. Barbara Mikulski) (“We, the women of the Senate, are concerned that even being a woman is being viewed by the insurance companies as a preexisting condition.”).

<sup>24</sup> 145 CONG. REC. S12065 (Dec. 1, 2009) (statement of Sen. Richard Durbin).

<sup>25</sup> 145 CONG. REC. H1878 (Mar. 21, 2010) (statement of Rep. Sheila Jackson Lee).

<sup>26</sup> See, e.g., 145 CONG. REC. S11918 (Nov. 21, 2009) (statement of Sen. Kristen Gillibrand) (“This bill also ends discrimination against women, which we have faced in our health care system for far too long. Women shoulder the worst of the health care crisis, including outrageous discriminatory practices in care and coverage.”); 145 CONG. REC. S13596 (Dec. 20, 2009) (statement of Sen. Thomas Harkin) (“They are delaying and obstructing women in this country who face systematic discrimination by health insurance companies.”); 145 CONG. REC. S13597 (Dec. 20, 2009) (statement of Sen. Deborah Stabenow) (“Our bill ends discrimination against women. As I said, currently they pay as much as 48 percent more for the same coverage a man has.”); 145 CONG. REC. H1865 (Mar. 21, 2010) (statement of Rep. Michael Thompson) (“Insurers are prohibited from charging women more than men for health insurance or discriminating on the basis of domestic violence as a pre-existing condition. Required maternity services as part of the essential benefits package in the exchange.”).

<sup>27</sup> 145 CONG. REC. H1879 (Mar. 21, 2010) (statement of Rep. Shelia Jackson Lee) (“The bill contributes to reducing health disparities. Minority communities are particularly vulnerable to being left uninsured and underinsured. . . . This historic bill is particularly important for minorities and women—who have gone without health care coverage for too long”); 145 CONG. REC. S13799 (Dec. 23, 2009) (statement of Sen. Edward Kaufman) (“This is an important moment because there are huge disparities in our health care delivery systems in America, bringing about huge disparities among different ethnic communities.”); 145 CONG. REC. S13624 (Dec. 20, 2009) (statement of Sen. Mark Begich) (“Access to care in the minority communities is much less than in the general communities at large.”).

<sup>28</sup> *Rumble v. Fairview Health Servs.*, No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at \*10-12 (D. Minn. Mar. 16, 2015).

liability, causation, and a plaintiff's burden of proof.”<sup>29</sup> Looking to the ACA as a whole, the court concluded: “Congress intended to create a new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff’s protected class status.”<sup>30</sup>

***Perverse Consequences Result from Any Other Interpretation of the Statute.***

An alternative interpretation of the statute would mean that the enforcement mechanisms and legal standards for bringing a claimed violation of Section 1557 vary depending on the protected class. As the *Rumble* court determined, anything but a uniform standard for enforcement of 1557 leads to “patently absurd consequences”<sup>31</sup> that “Congress could not possibly have intended.”<sup>32</sup> For example, to proceed under Section 1557, a plaintiff alleging age discrimination would first have to exhaust administrative remedies as the Age Discrimination Act requires.<sup>33</sup> By contrast, a plaintiff could file a private suit directly when claiming Section 1557 had been violated in the context of sex discrimination as allowed under Title IX.<sup>34</sup> Similarly, a policy resulting in disparate impact on disabled people would be actionable as a violation of Section 1557, but a policy with disparate impact on Latinos would not be.<sup>35</sup> Indeed, the second of the two district courts to consider Section 1557 took this approach, holding that the mechanisms and legal standards varied according to protected class. As a result, the Section 1557 plaintiffs could proceed with their claims that a policy disparately impacted them due to their disability, but their claims of race discrimination were barred.<sup>36</sup>

Failure to adopt a uniform standard also would render the ACA’s provision for data collection less relevant for race, color, and national origin discrimination than for disability, age, or sex discrimination. In requiring the collection and analysis of data based on race, ethnicity, sex, primary language, and disability status,<sup>37</sup> the ACA will surface disparate impacts previously unknown and allow for more effective enforcement by private plaintiffs long-disadvantaged by the lack of such data. Whether it is able to do so uniformly depends on HHS making clear that private enforcement of nondiscrimination for all protected classes includes both disparate treatment and disparate impact claims.

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<sup>29</sup> *Id.* at \*10.

<sup>30</sup> *Rumble v. Fairview Health Servs.*, No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at \*10-12 (D. Minn. Mar. 16, 2015).

<sup>31</sup> *Id.* (quoting *United States v. Brown*, 333 U.S. 18, 27 (1948)).

<sup>32</sup> *Id.* (quoting *F.B.I. v. Abramson*, 456 U.S. 615, 640 (1982) (O’Connor, J., dissenting)).

<sup>33</sup> See 42 U.S.C. § 6104 (e)(2).

<sup>34</sup> See *Cannon v. Univ. of Chi.*, 441 U.S. 677 (1979) (finding an implied cause of action under Title IX independent of administrative remedies).

<sup>35</sup> *Alexander v. Sandoval*, 532 U.S. 275, 293 (2001) (holding that no private right of action exists to enforce disparate impact regulations under Title VI); *Alexander v. Choate*, 469 U.S. 287, 299 (1985) (“assum[ing] without deciding that § 504 [of the Rehabilitation Act] reaches at least some conduct that has an unjustifiable disparate impact upon the handicapped”).

<sup>36</sup> See *Pennsylvania Transp. Auth. v. Gilead Sciences, Inc.*, No. CIV.A. 14-6978, 2015 WL 1963588, \*6 (E.D. Pa. May 4, 2015) (reading 1557 to “import the various different standards and burdens of proof into a Section 1557 claim, depending upon the protected class at issue”). The court concluded that “Congress could have listed the six protected classes without reference to those statutes and expressly provided for a single enforcement mechanism instead of incorporating mechanisms from all four statutes” and thus “the rights of action and corresponding remedies, including all of their limitations, are to be drawn from the four federal civil rights statutes listed in 42 U.S.C. § 18116(a) and applied depending upon the nature of the discrimination alleged by a putative Section 1557 plaintiff.” *Id.* at \*12.

<sup>37</sup> Affordable Care Act § 4302.

Employing dissimilar standards for the enforcement of a single healthcare civil rights statute would lead—as the *Rumble* court said to—“an illogical result” and “absurd inconsistency.”<sup>38</sup> In particular, intersectional discrimination claims would present an intractable problem.<sup>39</sup> When presented with claims, for example, that a health program had violated Section 1557 by discriminating against black elderly people, courts would lack guidance as to whether the claims should be analyzed under the standards governing race or age.

In sum, the application of a single, uniform standard to all violations of 1557 better comports with the statutory text in context and the overarching purpose of the nondiscrimination requirements. It also avoids the perverse consequences that flow from the contrary interpretation. HHS, accordingly, should explicitly interpret Section 1557 to authorize claims of disparate treatment and disparate impact through the full range of agency enforcement, administrative complaints, and private rights of action for race, sex, disability, and age discrimination. Claims that Section 1557 has been violated should allow the same process, remedies, and standards, irrespective of whether they relate to race, sex, disability or age.

**HHS should adopt a more comprehensive definition of sex discrimination and permit sex-specific health programs only where necessary.**

*Defining Sex Discrimination.* HHS’s commentary on the proposed rule appropriately embraces contemporary understandings of sex discrimination as including sexual orientation, gender identity, pregnancy, and sex stereotyping. The final Nondiscrimination Rule, however, should specifically list sexual orientation within the definition of “on the basis of sex.” Other federal agencies—including the Equal Employment Opportunity Commission<sup>40</sup>—have properly understood sex discrimination to encompass sexual orientation. HHS itself already has prohibited discrimination on the basis of sexual orientation in rules governing the insurance exchanges and qualified health plans.<sup>41</sup>

As HHS has recognized, Section 1557 protects an individual’s access to health programs and activities free from sex stereotypes. While HHS rightly defines sex stereotypes to refer to “stereotypical notions of masculinity or femininity,” HHS presents examples that focus almost exclusively on gender identity. We strongly urge HHS to make clear that such stereotypes also include expectations of female sexuality<sup>42</sup> and repronormativity, in other words, social expectations that all women should be mothers.<sup>43</sup> Requirements to protect pregnant and parenting teens as well as legal requirements not to discriminate on the basis of pregnancy

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<sup>38</sup> *Rumble* at \*11-12.

<sup>39</sup> *Id.* at \*12 (identifying this problem).

<sup>40</sup> *Baldwin v. Foxx*, EEOC Appeal No. 0120133080, Agency No. 2012-24738-FAA-03, at 5-6 (Jul. 15, 2015).

<sup>41</sup> *See, e.g.*, 45 C.F.R. § 155.120(c) (nondiscrimination in exchanges); *id.* at § 156.200(e) (for Qualified Health Plans); *id.* at § 147.104(e) (for marketing and benefit design).

<sup>42</sup> For example, the definition of sex discrimination under Title IX recognizes discrimination on the basis of false pregnancy, termination of pregnancy, and recovery from termination of pregnancy. 34 C.F.R. § 106.40(b) (applying this definition to students); *Id.* § 106.51(b)(6) (reaching discrimination against employees on these grounds). These provisions reflect a profound commitment to protecting women from gendered expectations about their reproductive lives.

<sup>43</sup> This term was coined by Professor Katherine Franke. *See* Katherine M. Franke, *Theorizing Yes: An Essay on Feminism, Law, and Desire*, 101 COLUM. L. REV. 181 (2001).

termination under Title IX reflect these commitments.<sup>44</sup> Like Title IX, the Nondiscrimination Rule should preclude discrimination on the basis of stereotypical notions of parental, family, marital and wage-earner status.<sup>45</sup> Women in particular have long faced discrimination in healthcare and insurance access related to stereotypes around their actual or potential parental, family, and marital status and their roles as wage earners.<sup>46</sup> Accordingly, HHS should revise its definitions of “sex stereotypes” to incorporate stereotypes around repronormativity, sexuality, and parental, family, marital, and wage-earner status.

***Limiting Sex-Specific Health Programs.*** Sex-specific health programs or activities must be limited to those that are necessary to accomplish an essential health purpose. Given Section 1557’s broad nondiscrimination mandate, sex-specific health programs or activities also should be allowed where they are necessary to serve the disadvantaged sex—typically women. Beyond these narrow circumstances, Section 1557’s nondiscrimination requirements should fully apply.

By its terms, Section 1557 does not import the exceptions to sex nondiscrimination that appear in Title IX.<sup>47</sup> Whereas Title IX’s text includes a list of exceptions, the language of Section 1557 is clear that nondiscrimination protections apply “Except as otherwise provided for in this title (or an amendment made by this title).”<sup>48</sup> This limiting language within Section 1557 should preclude importing more restrictive language from Title IX.

Moreover, Title IX’s exceptions are specific to the educational context and make little sense in the context of healthcare. The exceptions listed in Title IX recognize the distinct social tradition of single-sex education. They include fraternities and sororities and beauty pageants.<sup>49</sup> The

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<sup>44</sup> 34 C.F.R. § 106.21(c)(2) (2012) (barring pregnancy discrimination in school admissions); *Id.* at § 106.40(b) (defining sex discrimination to reach discrimination against students on “the basis of such student’s pregnancy, childbirth, false pregnancy, termination of pregnancy or recovery therefrom.”); *Id.* § 106.51(b)(6) (barring employment discrimination with respect to “[g]ranting and return from leaves of absences, leave for pregnancy, childbirth, false pregnancy, termination of pregnancy, leave for persons of either sex to care for children or dependents.”); *Id.* § 106.57(b)(making illicit discrimination against employees or prospective employees “on the basis of pregnancy, childbirth, false pregnancy, termination of pregnancy, or recovery therefrom.”). *See generally* Office for Civil Rights, *Pregnant or Parenting? Title IX Protects You from Discrimination at School*, U.S. DEP’T EDUC. <http://www2.ed.gov/about/offices/list/ocr/docs/dcl-know-rights-201306-titleix.html>.

<sup>45</sup> 34 C.F.R. § 106.40(a) (2012) (“A recipient shall not apply any rule concerning a student’s actual or potential parental, family, or marital status which treats students differently on the basis of sex.”); 34 C.F.R. § 106.57(a) (2012) (A recipient shall not apply any policy or take any employment action:(1) Concerning the potential marital, parental, or family status of an employee or applicant for employment which treats persons differently on the basis of sex; or(2) Which is based upon whether an employee or applicant for employment is the head of household or principal wage earner in such employee’s or applicant’s family unit.”); *see generally* Office for Civil Rights, *Pregnant or Parenting? Title IX Protects You from Discrimination at School*, U.S. Dep’t Educ. <http://www2.ed.gov/about/offices/list/ocr/docs/dcl-know-rights-201306-titleix.html>.

<sup>46</sup> *See, e.g.*, National Women’s Law Center, *Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act 3* (Mar. 2012) (reporting how women of reproductive age pay higher premiums for insurance in the individual market); Claudia Goldin & Lawrence F. Katz, *The Power of the Pill: Oral Contraceptives and Women’s Career and Marriage Decisions*, 110 J. OF POL. ECON. 730, 732-734 (2002) (describing a long history of obstructed access to oral contraceptives for unmarried women); Julie Deardorff, *Doctors Reluctant to Give Young Women Permanent Birth Control*, CHI. TRIB., May 13, 2014 (reporting on the difficulty young unmarried women without children face when attempting to receive tubal ligation procedures); *E.E.O.C. v. Fremont Christian School*, 781 F.2d 1362 (9th Cir. 1986) (precluding religiously affiliated employer from limiting health insurance benefits to employees who are the “head of the household,” defined to exclude married women).

<sup>47</sup> Title IX, 20 U.S.C. § 1681(a)(4)-(9).

<sup>48</sup> 42 U.S.C. § 18116(a).

<sup>49</sup> 20 U.S.C. § 1681(a)(1)-(9).

exceptions also carve out space for voluntary associations like the Boy Scouts and Girl Scouts. All of these programs are characterized by exclusion of one sex. No parallel exists in healthcare where institutions typically admit patients of all sexes and only exclude patients of a particular sex where health purposes require (for example, in birthing centers). Accordingly, sex segregation permitted under Title IX should not be extended to healthcare providers under the Nondiscrimination Rule.

**“Federal financial assistance” includes Medicare Part B payments as “contracts of insurance.”**

The text of Section 1557 precludes HHS’s proposal to exclude Medicare Part B payments from the definition of “federal financial assistance.” Section 1557 explicitly defines “Federal financial assistance” as “including credits, subsidies, or contracts of insurance.”<sup>50</sup> It differs from previous civil rights statutes, which excluded contracts of guarantee and insurance from the definition of federal financial assistance.<sup>51</sup> Interpreting these earlier statutes, the precursor agency to HHS understood Medicare Part B to be a “contract of insurance” and thus not federal financial assistance.<sup>52</sup> The proposal to again exclude Medicare Part B payments from the ambit of “federal financial assistance” does violence to the statutory text.<sup>53</sup> The agency effectively reads “contract of insurance” out of the statute.

The only permissible interpretation of Section 1557 includes Medicare Part B payments within the definition of federal financial assistance. HHS must revise its proposed rule according.

**Granting religious exemptions would contravene Section 1557.**

HHS may not, consistent with statute, issue religious exemptions to Section 1557’s prohibition on sex discrimination. The language of Section 1557 is clear as to the exemptions that apply to its antidiscrimination requirements. The statute extends nondiscrimination protections “Except as otherwise provided for in this title (or an amendment made by this title).”<sup>54</sup> Title I of the ACA, in which 1557 is found, specifically incorporates existing federal conscience protections<sup>55</sup> and exemptions for objections to assisted suicide<sup>56</sup>; it also allows states to prohibit abortion coverage in the state exchanges.<sup>57</sup> Title I further indicates that the ACA shall not “preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the

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<sup>50</sup> 42 U.S.C. § 18116 (a) (“Federal financial assistance, including credits, subsidies, or contracts of insurance”).

<sup>51</sup> Section 504 of the Rehabilitation Act of 1973, 42 U.S.C. § 6103(a)(4) (2006); the Age Discrimination Act, 20 U.S.C. § 1682 (2006); Title IX of the Education Amendments of 1972, 29 U.S.C. § 794 (2006); Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d-4.

<sup>52</sup> Sara Rosenbaum, David M. Frankford, Sylvia A. Law, & Rand E. Rosenblatt, *Law and the American Health Care System* 118 (discussing this history).

<sup>53</sup> Barry R. Furrow et al., *Health Law: Cases, Materials, and Problems* 620 (2013) (noting that “[t]he precursor agency to HHS, however, declared that Title VI did not apply to physicians who received payment under Part B of Medicare, interpreting that program as a “contract of insurance” rather than payment of public funds” and concluding that “The Affordable Care Act displaces this narrow interpretation.”).

<sup>54</sup> 42 U.S.C. § 18116(a) (2010).

<sup>55</sup> 42 U.S.C. § 18023(c)(2)(a)(i) (2010) (“Nothing in this Act shall be construed to have any effect on Federal laws regarding . . . conscience protection.”).

<sup>56</sup> 42 U.S.C.A. § 18113 (2010).

<sup>57</sup> 42 U.S.C.A. § 18023 (2010).

performance of an abortion on a minor.”<sup>58</sup> The ACA is also subject to Religious Freedom Restoration Act. These existing protections in federal law adequately address religious concerns.

Congress specifically considered and rejected broader religious exemptions in the context of the Women’s Health Amendment.<sup>59</sup> It also refused to expand the federal conscience clause to prohibit “requir[ing] an individual or institutional health care provider to provide, participate in, or refer for an item or service to which such provider has a moral or religious objection, or require such conduct as a condition of contracting with a qualified health plan.”<sup>60</sup> Expanded exemptions within the Nondiscrimination Rule would be inconsistent with Congress’s considered judgment in enacting Section 1557.<sup>61</sup>

Expanded religious exemptions to the Nondiscrimination Rule would impose significant costs on patients already disadvantaged by reasons of sex, sexual orientation, or gender identity. Exemptions would impair their healthcare access, health outcomes, and equality.

Sex discrimination—whether religiously motivated or not—can inflict significant and even health- and life-threatening harms in the healthcare context. Discrimination in healthcare sometimes presents as a matter of life or death and frequently occurs when a patient may be particularly vulnerable due to disease or injury.<sup>62</sup> The harms of discrimination include outright denials of care, delay, and inadequate care.<sup>63</sup> In addition to physical and psychological injuries, individuals face economic costs as they search for alternate providers of insurance or healthcare—a search that may be rendered more difficult in the many areas of the country with highly consolidated healthcare or health insurance markets.<sup>64</sup>

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<sup>58</sup> 42 U.S.C. § 18023(c)(1)-(2).

<sup>59</sup> See, e.g., 155 CONG. REC. S13193-01 (2009).

<sup>60</sup> *Id.*

<sup>61</sup> *INS v. Cardoza-Fonseca*, 480 U.S. 421, 442-43 (1987) (quoting *Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 392-93 (1980) (Stewart, J., dissenting)) (“Few principles of statutory construction are more compelling than the proposition that Congress does not intend sub silentio to enact statutory language that it has earlier discarded in favor of other language.”); see also William N. Eskridge, *Interpreting Legislative Inaction*, 87 MICH. L. REV. 84-89 (1988) (analyzing the Supreme Court’s use of the rejected proposal rule, according to which statutes should not be interpreted to reach results or include language that Congress rejected).

<sup>62</sup> Press Release, Gay and Lesbian Activists Alliance of Washington D.C., District Settles Hunter Lawsuit for \$1.75 Million (Aug. 10, 2000), <http://www.glaa.org/archive/2000/tyrasettlement0810.shtml> (recounting settlement of lawsuit following the death of Tyra Hunter, a transgender woman, who had been seriously injured in a car accident and was left untreated after emergency medical professionals discovered she had male genitalia); LESLIE FEINBERG, *TRANS LIBERATION* (1998) (recounting experience of being denied care for a heart condition in an emergency department after Feinberg was revealed to be transgendered); LAMBDA LEGAL, *TRANS GENDER RIGHTS TOOLKIT: TRANSITION-RELATED HEALTH CARE* (Feb. 7, 2013), [http://www.lambdalegal.org/publications/trt\\_overcoming-health-care-discrimination](http://www.lambdalegal.org/publications/trt_overcoming-health-care-discrimination) (reporting refusal of care to a transgender man, Nakoia Nelson, after he had a near-fatal allergic reaction).

<sup>63</sup> See, e.g., Council on Ethical and Judicial Affairs of the American Medical Association, *Gender Disparities in Clinical Decision Making*, 266 JAMA 559 (1991) (noting ways in which gender bias results in women receiving inadequate care); LAMBDA LEGAL, *WHEN HEALTH CARE ISN’T CARING: SURVEY ON DISCRIMINATION AGAINST LGBT PEOPLE AND PEOPLE LIVING WITH HIV 5* (2010), [http://www.lambdalegal.org/sites/default/files/publications/downloads/whic-report\\_when-health-care-isnt-caring.pdf](http://www.lambdalegal.org/sites/default/files/publications/downloads/whic-report_when-health-care-isnt-caring.pdf) (reporting that almost 8 percent of LGB survey respondents and almost 27 percent of transgender respondents had been denied care due to sex discrimination); Nat’l Women’s L. Ctr, *Fact Sheet, Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS* (May 2014), [http://www.nwlc.org/sites/default/files/pdfs/lgbt\\_refusals\\_factsheet\\_05-09-14.pdf](http://www.nwlc.org/sites/default/files/pdfs/lgbt_refusals_factsheet_05-09-14.pdf) (compiling studies and examples of mistreatment and refusals of healthcare to LGBT people and people living with HIV/AIDS).

<sup>64</sup> See, e.g., David M. Cutler & Fiona Scott Morton, *Hospitals, Market Share, and Consolidation*, 310 JAMA 1964, 1966 (2013) (“Nearly half of hospital markets in the United States are highly concentrated, another third are moderately concentrated, and the remaining one-sixth are unconcentrated. No hospital markets are considered highly competitive.”);

Further, the experience of sex discrimination causes patients substantial dignitary harm. LGBT people and people with HIV, in particular, frequently encounter hostile healthcare settings and are stigmatized by healthcare providers.<sup>65</sup> Stigma in turn may lead to future healthcare avoidance, resulting in potentially severe health consequences.<sup>66</sup>

Religious exemptions specific to sex would deny individuals equal citizenship in the healthcare system. As the Supreme Court has long held, discrimination inflicts “stigmatic injury,” which “is surely felt as strongly by persons suffering discrimination on the basis of their sex as by those treated differently because of their race.”<sup>67</sup> For the federal government to fund discriminatory practices would send a message of endorsement of sex discrimination to the detriment of members of disfavored minority groups and of society at large. As the Supreme Court has explained, sex discrimination “both deprives persons of their individual dignity and denies society the benefits of wide participation in political, economic, and cultural life.”<sup>68</sup>

Religious exemptions would retrench on preexisting rights of patients who do not share the commitments of conscience of their healthcare providers and insurers. For more than five years, people have had the protection of Section 1557 of the ACA. Women and transgender people have filed complaints against sex discrimination under Section 1557.<sup>69</sup> HHS already has included explicit prohibitions against sex and sexual orientation discrimination in final rules for health insurance exchanges and qualified health plans.<sup>70</sup> Healthcare has begun to become more integrated and nondiscriminatory on the basis of sex.

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Leemore Dafney, Mark Duggan, & Subramaniam Ramanarayanan, *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, 102 AM. ECON. REV. 1161, 1183-84 (2012) (“[M]ost Americans live in markets served by a small number of insurers, and most markets are becoming more concentrated over time. We estimate that the fraction of local markets falling under the “highly concentrated” category . . . increased from 68 to 99 percent between 1998 and 2006.”).

<sup>65</sup> LAMBDA LEGAL, SUPRA NOTE 63, AT 5 (survey of 5,000 people found that more than half reported experiencing discrimination in care).

<sup>66</sup> Fearing stigma and discrimination, almost one quarter of LGBT older adults have not revealed their LGBT status to their primary care physicians. Karen Fredriksen-Goldsen et al., *The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults 2* (2011); *see also* MetLife Mature Market Institute, *Out and Aging: The MetLife Study of Lesbian and Gay Baby Boomers 14* (2006) (reporting that 19 percent of gay and lesbian baby boomers had little or no confidence that the health care system would treat them respectfully).

<sup>67</sup> *Roberts v. U.S. Jaycees*, 468 U.S. 609, 625 (1984).

<sup>68</sup> *Id.* at 625 (1984) (recognizing the government’s “compelling interest in eradicating discrimination against its female citizens”).

<sup>69</sup> *See, e.g.*, *Rumble v. Fairview Health Servs.*, No. 14-CV-2037, 2015 WL 1197415, \*1 (D. Minn. Mar. 16, 2015) (holding that a transgender patient could proceed in a suit against his local hospital for discrimination based on his suffering verbal insults, delays that put him at risk of sepsis, and unnecessary and invasive procedures by physicians and nurses); Letter of Leon Rodriguez to Maya Rupert dated July 12, 2012 (OCR Transaction Number: 12-000800) (concluding that Section 1557’s sex discrimination prohibition includes discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity, as well as other forms of sex discrimination regardless of the individual’s actual or perceived sexual orientation or gender identity); Nat’l Women’s L. Ctr., Admin. Compl. Against Auburn Univ., June 4, 2013, [http://www.nwlc.org/sites/default/files/pdfs/2013-06-04\\_auburn\\_univ\\_1557\\_ocr\\_complaint.pdf](http://www.nwlc.org/sites/default/files/pdfs/2013-06-04_auburn_univ_1557_ocr_complaint.pdf) (alleging that university violated Section 1557 in excluding maternity care for female dependent children of male employees).

<sup>70</sup> *See, e.g.*, 45 C.F.R. § 155.120(c) (nondiscrimination in exchanges); *id.* at § 156.200(e) (for Qualified Health Plans); *id.* at § 147.104(e) (for marketing and benefit design).

For these reasons, we strongly urge the U.S. Department of Health and Human Services (HHS) to refrain from expanding religious exemptions beyond those already provided under federal law.

### **Conclusion**

At its core the ACA is civil rights statute designed to promote access and inclusion in the health-care system for all Americans. Any interpretation of Section 1557 must reflect this fundamental purpose. To that end, we urge HHS to revise the proposed Nondiscrimination Rule to:

- 1) Provide uniform mechanisms and legal standards for the private enforcement of Section 1557 across categories of race, sex, disability, and age;
- 2) Adopt a more comprehensive definition of sex discrimination, which includes sexual orientation and allows sex segregation only where medically necessary;
- 3) Include Medicare Part B within the definition of “federal financial assistance” as the statute requires; and
- 4) Refrain from expanding religious exemptions to sex nondiscrimination obligations, contrary to statute.

Thank you for your consideration.

Respectfully submitted,<sup>71</sup>

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