The Leadership Conference
on Civil and Human Rights

1620 L Street, NW
Suite 1100
Washington, DC
20036

202.466.3311 voice
202.466.3435 fax
www.civilrights.org

Memorandum

The Leadership Conference

To: Interested Parties
From: June Zeitlin, The Leadership Conference Health Care Task Force
Mara Youdelman, Co-Chair, The Leadership Conference Health Care Task Force
Date: June 8, 2021
Re: Section 1557 of the Affordable Care Act

INTRODUCTION

The inclusion of Section 1557 ("Sec. 1557") in the Affordable Care Act (ACA) was a critical way to ensure the promises of the ACA would redound to the benefit of everyone in the U.S. regardless of race, color, national origin (including language), age, sex, and disability. After enactment of Sec. 1557, also called the Health Care Rights Law, The Leadership Conference on Civil and Human Rights led the advocacy community's efforts working with the Obama administration to implement the law. We worked closely with the Office for Civil Rights, the White House, and others to ensure the promises of Sec. 1557 would become reality. In 2016, the Obama administration finalized long-awaited regulations implementing Sec. 1557 of the Affordable Care Act. In 2020, the Trump administration finalized new regulations drastically rewriting the Obama-era regulations purporting to severely limit Sec. 1557's application.

Given the Trump Administration's attacks on civil rights in general and Sec. 1557 in particular, we strongly urge the Biden-Harris Administration through the Department of Health and Human Services (HHS) and its Office for Civil Rights (OCR) to quickly draft new regulations that rescind the 2020 regulations, bring back significant portions of the 2016 regulations, and expand beyond the 2016 regulations in important ways. This memo outlines the major issues that we recommend adding to the 2016 regulations to ensure comprehensive protection against all forms of discrimination intended by Sec. 1557.

One of the major issues that new regulations must address is continuing litigation challenging both the 2016 rule and the statute itself (*Franciscan Alliance* and *Religious Sisters of Mercy*). Any proposed regulation that merely rescinds the 2020 regulations and reinstates the 2016 regulations will unfortunately leave in place prohibitions on protections from discrimination on the basis of termination of pregnancy and gender identity due to a vacatur that preceded the 2020 rule changes and an injunction HHS is currently appealing. Since the challengers in these cases now seek further relief against both the 2016 rules and the statute itself, HHS must adopt a new rule that reflects the recent Supreme Court decision in *Bostock v. Clayton County* and other developments and responds to these challenges.

For the purposes of Sec. 1557, we recommend an expansive definition of "on the basis of sex". This definition should include pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, reproductive health decisions, sexual orientation, gender identity, gender expression, gender transition, transgender status, sex stereotypes, and sex characteristics (including intersex traits).

Additionally, we strongly recommend new rulemaking address a number of issues that were either not sufficiently addressed in or have changed since the 2016 regulations. This memo covers some of these issues, grouped by broad categories. It is not intended as a comprehensive discussion of all the changes to be made to the 2016 regulations but to introduce our major concerns. We look forward to working with the HHS and OCR to identify and clarify those and any additional issues.

This memo is organized around the following major topics (the full Table of Contents begins on page 4):

- Intersectional Issues
- Preventing Sex Discrimination
- Preventing Disability Discrimination
- Preventing Discrimination on the Basis of Language
- Preventing Age Discrimination
- Application/Covered Entities/Religious Exemptions
- Enforcement

The members of the Health Care Task Force of The Leadership Conference look forward to addressing these issues, offering technical support and suggestions, and providing additional detail as the Biden-Harris administration moves forward with new rulemaking. For more information, please contact June Zeitlin, The Leadership Conference (zeitlin@civilrights.org) or the co-chair of the Health Care Task Force, Mara Youdelman, National Health Law Program (youdelman@healthlaw.org).

ACKNOWLEDGEMENTS

We want to acknowledge all the individuals and organizations who helped develop this document. The organizations, primarily members of the Health Care Task Force, include:

- Arab Community Center for Economic and Social Services (ACCESS)
- Asian & Pacific Islander American Health Forum (APIAHF)
- Association of Asian Pacific Community Health Organizations (AAPCHO)
- Autistic Self Advocacy Network
- Bazelon Center for Mental Health Law
- Center for American Progress
- Center for Reproductive Rights
- Coalition for Disability Health Equity
- Community Catalyst
- Disability Rights Education & Defense Fund
- Freedom from Religion Foundation
- Hispanic Federation
- Human Rights Campaign
- interACT: Advocates for Intersex Youth
- Interfaith Alliance
- Lawyers' Committee for Civil Rights Under Law
- The Leadership Conference on Civil and Human Rights
- Lyon-Martin Health Services
- National Center for Lesbian Rights
- National Center for Transgender Equality
- National Disability Rights Network
- National Health Law Program
- National Immigration Law Center
- National Partnership for Women & Families
- National Women's Law Center
- Out2Enroll
- Planned Parenthood Federation of America
- Southern Poverty Law Center
- UnidosUS
- Whitman-Walker Institute

The Leadership Conference

TABLE OF CONTENTS

- Require creation of an "access plan" encompassing both language access and services for people with disabilities

Preventing Age Discrimination

- Revisit requirements regarding exhaustion of administrative remedies under the Age Discrimination Act of 1975

Application/Covered Entities/Religious Exemptions

- Expand application of Sec. 1557 to all health insurers, third party administrators, short term limited duration plans
- Affirm 1557 applicability to all federal health programs and activities (and not just those established under ACA Title I)
- Eliminate the exemption of Medicare Part B providers (as well as from Title VI and Section 504)
- Require that all subcontractors of covered entities are subject to Sec. 1557
- Apply nondiscrimination on the basis of association to providers and caregivers
- Expand Sec. 1557 implementation and compliance procedures to all federal fund recipients, not merely those with 15 or more employees
- Expand application of Sec. 1557 to employees of covered entities
- Apply HHS' rule to all federal health programs and activities or coordinating with DOJ on a "common rule" applicable to all federal agencies, programs and activities covered by Sec. 1557
- Do not incorporate exemptions in Sec. 1557 beyond those expressly enumerated in the ACA
- Refrain from incorporating Title IX exemptions and promulgate new regulations irrespective of the Texas federal court's opinions in *Franciscan Alliance* which does not preclude new Sec. 1557 rulemaking
- Do not incorporate the religious and abortion provision and funding exemptions from Title IX into Sec. 1557 because they are unnecessary and would expand already harmful denials of care
- Prohibit religious and abortion exemptions that result in denials and delays in providing health care to individuals and discourage individuals from seeking necessary care, with serious and sometimes life-threatening results
- Prohibit health care professionals from opting out of providing medically necessary services which disregards evidence-based standards of care
- Prohibit religious and moral exemptions that would harm any third party and are barred by the Establishment Clause of the First Amendment

Enforcement

- Clarify that the same scope of claims and remedies exist under Section 1557 regardless of the type of discrimination, or stay silent on this question
- Explicitly articulate a cause of action for claims of intersectional discrimination

- Ban forced arbitration of consumers' claims arising from Section 1557 complaints
- Require a yearly report from OCR including information about all complaints filed and resolutions; information should be disaggregated by the bases for the complaints (e.g. race, color, national origin, sex, disability, age), the number of investigations initiated, the number of complaints resolved, the number of complaints closed without resolution
- Substantially reform and improve OCR's complaint handling process and provide the public with detailed guidance through written decisions and otherwise

Intersectional Issues

- DATA COLLECTION: Include specific requirements for collecting and reporting comprehensive disaggregated demographic data by all those covered by Section 1557 (including federal fund recipients and also federally administered programs/activities)

- INDEPENDENCE OF SEC. 1557: Clarify that Section 1557, as part of the ACA, is an independent non-discrimination provision and does not incorporate the limitations of the laws, such as Title VI, Title IX, the ADA and Section 504, that were being remediated by the Act

The Leadership Conference

INTERSECTIONAL ISSUE – DATA COLLECTION: Include specific requirements for collecting and reporting comprehensive disaggregated demographic data by all those covered by Section 1557 (including federal fund recipients and also federally administered programs/activities)

Since the beginning of the COVID-19 pandemic, the lack of comprehensive and accurate data has exposed the country's challenges in identifying those most impacted and developing targeted and appropriate interventions. The data that have been available have been key in helping us understand which communities we need to prioritize in our response to the virus.

The collection of high quality data, including on smaller populations and populations with multiple identities, is a critical first step in understanding and eliminating disparities in healthcare access and health outcomes and ensuring compliance with nondiscrimination requirements. The dearth of comprehensive, disaggregated accurate demographic data hinders our ability to fight discrimination, health disparities and structural racism. OCR should use the authority of Sec. 1557 (and other federal civil rights laws) to require the collection of demographic data so that covered entities can document compliance with federal laws and demonstrate that they do not discriminate. Having accurate data also helps covered entities plan how to provide language services and auxiliary aids and services.

One tenet of ensuring compliance with nondiscrimination requirements is to ensure robust data collection. We urge HHS to require disaggregated demographic data collection for all covered entities, including race, ethnicity, preferred language, sex, gender identity, sexual orientation, intersex status, disability status, pregnancy status, and age. Further, covered entities should be required to ascertain the populations they serve and are eligible to be served so that they can appropriately plan how to meet their needs. In addition to Sec. 1557, ACA Section 4302 provides OCR the authority to require data collection.

While the existence of health disparities has been well documented, the complex factors that contribute to and mitigate against them are still not fully understood. In part, this is due to a lack of high quality, large scale, and easily available data. For example, data on smaller racial and ethnic groups is often not extensive enough to lend itself to meaningful analysis. Similarly, data is often not available for intersecting sub-populations that might experience multiple barriers to access. While discrimination investigations often focus on a single demographic variable, in our increasingly multicultural society, it is vital that OCR's civil rights enforcement support analyses based on multiple demographic variables.

OCR should adopt standardized categories and definitions for all demographic variables. Racial, ethnic and preferred language data should be collected at a granular level to allow for disaggregation, particularly for Asian Americans, Native Hawaiians and Pacific Islanders (AANHPI) and allow for inclusion of Middle Eastern and Northern African (MENA) populations. OCR should adopt the minimum standards for AANHPI as recommended by NCAPA and for MENA the recommendations from ACCESS. Sexual orientation, and gender identity, and intersex status (SOGII) data should build on the questions employed by other federal agencies, and the forthcoming recommendations from the National Academies of Sciences, Engineering and Medicine. Standardized disability questions should identify

people with functional limitations associated with certain cognitive, emotional, or learning impairments and use the American Community Survey questions about functional limitations as a starting point.

Demographic data can help researchers, policy makers, public health workers, and healthcare practitioners target interventions to the populations that need them most, tailor interventions to the specific needs of a community and prevent discrimination. Further, health disparities data collection is crucial for measuring quality. Yet complaint data isn't enough for civil rights enforcement, we need to be able to see disparities in other data to do systemic compliance reviews and investigations. Broad collection of demographic data is integral to understanding whether a particular program is upholding civil rights requirements and improving the health outcomes of all groups. Without this data, average improvement in the health outcomes could mask a lack of improvement or even deterioration in outcomes for a specific population.

Demographic data collection is especially important as we move towards a health care payment system that rewards quality rather than quantity. The ACA recognizes the central role of data in quality care, and appropriately requires demographic data collection as a component of federal quality reporting requirements.

Additionally, we must ensure that data collected is maintained safely and securely by the appropriate entities. Strict standards must be adopted to ensure that data cannot be used for negative actions such as immigration or law enforcement, redlining or targeting of specific groups. Individuals must feel comfortable disclosing personal information. We encourage OCR to ensure that the privacy protections applied to demographic data comply with the privacy and security standards set forth in ACA Section 3101, which built upon the privacy protections required by HIPAA. Individuals should be made aware of their privacy protections and rights – including those granted under applicable state laws as well as the ACA – and have a clear understanding of why demographic data is being collected and who will have access to which forms of information.

While all covered entities must be required to ask for data, individuals' responses must be voluntary and should be self-reported to ensure accuracy. It is critical to train relevant staff on the collection of demographic data, including how to explain why data is being collected. The Health Research and Educational Trust (HRET) developed a toolkit for collecting race, ethnicity and language data after testing different rationales for collecting this data. We recommend that OCR work with other HHS agencies to develop a similar toolkit focused on collecting demographic data beyond patient care settings and beyond race, ethnicity and language.

Further, covered entities should only collect demographic data that is essential to ensuring civil rights compliance and program eligibility. For example, a parent or guardian's disability status or SOGII data is unlikely to be relevant on an eligibility application for a child or dependent, while their preferred language may be very relevant. Similarly, the immigration status or Social Security Numbers of non-applicants should not be collected because requests for this information can deter non-applicants from

obtaining coverage for eligible individuals in their household. At a minimum, OCR should consider codifying in regulations the concepts embedded in "Tri-Agency Guidance".

The Leadership Conference

INTERSECTIONAL ISSUE – INDEPENDENCE OF SEC. 1557: Clarify that Section 1557, as part of the ACA, is an independent non-discrimination provision and does not incorporate the limitations of the laws, such as Title VI and Title IX of the Civil Rights, Act, the ADA and Section 504 of the Rehabilitation Act, that were being remediated by the Act.

Before the ACA, lower court interpretations of the Americans with Disabilities Act ("ADA") and Section 504 of the Rehabilitation Act prevented people with disabilities from challenging the discriminatory actions of private insurers. For example, if an insurer excluded coverage of services and devices such as wheelchairs or ventilators that disabled people uniquely relied on, or imposed exorbitant limitations or cost-sharing on such coverage, then such policies were largely insulated from legal challenge. This was due to misinterpretations of the ADA's "safe harbor" for providers of insurance. 42 U.S.C. § 12201(c). Further, Section 504, even before the development of insurance marketplaces, had been incorrectly interpreted by many lower courts to prohibit claims challenging the discriminatory design of health insurance plan benefit design.[1]

Further, the Supreme Court determined that disparate impact discrimination under Title VI of the Civil Rights Act of 1964 could not be enforced in court but only through administrative action.[2] This relegated much enforcement of Title VI to the vagaries of an Administration that may not be committed to enforcing civil rights laws. It is inappropriate to read Title VI's carve out of employment discrimination claims into 1557, as the 2016 regulations did, without any real attempts to justify, even though Title IX and Section 504, which like 1557 have no such carve outs, reach employment discrimination in covered programs and activities.

And neither Title IX's religious exemption (20 U.S.C. § 1681(a)(3)) nor its abortion provision and funding exemption (20 U.S.C. § 1688) are incorporated into Sec. 1557, as evident from both the plain language of the text and the legislative history indicating Congress's intent in passing both 1557 and the ACA more broadly was to eliminate sex discrimination in health care and health insurance.

The ACA included reforms to address these situations, ushering in a new era for health equity. It implemented sweeping reforms to expand coverage; created protections in enrollment, cost-sharing, and benefit design; and improved the scope and quality of private health insurance. As an integral component of these reforms, Congress included Sec. 1557, which deliberately extended civil rights to the private health insurance context and to federal programs. It explicitly does not include limitations in the ADA (such as the safe harbor provision or religious exemptions), the Supreme Court's view of Title VI, or other laws. The statutory language of Sec. 1557 explicitly creates rights, remedies, and procedures that other, existing nondiscrimination laws may add to, but not take away from. 42 U.S.C. § 18116(b).

---

[1] *See, e.g.*, *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557 (7th Cir. 1999) (citing *Alexander v. Choate*, 469 U.S. 287 (1985); *see also* Samuel R. Bagenstos, *The Future of Disability Law*, 114 Yale L.J. 1, 41 (2004).

[2] *Alexander v. Sandoval*, 532 U.S. 275 (2001).

Although Sec. 1557 references the "grounds" and "enforcement mechanisms" of other major civil rights statutes, it creates a separate right. If those provisions as written and interpreted were sufficient to protect against discrimination in health care to the extent the ACA demanded, then Sec.1557 would not have been required. The ACA changed what was acceptable in health care and significantly changed the obligations of covered entities, therefore the pre-ACA case law and limitations should not be dispositive when determining the scope of Sec. 1557's protections and remedies.

Despite clear legislative intent from the breadth and scope of the ACA and the inclusion of Sec. 1557 as a key enforcement mechanism ***in addition to*** existing mechanisms, courts have frequently looked to Sec. 504 case law and interpretation to inform the interpretation of Sec. 1557. This includes limiting claims of discriminatory benefit design and other claims of discrimination. For example, several cases have applied the principles of analyzing disparate impact disability discrimination in insurance benefits under Sec. 504 as prescribed in *Alexander v. Choate* to Sec. 1557 claims. Doing so should not only be improper because it fails to recognize Sec. 1557 within the larger reform of the ACA, but also because many of these Sec. 1557 decisions have applied an overly narrow read of these Sec. 504 standards to Sec. 1557 claims.

While we do not argue that Sec. 1557 requires covered entities to provide limitless benefits, the ACA set new standards for what insurers could and could not do, what essential health coverage looked like, and that people must have access to coverage at affordable prices regardless of their conditions. For example, Congress directed that the health care needs of diverse segments of the population be considered and that essential health benefits "not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life," among other considerations.[3] Plans may still use an array of methods to limit coverage, but must do so in a nondiscriminatory fashion.[4] The ACA requires not just access to coverage, but sets requirements for the content of that coverage.

Importantly, pre-ACA cases, like *Choate* and *Sandoval*, were decided in a different world and conception of coverage. *Choate* created a "meaningful access" standard within the context of coverage at that time, which the ACA has dramatically changed. Subsequent courts have misinterpreted *Choate* to not reach the "content" of a health benefit policy, but only the ability to "access" the benefit; these interpretations have infiltrated Sec. 1557 enforcement. Such interpretations are improper even under Sec. 504 because *Choate* explicitly went beyond the pure "access" question and also considered whether the structure of the benefit policy disproportionately prevented people with disabilities from receiving a meaningful benefit from the inpatient coverage. In addition, a framing of discrimination in health insurance as only a matter of access would allow an insurer to manipulate their benefit design to elude discrimination law, despite discriminatory effects. The impact of such decisions on insurers can be seen in some of the practices for which the ACA corrected.

---

[3] 42 U.S.C. § 18022(b)(4).
[4] *See, e.g., id.* §§ 300gg-6, 18022(c).

The ACA was a sea change of what was and was not allowed in health insurance coverage. The express objective of the ACA was to ensure equal and comprehensive access to health care benefits, including the content of those benefits. The creation of Sec. 1557 within the larger context of the ACA made it clear that the discrimination that had been allowed previously under Title VI, the ADA and Sec. 504 would no longer be allowed under the protections of the ACA and its nondiscrimination provision. Sec. 1557 corrected for decades of discrimination. OCR should make clear that Sec. 1557 cannot be undone by bringing in the very discrimination allowed under Sec. 504 and the ADA and the limits on enforcement of Title VI that Sec. 1557 and the ACA address. If OCR is unable to fully incorporate an explicit cause of action for intersectional discrimination along with the accompanying suite of remedies in the newly revised regulations, the matter should be allowed to continue to percolate in the courts.

Preventing Sex Discrimination

- Reinstate the 2016 Rule's definition of "on the basis of sex" in its entirety, including with respect to "termination of pregnancy"
- Add "Reproductive Health Decisions" to the definition of "on the basis of sex"
- Prohibit discrimination against people who have obtained or are seeking reproductive health care
- Restore and strengthen the definition of sex to explicitly include sexual orientation, gender identity, gender expression, gender transition, transgender status, sex stereotypes, and sex characteristics (including intersex traits)
- Restore and expand explicit nondiscrimination protections under all CMS rules
- Make clear Sec. 1557 protects LGBTQI+ patients in health care and coverage
- Clarify that Sec. 1557 prohibits all sex discrimination related to all forms of reproductive health care, including discrimination based on sexual orientation and gender identity

The Leadership Conference

PREVENTING SEX DISCRIMINATION: Reinstate the 2016 Rule's definition of "on the basis of sex" in its entirety, including with respect to "termination of pregnancy"

Although "termination of pregnancy" is a subgroup of "pregnancy," its inclusion in the 2016 Rule made explicit that Sec. 1557 both (1) reaches abortion care, and (2) provides protection against discrimination for people who have experienced or are seeking care for a miscarriage, ectopic pregnancy, or other pregnancy loss. Specifically, OCR must clarify in its new rulemaking and through sub-regulatory guidance and enforcement that inclusion of "pregnancy" and "termination of pregnancy" is properly understood to both:

- prohibit discrimination because a person previously had an abortion, miscarriage, or other pregnancy loss; and
- require the provision, coverage, or referral for abortion, care for pregnancy loss, or care for any related complications when refusing such care would constitute discrimination—*e.g.*, if the provider or payer otherwise offers comprehensive care or coverage.[5]

Restoring the 2016 Rule's inclusion of "termination of pregnancy" is necessary to be consistent with longstanding civil rights law

The 2016 rule correctly recognized that its definition of "on the basis of sex" was "based upon existing regulation and previous Federal agencies' and courts' interpretations." 81 Fed. Reg. 31,388. Sec. 1557 incorporates "the ground [of discrimination] prohibited under" Title IX, and the Department of Education's Title IX regulations prohibit discrimination related to "termination of pregnancy or recovery therefrom." 34 C.F.R. § 106.40(b)(1). Sec. 1557 therefore does too. Other federal civil rights laws that prohibit sex discrimination have been interpreted to prohibit discrimination related to termination of pregnancy, including with respect to abortion. For example, several court decisions make clear that Title VII's protection against discrimination on the basis of sex, including, "pregnancy . . . or related medical conditions" reach abortion.[6] Sec. 1557 prohibits discrimination on the bases set out in Title IX which includes a longstanding and consistent interpretation by federal agencies to reach this discrimination.

---

[5] OCR can simultaneously define sex discrimination broadly while recognizing statutory exemptions. Sec. 1557 contains one exemption—"except as otherwise provided for [under Title I of the ACA]." This language incorporates into Sec. 1557 specific provisions related to abortion contained in Section 1303 of the ACA. 42 U.S.C. § 18023. Among other provisions, Section 1303 incorporates into Sec. 1557 harmful federal laws that allow certain health care entities to refuse to provide abortion care. *See* 42 U.S.C. § 18023(c)(2). Critically, the existence of these laws does not preclude HHS from defining sex discrimination broadly to reach provision and coverage of abortion where those exemptions do not apply. Indeed, the 2016 rule properly recognized that discrimination "on the basis of sex" prohibits discrimination related to abortion notwithstanding Section 1303. *See* 81 Fed. Reg. 31,388.

[6] *See, e.g.*, *Doe v. C.A.R.S. Prot. Plus, Inc*., 527 F.3d 358, 364 (3d Cir.), order clarified, 543 F.3d 178 (3d Cir. 2008); *Turic v. Holland Hosp., Inc*., 85 F.3d 1211 (6th Cir. 1996).

No court decision precludes OCR from including "termination of pregnancy"

OCR is well within its delegated authority to reinstate the 2016 definition of "on the basis of sex," including "termination of pregnancy." The 2020 rule placed undue reliance on the flawed reasoning in *Franciscan Alliance* to conclude that Sec. 1557 incorporates abortion and religion exemptions from Title IX and does not protect individuals who are seeking abortion care or coverage. HHS repeatedly invoked this decision to justify deleting the definition of "on the basis of sex" and refusing to clarify protections related to "termination of pregnancy" and other reproductive health care ("RHC"). *E.g.*, 85 Fed. Reg. 37,192–93. Yet *Franciscan Alliance* is neither binding on HHS nor persuasive.

Because the judgment was limited to the 2016 rule, it does not constrain future rulemaking. In any event, the decision was wrong. Sec. 1557's text includes just one exemption—the phrase "except as otherwise provided in this title." The court erred by concluding that Sec. 1557 unambiguously incorporates Title IX's exemptions and giving no deference to HHS's contrary expert determination in 2016. 81 Fed. Reg. 31,380, 31,388. It was doubly erroneous for the court to vacate the entire phrase "termination of pregnancy," given that that term extends beyond provision and coverage of abortions. OCR can and must act to clarify that Sec. 1557 prohibits all forms of discrimination related to "termination of pregnancy."

The Leadership Conference

PREVENTING SEX DISCRIMINATION: Add "reproductive health decisions" to the definition of "on the basis of sex"

The 2020 rule also sowed confusion regarding whether Sec. 1557 prohibits discrimination against individuals who are seeking or who have obtained reproductive health care other than abortion, such as fertility treatments, contraception, or maternity care. 81 Fed. Reg. at 37,192–93. Adding "reproductive health decisions" to the definition of "on the basis of sex" is thus necessary to clarify that Sec. 1557 prohibits such discrimination, even though the broader term "pregnancy" encompasses these protections. This term will also provide additional clarity that Sec. 1557 prohibits discrimination against those who obtained or are seeking abortion care. Finally, this will further restore Sec. 1557's consistency with other civil rights statutes. Title VII, for example, not only prohibits discrimination related to abortion, it also encompasses discrimination related to other reproductive health care ("RHC") such as refusal to cover contraception,[7] and discrimination for undergoing fertility treatment.[8] Thus, to ensure the broadest possible protection against discrimination related to RHC, and to align Sec. 1557 with existing civil rights law, we urge HHS to add "reproductive health decisions" to "on the basis of sex" and to make these protections explicit in the new rule and through guidance and enforcement.

HHS has a compelling interest in including these terms in the definition

HHS has a compelling interest in strengthening protections for those who face discrimination related to their receipt or pursuit of RHC. Such care, including abortion, is time-sensitive, essential health care needed across race, sexual orientation and gender identity. Moreover, the ability to control one's reproductive life is a fundamental right enshrined in the U.S. Constitution that is critical to ensuring equal participation in the social and economic life of the country.[9] Nonetheless, RHC is under attack. States continue to pass medically unnecessary and harmful laws to restrict abortion access. Abortion providers, staff, and patients have experienced increased violence. The prior administration relentlessly attacked access to RHC, including contraception. The 2020 rule only worsened the situation by creating confusion about the protections against and remedies for discrimination related to RHC. By singling out RHC for adverse treatment, the 2020 rule stigmatized reproductive decision-making in a manner that perpetuates sex stereotypes and antiquated notions of women's role in society.[10] The 2020 rule thus simultaneously burdens individuals exercising a fundamental right and itself discriminates on the basis of sex. Accordingly, it must receive exacting scrutiny under the Constitution's guarantee of equal protection.[11] OCR thus has a compelling interest in reversing the damage from the 2020 rule and clarifying Sec. 1557's robust protections against discrimination related to RHC.

---

[7] *Erickson v. Bartell Drug Co*., 141 F. Supp. 2d 1266 (W.D. Wash. 2001).
[8] *See, e.g.*, *Hall v. Nalco Co*., 534 F.3d 644 (7th Cir. 2008), *Ciocca v. Heidrick & Struggles, Inc.*, No. CV 17-5222, 2018 WL 2298498 (E.D. Pa. May 21, 2018).
[9] *See Planned Parenthood v. Casey*, 505 U.S. 833, 856 (1992).
[10] *Nevada Dep't of Human Res. v. Hibbs*, 538 U.S. 721, 736 (2003).
[11] *See Skinner v. Okla. ex rel. Williamson*, 316 U.S. 535, 541 (1942); *United States v. Virginia*, 518 U.S. 515, 532 (1996).

The Leadership Conference

PREVENTING SEX DISCRIMINATION: Prohibit discrimination against people who have obtained or are seeking reproductive health care

Reproductive health care ("RHC") is critical to ensuring bodily autonomy. Every person has the right to make decisions about their reproductive life and choose if, when and how to become a parent. Access to respectful and nondiscriminatory contraception, abortion, fertility, and maternal health care is key to fulfilling this right, and a person may need any or all of these services in the course of their reproductive life. Accordingly, HHS must interpret Sec. 1557 to prohibit all discrimination related to pregnancy, including the pervasive discrimination experienced by people who have obtained or are seeking RHC. To do this, HHS must take the following actions:

- Promulgate new regulations implementing Sec. 1557 that:
  - Restore the 2016 rule's definition of "on the basis of sex" in its entirety, including reinstating "termination of pregnancy" in that definition (as discussed above);
  - Add "reproductive health decisions" to the definition to clarify that people are protected for all such decisions, including but not limited to having an abortion; and
- Clarify in the preamble, sub-regulatory guidance, and through enforcement that Sec. 1557 broadly protects all people who have obtained or are seeking RHC. This includes clarification that access to or coverage of RHC cannot be denied based on gender identity or sexual orientation, just as it cannot be denied based on any protected class.

The 2016 rule correctly defined "on the basis of sex" to provide robust nondiscrimination protections related to RHC. 45 C.F.R. § 92.4 (2016). Yet, the 2020 rule repealed this definition in its entirety and added exemptions that, taken together, gut protections for people seeking access to or coverage for abortion care.[12] The 2020 rule also sowed confusion as to what protections exist for people who have obtained or are seeking RHC beyond access to or coverage for abortion care. *See, e.g.*, 85 Fed. Reg. 37,192–93; 84 Fed. Reg. 27,870 n.159 (refusing to clarify scope of protections).

At the same time, one district court decision, *Franciscan Alliance v. Burwell*, improperly vacated the entirety of "termination of pregnancy" from the definition of "on the basis of sex," even though that case challenged that provision only to the extent it could require the provision or coverage of abortions. As a result, it created additional confusion about the scope of Sec. 1557's protections related to "termination of pregnancy," including for people who have experienced discrimination related to a miscarriage, or because they had an abortion in the past.

[12] *See Religious Sisters of Mercy v. Azar*, No. 3:16-CV-00386, 2021 WL 191009, at *12 (D.N.D. Jan. 19, 2021) (concluding that due to these regulatory changes "[a]s interpreted today, Sec. 1557 does not proscribe refusal to perform or insure abortions.").

Both the 2020 rule and *Franciscan Alliance* deviated from longstanding civil rights law that makes clear that pregnancy, including termination of pregnancy and other RHC, is protected by prohibitions against sex discrimination. HHS must take the actions proposed to undo the damage and clarify that Sec. 1557 provides robust protections related to RHC.

The Leadership Conference

PREVENTING SEX DISCRIMINATION: Restore and strengthen the definition of "on the basis of sex" under Sec. 1557 regarding sexual orientation, gender identity, gender expression, gender transition, transgender status, sex stereotypes, and sex characteristics (including intersex traits)

The 2016 Sec. 1557 rule correctly interpreted the ACA to prohibit all forms of sex discrimination, whether based on gender identity or expression, gender transition or transgender status, intersex traits or other sex characteristics, or sex stereotypes. That view was vindicated by the Supreme Court in *Bostock v. Clayton County*. The Justice Department concluded that given statutory language that is "sufficiently similar ... as to be considered interchangeable," *Bostock* applies fully to Title IX of the Education Amendments. HHS has now formally applied that view to Sec. 1557 as well. Federal courts since *Bostock* have done the same.[13] Nevertheless, in 2020 HHS rescinded all provisions recognizing that the Act prohibits anti-LGBTQI+ discrimination, and opined in the rule's preamble that it does not. Courts have already found that action to be, at best, in tension with *Bostock*.[14]

OCR should restore and strengthen the broad definition of "On the basis of sex." To provide the maximum clarity in accordance with current law, Part 92 should state that the Act prohibits discrimination based on: *sexual orientation*, *gender identity*, *gender expression*, *gender transition*, *transgender status*, *sex stereotypes*, and *sex characteristics (including intersex traits).*

- **Sex stereotypes**, **gender identity**, and **gender expression** were listed in the definition, or subsidiary definitions, in the 2016 rule.
- **Gender transition** was not listed in the 2016 definition, but was included in the rule's insurance provisions.
- **Sex characteristics (including intersex traits)** were partially addressed by rule language referencing "stereotypical...expectations" related to "body characteristics," and more expressly incorporated in the preamble. This term has also since been included in similar in proposed bills related to sex discrimination (e.g. Equality Act, Paycheck Fairness Act).

---

[13] Grimm v. Gloucester Cty. Sch. Bd., 972 F.3d 586 (4th Cir. 2020); Adams v. Sch. Bd. of St. Johns Cty., 968 F.3d 1286 (11th Cir. 2020); C.P. v. Blue Cross of Ill., No. 3:20CV06145 (W.D. Wash. May 5, 2021); Kearney v. W. Carol. Univ., No. 1:20CV00100, 2021 WL 1429472 (W.D.N.C. Feb. 22, 2021); Koenke v. St. Joseph's Univ., No. 19CV4731, 2021 WL 75778 (E.D. Pa. Jan. 8, 2021), *app. filed*, No. 21-1057 (Jan 12, 2021); Hecox v. Little, 479 F. Supp.3d 930 (D. Idaho 2020), *app. filed*, No. 20-35815 (Sep 17, 2020); Doe v. Univ. of Scranton, No. 3:19CV01486, 2020 WL 5993766 (M.D. Pa. Oct. 9, 2020); Maxon v. Fuller Theol. Seminary, No. 219CV09969, 2020 WL 6305460 (C.D. Cal. Oct. 7, 2020), *app. filed*, No. 20-56156 (Nov 04, 2020); *but see* Hennessy-Waller v. Snyder, No. 20CV00335, 2021 WL 1192842 (D. Ariz. Mar. 30, 2021), *app. filed*, No. 21-15668 (Apr 19, 2021) (dicta, without analysis: "Bostock does not apply to the ACA"). State courts have applied *Bostock* to Title IX and analogous state laws. Clark Cty. Sch. Dist. v. Bryan, 478 P.3d 344 (Nev. 2020); N.H. v. Anoka-Hennepin Sch. Dist. No. 11, 950 N.W.2d 553 (Minn. App. 2020).

[14] Whitman-Walker v. HHS, 485 F. Supp.3d 1 (D.D.C. 2020), *app. filed*, No. 20-5331 (Nov. 9, 2020); Washington v. HHS, 482 F. Supp.3d 1104 (W.D. Wash. 2020); Walker v. Azar, 480 F.Supp.3d 417 (E.D.N.Y. 2020), *app. filed*, No. 20-3580 (Oct. 16, 2020); Religious Sisters of Mercy v. Azar, — F.Supp.3d —, 2021 WL 191009 (D.N.D. 2021), *app. filed*, No. 21-1890 (Apr 21, 2021).

- While HHS chose "not to resolve" the issue in 2016, the question of **sexual orientation** has been squarely resolved by *Bostock*.[15]
- **Transgender status** was not included in the 2016 regulatory language, but was recognized as being included by the preamble.

While the *Bostock* Court and principle dissent both refer to discrimination based on *gender identity* and *transgender status* interchangeably, the prior Administration and others have nevertheless sought to press distinctions between the two concepts in order to justify discriminatory actions. It is therefore important to remove all doubt by codifying both terms.

[15] *Bostock* uses "sexual orientation" and "being homosexual" (*sic*) interchangeably. 140 S. Ct. 1731, *passim* (2020).

PREVENTING SEX DISCRIMINATION: Restore and expand explicit nondiscrimination protections under all CMS rules

HHS noted in 2016 that the Centers for Medicare and Medicaid Services (CMS) had adopted several rules under other statutory authorities prohibiting sexual orientation and gender identity discrimination. With little explanation, the 2020 rule rescinded portions of these and other CMS rules, though they were unrelated to Sec. 1557 and in some cases to the ACA. Whether via the same or concurrent rulemaking, HHS should add inclusive nondiscrimination language to CMS rules under the ACA, Medicaid, and Medicare. These protections should be spelled out not only where they were removed in 2020 but in other key rules, including conditions of participation for hospitals (as planned in 2016) and other providers. At a minimum, CMS rules should codify protections based on *sex (including sex characteristics, sexual orientation, and gender identity*), and cite the Sec. 1557 rule. CMS should also issue guidance to state Medicaid directors, including on transgender exclusions.

PREVENTING SEX DISCRIMINATION: Make clear Sec. 1557 protects LGBTQI+ patients in health care and coverage

Experience shows codifying these broad categories alone is insufficient. HHS must make clear through both regulatory and preamble language, sub-regulatory guidance, technical assistance, and enforcement efforts the wide variety of situations in which sex-based discrimination can occur. For example, the rule should make clear that insurance plans may not employ claims practices or benefit designs that deny, limit, exclude, or restrict coverage or otherwise discriminate against transgender people. HHS must also codify the principle, stated in the 2016 preamble, that sex-specific programs or restrictions must be substantially related to important health-related or scientific objectives.

HHS must further flesh out through the preamble, FAQs, and other guidance—both from OCR and other Operating Divisions, including CMS—how these principles apply to particular examples of sex-based claims practices, insurance exclusions, harassment, or other denials of care or coverage—particularly with regard to transgender and intersex people. Guidance should also address LGBTQI+ specific concerns related to health information privacy protections. OCR should prioritize investigating and resolving complaints of anti-LGBTQI+ discrimination, publicizing key case resolutions whenever possible, and field outreach to state and local community organizations.

The Leadership Conference

PREVENTING SEX DISCRIMINATION: Clarify that Sec. 1557 prohibits all sex discrimination related to all forms of reproductive health care, including discrimination based on sexual orientation and gender identity

As set forth above, Sec. 1557's protections against discrimination on the basis of sex, including on the basis of pregnancy and reproductive health decisions, include robust protections against discrimination for people who are seeking reproductive health services including abortion care, infertility care, contraception, and maternity care. At the same time, Sec. 1557's prohibition on sex discrimination precludes covered entities from denying access to or coverage of reproductive health services to a person due to their gender identity or sexual orientation. Thus, for example, it is a violation of Sec. 1557 to limit access to and coverage of reproductive health services such as maternity care and contraceptive services to "female" beneficiaries.[16] (*See, e.g.,* the Maryland, Alaska, Wyoming, and Rhode Island EHB benchmark plans, and formularies that limit contraceptive coverage to "females"). And, it is discrimination to limit access to or coverage of infertility treatments for same-sex couples or single people. HHS must clarify these protections through its new regulation, guidance, and enforcement.

One critical application requiring clarification is that Sec. 1557 prohibits discrimination in coverage of and access to infertility treatment

Access to infertility diagnosis, treatment, and services including assisted reproductive technology ("ART"), should be available to patients without discrimination based on their sex, including their gender identity, sexual orientation, or sex characteristics (including intersex traits).

Sex discrimination is common when it comes to accessing infertility care. This discrimination can take many forms, including:

- a refusal by insurance companies to cover certain types of care that are traditionally used by women (e.g., IVF);
- an insurance requirement that patients provide proof of clinical infertility, which excludes same-sex couples and single individuals who experience social infertility;
- public policies that require a patient to provide their own and their spouse's genetic material for insurance coverage eligibility, thus excluding same-sex couples, single people, and anyone else who would require donated gamete(s) to reproduce; and
- discrimination against patients by providers or insurers based on the patient's sexual orientation or gender identity.

Definitions of infertility generally refer narrowly to clinical infertility and fail to include social infertility, which is the inability to reproduce via sexual intercourse due to social factors such as a person's lack of partner or because of a person's sexual orientation. The Centers for Disease Control and Prevention, for

[16] Sec. 1557 does not preempt the women's preventive services requirement of the ACA, 42 U.S.C. § 300gg–13(a)(4), which requires most health plans to cover certain preventive services, including contraceptives and well-woman visits, for "women" without cost-sharing. Accordingly, people who do not identify as women may not be eligible for these services without cost-sharing. However, Sec. 1557 *does* require plans to cover these services without respect to sex, including gender identity, even if cost-sharing may be required.

example, defines infertility as the inability to become pregnant after six months or one year of unprotected sexual intercourse. Public and private insurers often discriminate against patients based on sex by requiring evidence of clinical infertility before providing IVF coverage. This requires patients in opposite-sex relationships to demonstrate that they have unsuccessfully tried to become pregnant by having unprotected sex for six months or a year, depending on their age. To receive the same clinical infertility diagnosis, same-sex couples and single individuals are often required to undergo six to twelve unsuccessful cycles of intrauterine insemination (IUI) before becoming eligible for IVF coverage. While less expensive than IVF, a single cycle of IUI can cost between $150 and $4,000 depending on whether it includes hormone treatment and medical monitoring.
Some states that require insurance providers to provide IVF coverage also require that patients use their spouse's sperm to fertilize their eggs to be eligible for IVF insurance coverage.[17] Texas, which only requires insurance providers to *offer* IVF insurance, also includes this same eligibility requirement.[18]

Health care providers have also denied infertility care based on religious objections to providing care to LGBTQ+ individuals. In *Benitez v. North Coast Women's Care Medical Group*, Guadalupe Benitez underwent a year of invasive, costly treatments by the only in-network provider only to then be denied the treatment she needed based on the provider's religious objections to performing the procedure because Benitez identified as a lesbian, forcing her to pay out-of-pocket at another clinic. Comments on the 2020 rule implementing Sec. 1557 raised *Benitez* as a "real-world example of discrimination" in access to infertility treatments on the basis of sex, which the prior administration ignored. 85 Fed. Reg. 37192 (2020). It is thus critical that HHS provide clarity that Sec. 1557 prohibits such discrimination.

Preventing Disability Discrimination

- Clarify that disability discrimination under the ACA does not incorporate the limitations from other statutes that were interpreted to allow the very discrimination the ACA prohibits and that Section 1557 prohibits discrimination in benefit design

- Explicitly require compliance with the revised Medical Diagnostic Equipment Accessibility Standards finalized in 2021 by the National Council on Disability, and develop applicable scoping for the application and enforcement of said standards

[17] *E.g.,* Haw. Rev. Stat. § 431:10A-116.5 (1987); Ark. Code R. 054.00.1–5(B) (1991).
[18] Tex. Ins. Code Ann. § 1366.005.

DISABILITY DISCRIMINATION: Clarify that disability discrimination under the ACA does not incorporate the limitations from other statutes that were interpreted to allow the very discrimination the ACA prohibits, and that Section 1557 prohibits discrimination in benefit design

Prior to the ACA, private health insurers could frequently discriminate in the administration and design of health care benefit plans with few federal legal consequence. The business model of health care incentivized insurers to "lemon drop and cherry pick" by denying coverage to individuals with high health needs or who would otherwise be costly to the plan. The ACA included changes to insurance specific to many of the common methods of disability discrimination in insurance that had been allowable under existing protections against disability discrimination, including denying enrollment, limiting benefits, and imposing high premiums and special cost-sharing on enrollees with disabilities and pre-existing conditions

As an integral component of these reforms, Congress included Sec. 1557, which deliberately extended civil rights protections to the private health insurance context. While the ACA addressed many of the discriminatory coverage provisions previously allowed under the ADA and Section 504, Sec. 1557 explicitly created a right to enforce non-discrimination in health care under the ACA's vision of health care. It also clearly did not bring in any of the exemptions from those other laws so that the sea change in non-discrimination in health care under the ACA would be clear.

In its 2016 regulations implementing Sec. 1557, HHS prohibited the administration of discriminatory health insurance plans, including discrimination in benefit design. Yet the final rule did not define the term "benefit design," nor did it describe what would constitute disability-based discrimination in benefit design outside of a footnote and identifying factors OCR would use when determining whether a benefit design is discriminatory. These factors included whether a neutral principle or rule was used and evaluating the reasons for any difference in coverage. However, as the U.S. Supreme Court has recognized, a neutral rule or principle may still run afoul of the ADA.[19] A critical requirement of non-discrimination on the basis of disability is that a reasonable accommodation or modification may be required so that the individual with a disability may enjoy equal access to the program or service at issue, even if that accommodation may provide preference or treat that individual differently—that is the point of such provisions.

The application of Sec. 1557 to the benefit design of health care coverage is one of the most significant protections of the law. The decisions of states and private insurers concerning how healthcare benefits are designed, including decisions about what services are covered and how provider networks are structured, may discriminate based on disability or other protected factors in a variety of important ways. For example, adverse tiering of prescription drugs, coverage exclusions of services for certain diagnoses (e.g., hearing loss or autism), narrow provider networks that exclude certain specialists, arbitrary or unreasonable utilization management, coverage distinctions not justified by actuarial data or that relies on discriminatory data, and coercive wellness programs that prevent participation by persons with disabilities.

---

[19] *See U.S. Airways v. Barnett*, 595 U.S. 391, 397-98 (2002).

Utilization management has been shown to be especially pernicious in its discrimination, for example in the denials of behavioral care exposed in mental health parity and coverage cases. It is critical that people be able to enforce benefit design protections so that plans cannot bury discriminatory measures through less obvious mechanisms. The history of trying to end discrimination between medical/surgical benefits and behavioral health benefits through mental health parity has demonstrated that insurers will adjust and evade non-discrimination provisions, burying discriminatory standards and treatment limitations in more closely held standards. Sec. 1557 regulations must be clear now, not years down the road, that discriminatory benefit design is both not allowed and is inclusive of many plan mechanisms that may limit access for people with disabilities.

Of particular note is the preference in insurance plans for addressing acute needs rather than chronic ones, and for relying on institutionalization, which may occur for financial reasons as often insurance coverage in institutions may end after a short-period and the person is transferred to Medicaid coverage. As a non-discrimination provision protecting people with disabilities, Sec. 1557 must also protect against discrimination that isolates and segregates people with disabilities from the community.[20] Benefit design decisions can result in the needless segregation of people with disabilities, including by depriving them of the opportunity to receive needed services in integrated settings and offering those services only in segregated or less integrated settings.[21] HHS should include protections in Sec. 1557 regulations that prohibit covered entities from taking actions that result in the segregation of people with disabilities. Specifically:

- OCR should prohibit insurers from covering a service (such as personal care or an item of durable medical equipment) for individuals in institutional settings but not covering the same service for individuals living in their own homes or other community settings. Similarly, services such as personal care should not be covered in greater amounts for individuals in segregated settings.

- OCR should prohibit states from making EHB coverage decisions that result in people with disabilities being served in segregated settings when community-based settings meet their needs. For example, failure to cover services essential for people with disabilities to live in their community based settings would violate the non-discrimination provision if it results in individuals being served in segregated settings such as hospitals, nursing facilities, ICF/DDs or board and care homes, and covering the services to support them in integrated settings would not be unduly expensive.

- OCR should prohibit states from setting reimbursement rates for Essential Health Benefits in a way that results in individuals with disabilities being served in

[20] *Olmstead v. L.C.*, 527 U.S. 581 (1999).
[21] *See, e.g., Steimel v. Wernert,* 823 F.3d 902 (7th Cir. 2016).

segregated settings rather than appropriate community-based settings. For example, states cannot set reimbursement rates for services (including medications) in segregated settings (such as hospitals) higher than rates for similar services in integrated settings.

Cases and complaints filed using Sec. 1557 have shown the breadth of the need for benefit design to clearly include disability discrimination against the full array of covered entities. Accordingly, it is critical for OCR to reinstate the language from the 2016 final rule specifying that Sec.1557 protects against discrimination in benefit design and to add clear examples of discriminatory plan benefit design.

The Leadership Conference

DISABILITY DISCRIMINATION: Explicitly require compliance with the revised Medical Diagnostic Equipment Accessibility Standards finalized in 2021 by the National Council on Disability, and develop applicable scoping for the application and enforcement of said standards

Individuals with physical disabilities face significant physical barriers that impede their access to health care, resulting in unmet health care needs. Among the most significant barriers is the absence of accessible medical diagnostic equipment (MDE). In a recent study by the National Council on Disability, people with disabilities reported their healthcare professionals often created ad hoc "accommodations" due to inaccessible MDE. This included healthcare professionals who skipped parts of an examination or refused to treat a patient due to the facility's inaccessibility. Staff are also unfamiliar with the proper use of accessible MDE even when it is available.

While OCR has administrative complaint mechanisms related to inaccessible MDE, this has not resulted in widespread change to increase the availability of accessible MDE in health care facilities. As recently as May 20, 2021, the National Council on Disability recommended HHS adopt the January 9, 2017 accessible medical diagnostic equipment standards (MDE Standards) developed by the U.S. Access Board. In the 2016 final rule, OCR did not include accessibility standards for medical diagnostic equipment because the U.S Access Board was developing standards. OCR deferred proposing standards while recognizing that use of medical diagnostic equipment did fall under the purview of Sec. 1557's general prohibition of discrimination on the basis of disability.

Federal regulations requiring availability of accessible medical and diagnostic equipment in health care facilities are critical to preventing discriminatory health care against people with mobility disabilities and reducing the economic costs of treating chronic illnesses resulting from preventable illnesses. Without accessible medical equipment, people with mobility disabilities will remain less likely to receive recommended preventive health care services—like cervical cancer screening; colorectal cancer screening; obesity screening; and breast cancer screening. Moreover, the absence of accessible medical equipment perpetuates health care disparities between people with physical disabilities and their nondisabled counterparts.

The types of accessible medical equipment should include:

- height adjustable examination tables;
- accessible mammography equipment;
- accessible weight scales; and
- lift equipment to facilitate transfers.

Now is the time to give the MDE Standards the force of law. OCR should include specific language formally adopting the 2017 MDE standards, establishing scoping requirements and requiring health care providers, subject to their jurisdiction under Sec. 1557 (as well the ADA and Sec. 504) to acquire accessible medical diagnostic equipment that complies with the MDE Standards. OCR should also provide technical assistance on accessible MDE.

The Leadership Conference

Preventing Discrimination on the Basis of Language

- Restore requirements for in-language taglines and determine how to define significant documents
- Require translation of vital documents
- Require standards for foreign language video remote interpreting
- Reinstate the "two factor" test
- Require creation of an "access plan" encompassing both language access and services for people with disabilities

The Leadership Conference

LANGUAGE ACCESS: Restore requirements for in-language taglines and determine how to define "significant" documents

We recommend that HHS return to the 2016 final rule's requirement that covered entities include taglines in the top 15 languages, tailored for each state, for significant publications, with some needed clarifications. Taglines provide a minimal way for covered entities to inform limited English proficient and other populations of how to access in-language services.

HHS should work with civil rights advocates and covered entities to determine how to define what "significant" documents are in a way that ensures LEP individuals receive the taglines when publications are critical for accessing a program or benefit, or contain critical legal information. This definition should ensure LEP individuals receive the taglines when publications are relevant for accessing a program or benefit, or contain legal information. Further, the definition of significant documents should not be over-interpreted by covered entities in a way that leads to accompaniment on publications that may not be relevant to accessing a program or benefit, or do not contain legal information.

HHS should also work to improve the usability and accessibility of taglines, requiring that they are written at the 4th grade reading level, machine readable and in large print. Taglines should be required to be placed in visible locations at the front of a document or header of a website rather than at the end of a multi-page document or bottom of a screen. While taglines are important for LEP individuals, having a low-literacy, large print tagline in English at the front of documents will also assist individuals with cognitive disabilities who may have difficulty understanding long or complex documents who then can identify other methods of accessing assistance.

Content wise, taglines should make some reference as to the nature of the document rather than generic language, for example "This Document is an Important Notice about Renewing Your Health Insurance". Covered entities should be encouraged to user test their taglines to ensure they meet these standards for LEP populations they are serving.
In addition to adopting a standard of requiring taglines in the top 15 languages in each state, HHS should not allow entities that serve more than one state to aggregate the top 15 languages across their service area, rather than specific states. For entities that serve a smaller metropolitan area within a state, defined by an area with a certain percent of LEP persons, they should provide taglines in the top 15 languages in that area.

The Leadership Conference

LANGUAGE ACCESS: Require translation of vital documents

HHS should increase standards for when translated, culturally competent documents are made available to limited English populations. They should especially be available quickly if needed to respond to a time sensitive matter, such as potential termination from a program or to provide informed consent for medical procedures.

Often, limited English proficient populations rely on under-resourced community organizations for help in translating and understanding critical documents, sometimes receiving assistance too late. Covered entities should be responsible for ensuring that language is not a barrier to understanding vital documents. HHS should require each of its divisions (e.g. CMS, HRSA, etc.) to identify a minimum list of vital documents that would be subject to this requirement.

LANGUAGE ACCESS: Require standards for foreign language video remote interpreting

HHS should restore the 2016 final rule's standards for remote foreign language interpreting services to include video interpreting. The updated standards should require that the video remote interpreting services be able to meet these standards for those who are limited English proficient as well as those who are deaf, hard-of-hearing, and/or cannot rely on speech to be heard and understood.

The Leadership Conference

LANGUAGE ACCESS: Reinstate the "two-factor" test

HHS's 2016 final Sec. 1557 rule articulated a two-factor test to determine compliance with providing meaningful access to individuals with limited English proficiency. HHS determined that including multiple illustrative factors – such as its prior four-factor test from its 2013 LEP Guidance – may create the erroneous impression that OCR will not consider other relevant factors. HHS also rejected using the four-factor test in evaluating compliance with Sec. 1557 because it failed to adequately implement Sec. 1557's protections against discrimination on the basis of national origin.

We support HHS's reasoning and recommend HHS return to the 2016 final rule's two-factor test. While all covered entities are required to provide meaningful access, they should and do have flexibility under Sec. 1557 on *how* to provide such language assistance. As HHS has previously reiterated from the Department of Justice's LEP Guidance, Title VI policies advance the longstanding principle that "federally assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English." We also suggest that HHS revert to the 2016 final rule's inclusion of both individuals served and likely to be encountered for both limited English proficient individuals and people with disabilities.

The Leadership Conference

LANGUAGE ACCESS: Require creation of an "access plan" encompassing both language access and services for people with disabilities

In addition, we recommend that HHS add requirements regarding communication with and accessibility for people with disabilities. We believe an entity should not only plan for the provision of language access but also address communication and access more broadly though an "access plan". If an entity fails to do so, OCR should consider the lack of an "access plan" as part of its evaluation of compliance.
HHS has long recognized the benefit of creating a language access plan. HHS' 2003 LEP Guidance included elements of an effective language access plan. And as noted in 2016 Sec. 1557 NPRM's preamble, many organizations already develop such plans based on the model described in HHS LEP Guidance. Doing so ensures that covered entities understand the scope of the populations they serve, the prevalence of specific language groups in their service areas, the likelihood of those language groups coming in contact with or eligible to be served by the program, activity or service, the nature and importance of the communications provided and the cost and resources available. Depending on an entity's size and scope, advance planning need not be exhaustive but is used to balance meaningful access with the obligations on the entity. The size and scope of the plan may vary depending on whether the covered entity is a small provider or a larger entity. OMH has also developed a reference guide for developing language access plans. Further, OCR can better monitor compliance of entities that have a language access plan (or develop one in response to a complaint).

Our experience is that entities are in a better position to meet their obligations to provide language assistance services in a timely manner when those entities identify, in advance, the types and levels of services available in each of the contexts in which the covered entity encounters individuals who are LEP. It is important to emphasize that such a plan should not be limited to servicing LEP populations but also people with disabilities.

OCR should go beyond recommending a language access plan by recommending covered entities develop a broader "access plan." This should include, for example, how the entity will provide sign language interpreters, large print/Braille documents or audio/video formats of materials, auxiliary aids and services for effective communication, and a range of other communication assistance. For the same reason that entities have been encouraged to identify their plans for providing language access in advance, they will likely be better prepared to meet the needs of individuals with disabilities by planning how to provide communication assistance and ensure accessibility. As one example, HHS has developed a checklist "Ensuring Language Access and Effective Communication During Response and Recovery: A Checklist for Emergency Responders and many of the issues included would be relevant for a broader access plan for covered entities.

In addition to communication issues, covered entities should plan to ensure accessibility for individuals with physical and/or behavioral health disabilities. This should include compliance with the Medical Diagnostic Equipment Accessibility Standards that were finalized by the Access Board in 2016. Yet it goes beyond physical accessibility.

We recommend OCR develop and include a "model access plan", and explain how covered entities should develop one, in its Sec. 1557 rule, similar to the language access plan included in its 2013 LEP Guidance.

For preventing discrimination on the basis of language and disability, as well as the intersectional nature of both, OCR should expect covered entities to develop a broader access plan and ensure entities consider those likely to be served.

Preventing Age Discrimination

- Revisit requirements regarding exhaustion of administrative remedies under the Age Discrimination Act of 1975

The Leadership Conference

PREVENTING AGE DISCRIMINATION*:* Revisit requirements regarding exhaustion of administrative remedies under the Age Discrimination Act of 1975

We encourage OCR to revisit the administrative exhaustion requirement for claims under the Age Discrimination Act before a discriminated individual can file an enforcement action in federal district court to challenge the discriminatory act or policy. Such requirement runs counter to the intent of Sec. 1557 by posing an additional barrier for older adults and introduces unnecessary complications for claims of intersectional discrimination on the basis of age and other classes protected under Sec. 1557.

The 2016 Rule implementing Sec.1557 retained an administrative exhaustion requirement for age discrimination claims, but at the same time, eliminated such a requirement for all other claims. 81 Fed. Reg. at 31441 ("Mediation and exhaustion of administrative remedies will still be required for age discrimination allegations in complaints, but not for allegations of other covered types of discrimination."). Although OCR contended that such an approach was consistent with OCR's existing procedures for complaints at the time, this runs counter to the intent and purpose of Sec. 1557 to remedy discrimination in healthcare. By imposing an additional procedural hurdle for victims of age discrimination, this process complicates how a victim would seek redress, possibly discouraging more individuals to fully pursue discrimination claims and leaving more discrimination — specifically on the basis of age — unaddressed. Furthermore, there is little reason to believe that OCR is better equipped than federal district courts to hear and analyze claims of discrimination under the Age Discrimination Act of 1975 as an initial matter and raises the question of whether the exhaustion requirement is the most effective use of OCR's limited enforcement resources.

In addition to running counter to the purpose of the statute, the exhaustion requirement also is inconsistent with caselaw and creates inconsistencies depending on the type of discrimination, leading to complications when addressing intersectional discrimination.

Several district courts, following *Rumble v. Fairview Health Servs.*, have interpreted Sec. 1557 to make clear that Congress intended to create a new, universal standard in addressing discrimination in healthcare. Keeping the procedural requirements for one covered basis of discrimination but not another results in the incoherency and inconsistency that the *Rumble* court warned about. In particular, it presents unnecessarily complicated issues when addressing intersectional discrimination for claims involving age and at least one other covered basis. Take, for example, an older adult of color seeking to challenge a healthcare entity's care rationing policies that discriminate against him because of his lower life expectancy as a man of color with certain chronic conditions and with the use of arbitrary age cut-offs. Alternatively, an older transgender woman seeking services from an adult day center that refuses to use she/her/hers pronouns is discriminating on the basis of her gender identity. Under the exhaustion requirement, it is unclear whether these individuals must first file a complaint with OCR or whether their discrimination claims can proceed directly to federal district court.

For these reasons, we encourage OCR to revisit and eliminate the administrative exhaustion requirement. Doing so will allow individuals who have been discriminated against on the basis of their age by health programs and activities to more fully challenge the discrimination and better fulfill the purpose of Sec. 1557.

The Leadership Conference

Application / Covered Entities / Religious Exemptions

- Expand application of Sec. 1557 to all health insurers, third party administrators, short term limited duration plans
- Affirm 1557 applicability to all federal health programs and activities (and not just those established under ACA Title I)
- Eliminate the exemption of Medicare Part B providers (as well as from Title VI and Section 504)
- Require that all subcontractors of covered entities are subject to Sec. 1557
- Apply nondiscrimination on the basis of association to providers and caregivers
- Expand Sec. 1557 implementation and compliance procedures to all federal fund recipients, not merely those with 15 or more employees
- Expand application of Sec. 1557 to employees of covered entities
- Apply HHS' rule to all federal health programs and activities or coordinating with DOJ on a "common rule" applicable to all federal agencies, programs and activities covered by Sec. 1557
- Do not incorporate exemptions in Sec. 1557 beyond those expressly enumerated in the ACA
- Refrain from incorporating Title IX exemptions and promulgate new regulations irrespective of the Texas federal district court opinions in *Franciscan Alliance* which does not preclude new Sec. 1557 rulemaking
- Do not incorporate the religious and abortion provision and funding exemptions from Title IX into Sec. 1557 because they are unnecessary and would expand already harmful denials of care
- Prohibit religious and abortion exemptions that result in denials and delays in providing health care to individuals and discourage individuals from seeking necessary care, with serious and sometimes life threatening results
- Prohibit health care professionals from opting out of providing medically necessary services which disregards evidence-based standards of care
- Prohibit religious and moral exemptions that would harm any third party and are barred by the Establishment Clause of the First Amendment

The Leadership Conference

APPLICATION/COVERED ENTITIES: Expand application of Sec. 1557 to all health insurers, third party administrators, short term limited duration plans

In the 2016 Final Rule, HHS recognized that Sec. 1557's civil rights protections are inexorably linked to broader ACA coverage requirements and other protections: "a fundamental purpose of the ACA is to ensure that health services are available broadly on a nondiscriminatory basis to individuals throughout the country." 81 Fed. Reg. 31379. This interpretation is consistent with the Supreme Court's recognition of the broader purpose of the ACA to "expand insurance coverage. . . . [and] ensure that anyone can buy insurance."[22]

However, the Trump Administration sought to drastically limit Sec. 1557's applicability by exempting most health insurers. The Trump administration argued that health insurance is not health care, contrary to the design, intent, and plain language of the ACA and Sec. 1557, which applies to "*any* health program or activity." HHS should affirm that health insurance is within the scope of health care, and that insurers receiving Federal Financial Assistance ("FFA") are subject to Sec. 1557.

In the 2016 Final Rule, HHS recognized that Sec. 1557 applies to all of the operations of entities "principally engaged" in health care, such as health plans offered by issuers outside the ACA exchanges. HHS should reinstate this provision and expand upon it, consistent with Title IX. As amended by the Civil Rights Restoration Act, Title IX establishes that a recipient of FFA need not be principally engaged in the business of providing education for an education program or activity it operates to be covered by Title IX.[23] The same principle should apply to Sec. 1557. Sec. 1557 should apply to the health programs and activities of an entity if any part of that entity receives FFA. For example, an employer that is not principally engaged in the business of providing health care must nonetheless comply with Sec. 1557 in its self-insured health plan, and other health programs or activities it operates, if it receives FFA. Similarly, a health insurance-like product offered by an entity not principally engaged in the business of health care, would be subject to Sec. 1557 if any part of that entity receives FFA. Broad applicability of Sec. 1557 is consistent with other civil rights laws which hold that federal tax dollars should not fund, either directly or indirectly, discriminatory practices.

OCR should further clarify that Sec. 1557 extends to all lines of an insurer's business, including non-major medical products such as short-term limited duration insurance. These products are typically marketed, often misleadingly and fraudulently, as an alternative to comprehensive coverage but have significant gaps that lead to high out-of-pocket costs and little financial protection for consumers. One major finding from a year-long investigation by the House of Representatives' Energy and Commerce Committee into the practices of insurers and brokers that offer short-term limited duration insurance is that these products discriminate against women by denying basic medical services such as pap smears,

---

[22] *King v. Burwell*, 135 S. Ct. 2480, 2493 (2015).

[23] See, *e.g.*, 20 U.S.C. §1687(3)(A)(i) & (ii); see also *Jeldness v. Pearce*, 30 F.3d 1220, 1225–26 (9th Cir. 1994) (holding that state prison, a non-educational entity that received Federal Financial Assistance, was subject to Title IX with respect to the education programs it operated.

maternity, and newborn care. The Committee found that many of the plans' exclusions appear designed to avoid enrolling women of child-bearing age and that all of the reviewed plans discriminated against women through gender rating, coverage exclusions, and other plan limitations. These products — which are medically underwritten and include significant benefit gaps — discriminate on the basis of age, sex, and disability. OCR should clarify that short-term limited duration insurance is subject to Sec. 1557 when offered by entities that receive FFA.

Sec. 1557 protections apply broadly to activities taken by covered entities in their role as third party administrators ("TPA"). All covered entities are barred from providing assistance to an entity, program or activity that discriminates on the basis of race, color, national origin, sex, age, or disability.

Yet, studies have shown that TPAs often administer plans that discriminate on prohibited bases under Sec. 1557. A TPA that administers a discriminatory plan should be liable for discrimination. This is not an unusual concept. For example, if an employer were to hire a search firm and in the description of the position said to exclude all women, minorities, and persons with disabilities, the search firm which followed that direction would be liable for discrimination. Likewise, a TPA that administers a discriminatory plan or who applies the plan terms in a discriminatory manner should be liable for that discrimination.

The Leadership Conference

APPLICATION/COVERED ENTITIES: Affirm Sec. 1557 applicability to all federal health programs and activities (and not just those established under ACA Title I)

The plain language of Sec. 1557, as well as the 2016 Final Rule, establishes that any health "program or activity" administered by an executive agency is subject to the law's provisions.[24] However, the 2020 Final Rule sought to exempt from Sec. 1557 most federal health programs and agencies administering those programs. OCR imagined that Congress sought to limit application of Sec. 1557 only to federal health programs or activities created under Title I of the ACA (*e.g.*, exchanges and Qualified Health Plans). This theory stands contrary to the statutory text, design, and intent of Sec. 1557 and the ACA. If Congress had intended to limit Sec. 1557 only to those entities created under Title I, it would not have included the clause pertaining to executive agencies.[25]

This interpretation has led to a bizarre situation whereby recipients of Federal Financial Assistance ("FFA") are subject to Sec. 1557, but the programs themselves, and the agencies administering them, are exempt. For example, state Medicaid programs are subject to Sec. 1557 as recipients of FFA, but the Centers for Medicare & Medicaid Services (CMS), which administers these programs, are exempt from Sec. 1557 under the 2020 Final Rule. Moreover, the CMS agency chiefly responsible for administering the ACA's Title I, the Center for Consumer Information and Insurance Oversight (CCIIO), would not be subject to Sec. 1557 under the Trump Administration's rule because it was not established by Title I (even though the entities it regulates — marketplaces and qualified health plans — were established under Title I).

Such an interpretation is inconsistent with the plain meaning of Sec. 1557. HHS should reverse the Trump Administration's changes which exempt most federal agencies and programs from Sec. 1557's protections. In addition, HHS should take steps to ensure compliance among federal health programs and activities administered by other federal agencies, such as the Office of Personnel Management and the Veterans Administration (see discussion on a "common rule" below).

---

[24] 42 U.S.C. § 18116 (a).

[25] *See*, *e.g.*, *Colautti v. Franklin*, 439 U.S. 379, 392 (1979) ("Appellants' argument . . . would make either the first or the second condition redundant or largely superfluous, in violation of the elementary canon of construction that a statute should be interpreted so as not to render one part inoperative.").

The Leadership Conference

APPLICATION/COVERED ENTITIES: Eliminate the exemption of Medicare Part B providers (as well as from Title VI and Section 504)

We recommend rescinding the exclusions of Medicare Part B providers by amending the definition of Federal Financial Assistance ("FFA"). 45 C.F.R. § 92.4 The relationship of Part B providers to HHS cannot rationally be distinguished from that of other providers who are treated as recipients of FFA, and this exclusion perpetuates the systemic racism that underlies the exclusion and is inconsistent with the plain language and purpose of the Sec. 1557 statute.

After the Civil Rights Act of 1964 was enacted, many white physicians did not want Black patients in their waiting rooms. In response, the agency crafted an exclusion, determining that Medicare Part B did not constitute FFA because the reimbursement was directly paid to a Medicare beneficiary and limited to 80 percent of the cost. A review of prior HHS documents discussing the agency's rationale for this exclusion shows that the agency's historical enforcement posture was based on two justifications: that providers' relationship with HHS fit into the "contract of insurance" exclusion found in Title VI and Title IX, and that Part B "is basically a program of payments to direct beneficiaries." (*See e.g.,* discussion at 45 C.F.R., Appendix A to Part 84.) However, as the U.S. Commission on Civil Rights concluded in 1980, Medicare Part B payments are clearly Federal Financial Assistance and should not be excluded from Title VI as either contracts of insurance or by reason of the method of their payment. Additionally, Part B payments are no longer directly made to recipients but to providers, further undercutting HHS' original (flawed) rationale.

First, the statutory language of Sec. 1557 explicitly *includes* "contracts of insurance" within the definition of FFA, demonstrating that Congress intended to bring contractual insurance payments such as Medicare Part B payments within the scope of Sec. 1557. Second, HHS's assertion that Part B "is basically a program of payments to direct beneficiaries" is unjustified when considering how the Medicare program operates and when comparing how similarly the agency deals with Part A providers, who have always been considered to be recipients of Federal Financial Assistance. Both Part A and Part B providers are required to enroll in Medicare, and have their claims processed by Medicare Administrative Contractors (MACs). Both Part A and Part B providers can appeal Medicare coverage determinations — they do not have to rely on the beneficiary to initiate an appeal. Like Part A providers, Part B providers must certify that they will abide by all Medicare laws, regulations and program instructions applying to them, including limits on the amounts that they charge Medicare enrollees and balance billing prohibitions when serving Qualified Medicare Beneficiaries (QMBs).

The notion that these enrolled providers, subject to multiple conditions for payment and multiple detailed requirements imposed by statute, regulation and sub-regulatory guidance, are merely getting payments passed on by beneficiaries is a fiction that is both rooted in and perpetuating systemic racism. HHS's decision to incorporate this fiction in the 2016 regulations also severely impinges on the clear intent of Sec. 1557, which is to extend and strengthen civil rights protections to health care. Part B providers—physicians, therapists, home health service providers, durable medical equipment suppliers, etc.—are

exactly the providers with whom Medicare beneficiaries interact most frequently. Those interactions are the ones where anti-discrimination protections, language access and disability access matter most and have the most direct impact on health outcomes. Moreover, the Part B exclusion creates confusion and uncertainty. We cannot imagine how a Medicare enrollee who is refused treatment, disability access or language services by a physician could begin to determine whether that particular provider had an obligation to meet their need, despite the fact that Medicare would be paying the provider for the visit. It also leads to Medicare enrollees potentially having different protections depending on whether they are enrolled in Original Medicare versus Medicare Advantage, under which all providers are subject to Sec. 1557. Finally, HHS itself has said that the number of excluded providers is quite small because most Part B providers receive other forms of Federal Financial Assistance. This is further proof that such an exclusion is neither necessary nor justified.

All Medicare providers, without exception, should be subject to Sec. 1557's civil rights mandates. Therefore, we strongly urge HHS to end its exclusion of Part B providers. Because including Part B providers would constitute a change in existing policy, we ask that HHS explicitly state in regulatory text that Part B provider payments constitute Federal Financial Assistance.

Although this memo is focused on Sec. 1557 regulations, we further urge HHS to reverse its exclusion of Part B providers from compliance with Title VI and Sec. 504 regulations as well. Simply put, the explanation that Medicare Part B payments did not constitute Federal Financial Assistance in the 1960's was wrong to begin with and is clearly overridden by the subsequent changes in program structure and reimbursement as well as the interpretation of similar funding such as student aid as well as APTCs (advanced premium tax credits) and CSRs (cost sharing reductions).

The Leadership Conference

APPLICATION/COVERED ENTITIES: Require that all subcontractors of covered entities are subject to Sec. 1557

We strongly recommend that OCR explicitly require subcontractors of federal fund recipients comply with Sec. 1557. Federal Financial Assistance does not stop being Federal Financial Assistance once the primary recipient of federal funds cashes the payment check. It is only because that primary entity receives Federal Financial Assistance that it will go out and build a network of secondary providers or subcontractors to undertake additional services for which the primary entity received the federal funds. Thus, the secondary recipients must also be subject to the same nondiscrimination requirements as the primary recipient or the nondiscrimination requirements may have no practical impact. The inclusion of subcontractors is particularly important given the extent to which health programs and activities contract with third parties to provide services. Take, for example, Medicaid transportation services or personal care services. To exempt these providers from Sec. 1557 simply because of their subcontractor status would render the statute's non-discrimination protections meaningless for a significant number of services.

The Leadership Conference

APPLICATION/COVERED ENTITIES: Apply nondiscrimination on the basis of association to providers and caregivers

Without explanation, the Trump administration eliminated regulations prohibiting discrimination on the basis of association. Congress intended Sec. 1557 to protect against discrimination by association, and these provisions should be reinstated
In the 2016 Final Rule, OCR explained that the statute does not restrict:

the prohibition to discrimination based on the individual's own race, color, national origin, age, disability or sex. Further, we noted that a prohibition on associational discrimination is consistent with longstanding interpretations of existing antidiscrimination laws, whether the basis of discrimination is a characteristic of the harmed individual or an individual who is associated with the harmed individual.

81 Fed. Reg. 31439.

The current regulation's language mirrors that of Title I and Title III of the ADA, which protect against discrimination based on association or relationship with a person with a disability.[26] Congress intended that Sec. 1557 provide at least the same protections for patients and provider entities. In accord with the ADA, the current regulation recognizes this protection extends to providers and caregivers, who are at risk of associational discrimination due to their professional relationships with patients, including those patient classes protected under Sec. 1557. See 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").

For example, an individual in an interracial marriage who experiences discrimination would be protected under Sec. 1557 because of the individual's association with a protected class. Similarly, a HIV-negative person in a sero-discordant relationship could not be denied access to pre-exposure prophylaxis (PrEP) to prevent HIV infection. Denying access to this treatment or other health care services would be prohibited associational discrimination, and would adversely affect vulnerable, highest risk populations including gay and bisexual men and other men who have sex with men.

OCR should further clarify that unlawful discrimination based on association occurs when a provider is subject to adverse treatment because it is known or believed to furnish services that are medically appropriate for, ordinarily available to, or otherwise associated with a patient population protected by Sec. 1557. This interpretation would, for instance, prohibit covered entities from using the provision of sex-specific services, such as abortion, as a disqualifying factor in recruiting otherwise eligible and qualified providers for participation in health programs supported by HHS. Providers should not be discriminated against for offering to competently care for a class of individuals with particular medical needs.

[26] See 42 U.S.C. §§ 12112, 12182 (2012).

APPLICATION/COVERED ENTITIES: Expand Sec. 1557 implementation and compliance procedures to all federal fund recipients, not merely those with 15 or more employees

All covered entities, and not just those with 15 or more employees, should designate a responsible employee to coordinate its efforts to comply with and carry out the responsibilities under Sec. 1557 and the regulations. We believe that the requirement should apply to all covered entities, given the importance of the Sec. 1557 protections and need to prohibit discrimination.

We believe that the requirement for a responsible employee and adoption of a grievance procedure is very important to holding covered entities responsible for the protections provided under Sec. 1557. Furthermore, we urge HHS to monitor compliance with these coordination and grievance procedure requirements, and to make such data publicly available.

The Leadership Conference

APPLICATION/COVERED ENTITIES: Expand application of Sec. 1557 to employees of covered entities

OCR should make clear that Sec. 1557's prohibition against discrimination applies to employment discrimination by a covered entity. Moreover, to fully effectuate this protection, OCR must also decline to incorporate the limitations contained in the former Sec. 92.208 of the 2016 rule. The plain meaning of Sec. 1557 includes employment discrimination. Sec. 1557 provides that an individual shall not "be subjected to discrimination under[,] any health program or activity, any part of which is receiving Federal Financial Assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)."

We disagree with earlier HHS approaches to not apply Sec. 1557 to discrimination by a covered entity against its own employees except with respect to certain employee health benefit programs, and then, only in very narrow circumstances due to the arbitrary limitations in former Sec. 92.208.

There is no carve-out in the text for employment discrimination. Rather, the text of the statute prohibits all "discrimination" under "any health program or activity" receiving funds under the ACA. The statute uses broad terminology that extends Sec. 1557's protections to any "individual" (not limited to a participant or a beneficiary) "under" (not limited to those participating or enrolled in) "any health program or activity." Moreover, there is no basis in the text of Sec. 1557 for the artificial limitations on employee claims for discriminatory employee health benefits contained in the former Sec. 92.208. Quite the contrary, as explained above, allowing claims against employers for discriminatory employee health benefit programs, even when the employer is not principally engaged in the business of providing health care, is fully consistent with Title IX, as amended by the Civil Rights Restoration Act. No justification exists for reading an employment discrimination exemption into Sec. 1557 that is broader than any found in the referenced statutes.

The Leadership Conference

APPLICATION/COVERED ENTITIES: Apply HHS' rule to all federal health programs and activities or coordinate with DOJ on a "common rule" applicable to all federal agencies, programs and activities covered by Sec. 1557

One important way to advance health equity beyond the 2016 Rule — and underscore the administration's commitment to nondiscrimination — is for HHS, in close coordination with DOJ and participating agencies, to develop a common rule to implement Sec. 1557. This common rule would build upon, not disturb, HHS's implementing regulations by explicitly extending the application of Sec. 1557 to health programs and activities that are administered by or receive federal funding from agencies *other than* HHS.

A common rule is appropriate, given the sweeping scope of Sec. 1557. The statute applies broadly to "any health program or activity, any part of which is receiving Federal financial assistance . . . or under any program or activity that is administered by an Executive Agency or any entity established" under Title I of the ACA. This includes federally funded health programs or activities, whether those programs or activities are funded by HHS or not. Indeed, many agencies — such as the Office of Personnel Management and the Department of Veterans Affairs — fund or administer health programs and activities. Despite this clear statutory language, HHS declined to extend the scope of its implementing regulations to these agencies in the 2016 Rule, and tried to further restrict the scope of Sec. 1557 in the 2020 Rule to only programs and activities administered or established under Title I of the ACA.

A common rule would:

- confirm, consistent with the text of the statute, that Sec. 1557 applies to health programs and activities funded or administered by non-HHS agencies;
- provide guidance to covered entities, and
- promote consistent enforcement of Sec. 1557.

HHS previously encouraged "expeditious implementation of Sec. 1557 by other departments" in the preamble of the 2016 Rule and OCR sent a memorandum encouraging the coordination of enforcement responsibilities to all federal agencies in November 2015. A common rule would build on these prior efforts, which have not gone far enough.

Ideally, the DOJ, in close coordination with HHS, would lead the multi-agency effort to develop a common rule. The DOJ has significant experience with this type of coordination and has long been tasked with ensuring consistent and effective implementation of federal civil rights laws in programs and activities that receive Federal Financial Assistance. Among other activities, DOJ has spearheaded common or coordinating rules and guidance to enforce Title IX and Title VI, both of which are

incorporated by Sec. 1557.[27] DOJ coordinated a common rule to implement Title IX alongside 19 participating agencies, including the Departments of Commerce, State, Housing and Urban Development, Defense, and Veterans Affairs and the Federal Emergency Management Agency. DOJ also developed regulations and guidelines to coordinate enforcement of Title VI and guidance on discrimination against persons with limited English proficiency. *See* 28 C.F.R. § 42.401 *et seq.*; 28 C.F.R. § 50.3.

One question is whether DOJ could be the lead agency in issuing a common rule. Sec. 1557(c) delegates implementing authority to HHS, stating that the Secretary of HHS "may promulgate regulations to implement" Sec. 1557. This authority differs from other federal civil rights statutes, such as Title VI and Title IX because Congress expressly delegated authority to HHS to implement Sec. 1557. Sec. 1557(c) should not, however, be read to limit the scope of Sec. 1557 or the ability of other agencies, including DOJ, to adopt rules to implement the statute.

If DOJ cannot lead a common rule joined by other participating agencies, HHS should do so, but in close coordination with DOJ. There is precedent for doing so. HHS has, for instance, developed a common rule on standards for research involving human subjects. This common rule adopts standard provisions while confirming that the head of each participating agency is responsible for determining whether a particular activity it conducts or supports is covered by the common rule. This common rule was codified in separate regulations by fourteen other federal agencies, including the Departments of Commerce, Labor, Education, and Veterans Affairs. HHS could consider a similar framework for Sec. 1557.

Even if HHS is the lead agency, DOJ may be best positioned to coordinate the multi-agency effort needed to develop the common rule. In addition to its experience and expertise in coordinating enforcement of federal civil rights statutes across agencies, DOJ has more capacity than HHS to lead this effort and ensure that consistent regulations are adopted across federal agencies. Coordination by DOJ is important to help minimize burdens on regulated entities, ensure consistent training of civil rights staff, and promote uniform and consistent implementation of precedent such as *Bostock* across agencies.

The need for government-wide adoption of Sec. 1557 calls for a coordinated approach led by HHS and DOJ. Absent a robust common rule or multi-agency effort, HHS should expand the scope of its existing regulations to explicitly require compliance with Sec. 1557 by other agencies.

---

[27] *See, e.g.*, Exec. Order No. 12250 of November 2, 1980, 45 Fed. Reg. 72995-97 (Nov. 4, 1980); *see also* Exec. Order No. 13166 of August 11, 2000, 65 Fed. Reg. 50121-22 (Aug. 16, 2000); Exec. Order No. 13160 of June 23, 2000, 65 Fed. Reg. 39775-78 (Jun. 27, 2000). (Title VI and Title IX direct each federal departments or agencies to issue rules, regulations, or orders to implement the statute but bar those rules from going into effect until approved by the President. The President delegated the authority to approve such rules under Title VI and Title IX to the Attorney General in Executive Order 12250.)

The Leadership Conference

APPLICATION/COVERED ENTITIES: Do not incorporate exemptions in Sec. 1557 beyond those expressly enumerated in the ACA

Congress did not include any carve-outs in the text of Sec. 1557 beyond "except as otherwise provided," nor did Congress incorporate exemptions into Sec. 1557 not already covered by the ACA. Nonetheless, the 2020 Rule attempted to incorporate the Title IX's exemption for certain educational operations of entities controlled by religious organizations, as well as Title IX's abortion provision and funding exemption, known as the Danforth Amendment. Already, a court has enjoined the provision of the 2020 Rule incorporating Title IX's religious exemption into Sec. 1557, based in part on the negative implications incorporating that exemption would have for access to health care, which the agency failed to consider in promulgating the rule.[28]

Incorporating Title IX's religious entity and abortion provision and funding exemptions violates the text and purpose of Sec. 1557. Sec. 1557's plain text prohibits discrimination "on the ground[s]" prohibited by Title IX and other antidiscrimination statutes.[29] Put another way, the plain text does not incorporate each and every subsection of Title VI, Title IX, the Age Discrimination Act, and the Rehabilitation Act; it prohibits health programs from discriminating "on the ground prohibited by" those statutes, *i.e.* because of race, ethnicity, national origin, sex, age, and disability. Title IX's exemptions are not encompassed by Sec. 1557's incorporation of the *grounds* covered by that statute. And Congress already notes that Sec. 1557 applies "[e]xcept as otherwise provided for in this title," indicating that Congress contemplated no other exemptions. Accordingly, going beyond the grounds and enforcement mechanisms covered by Title IX to incorporating the religious and abortion provision and funding exemptions would exceed HHS's statutory authority.

Practically, the extensive exemptions in Title IX are tailored to educational institutions and make no sense when applied to hospitals and insurance policies. As HHS noted in promulgating the 2016 Rule, in the education context, families may select religious educational institutions as a "matter of choice." 81 Fed. Reg. at 31,380. By contrast, in the healthcare context, many patients (especially those in rural areas) have no alternative healthcare providers and often need urgent or emergency care. They may have to go to a religiously affiliated health care provider and should have protectiosn against discrimination. Further, incorporating the statutory exemptions for Title VI and the Rehabilitation Act does not weigh in favor of incorporating the Title IX exemptions, because those statutes already apply to all programs and activities that receive FFA, whereas Title IX applies only in the context of education programs and not to the majority of the programs subject to Sec. 1557.

Further, it is the policy of the ACA to expand access to health care and coverage.[30] Incorporating the religious exemption in particular could lead to delay or denial of healthcare, as discussed elsewhere in this

---

[28] *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Hum. Servs.*, 485 F. Supp. 3d 1, 43 (D.D.C. 2020).
[29] 42 U.S.C. § 18116(a).
[30] *See* 42 U.S.C. § 18114.

memo. The 2020 Rule's inclusion of a religious exemption was enjoined because HHS failed to address "that the more likely outcome [of including the exemption] would be patients' being *denied* care."[31]

[31] *Whitman-Walker*, 485 F. Supp. 3d at 44 (emphasis in original).

The Leadership Conference

APPLICATION/COVERED ENTITIES: Refrain from incorporating Title IX exemptions and promulgate new regulations irrespective of the Texas federal district court's opinions in *Franciscan Alliance,* which does not preclude new Sec. 1557 rulemaking

The holding in *Franciscan Alliance* does not preclude new rulemaking, nor does it require that Title IX's exemptions be incorporated into regulations implementing Sec. 1557. *Franciscan Alliance v. Burwell* is a single district court decision, impacting only the 2016 Rule, and other courts have held that Sec. 1557 does not explicitly incorporate Title IX's religious exemption.[32] No federal circuit court has reached the same conclusion as the district court in *Franciscan Alliance*. While the district court held that certain provisions of that rule violated RFRA (the Religious Freedom Restoration Act), the government did not present merits arguments in that case; that means the government never presented - and the court never considered - arguments that the rule served a compelling governmental interest or that it was the least restrictive means of fulfilling that interest. The decision does not prevent HHS from issuing new rulemaking relying on the government's compelling interest in protecting the public from discrimination in health care.

Further, in *Franciscan Alliance*, the Trump Administration stopped defending the 2016 Rule, declined to appeal the preliminary injunction or vacatur of provisions of the Rule, and argued in favor of permanently enjoining those provisions of the Rule. The ACLU was permitted to intervene in the case due to this lack of adversity. Circumstances are different with a new administration that will be limiting the effect of this single, outlier district court decision.

[32] See *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Hum. Servs.,* 485 F. Supp. 3d 1, 43–46 (D.D.C. 2020).

The Leadership Conference

APPLICATION/COVERED ENTITIES: Do not incorporate the religious and abortion exemptions from Title IX into Sec. 1557 because they are unnecessary and would expand already harmful denials of care

Not only are the religious and abortion provision and funding exemptions not allowed by the text and purpose of Sec. 1557, but they are also unnecessary and harmful. Federal law already requires employers, including health care entities such as hospitals and other health care facilities, to accommodate employees' religious beliefs. For decades Title VII's reasonable accommodation/undue hardship framework has struck a balance to protect individual health care providers' religious beliefs while ensuring patients can access the care they need. Specifically, Title VII states that employers must "reasonably accommodate" employees' religious beliefs unless that accommodation imposes "undue hardship on the employer."[33] Sec. 1557 does not alter this framework, and individual health care providers maintain their rights as employees' under Title VII. However, incorporating Title IX's religion and abortion provision and funding exemptions into Sec. 1557 upsets this careful balance, and could result in patients' losing access to critical health care.

In addition, several existing federal statutes already allow health care entities to refuse to provide certain health care services, particularly abortion and sterilization. These statutes, incorporated by reference to Sec. 1557, prioritize the beliefs of health care entities — including hospitals and insurance companies — over patient care. These statutes already impose additional barriers to care and deny some patients the health care they need altogether. Adding Title IX's religion and abortion provision and funding exemptions to 1557 would compound the harm of these statutes.

In the 2020 rule, HHS relied on the Religious Freedom Restoration Act (RFRA) and the district court decision in *Franciscan Alliance* to rollback Sec. 1557's protections. While freedom of religion is a fundamental value, the previous administration repeatedly and unlawfully used RFRA to undermine civil rights protections and expand religious exemptions and denials of health care.

When promulgating a new rule, OCR should not rely on RFRA. RFRA is not a prophylactic statute that imposes rulemaking requirements on government agencies. Instead, RFRA violations are determined on an individual basis when an individual asserts a claim and a court applies the statute and engages in a fact-specific inquiry. While the government may decide to grant exemptions in order to prevent a RFRA violation before it happens, these exemptions must also be considered on a case-by-case basis. Under Sec. 1557, OCR is not required to rely on RFRA when considering new rulemaking.

[33] 42 U.S.C. §2000e(j).

APPLICATION/COVERED ENTITIES: Prohibit religious and abortion exemptions that result in denials and delays in providing health care to individuals and discourage individuals from seeking necessary care, with serious and sometimes life threatening results

The 2020 Rule's creation of broad religious exemptions for health care providers and its importation of Title IX's abortion provision and funding exemption undermines the overall goals and purpose of Sec. 1557's non-discrimination provision

Creating large exceptions to these nondiscrimination rules invites the very kind of discrimination that Sec. 1557 was designed to prevent. Prior to promulgating the 2016 Rule, HHS solicited comments on whether these regulations should include religious exemptions and concluded:

[m]ost of the organizations that commented on this issue, including professional medical associations and civil rights organizations, and the overwhelming majority of individual commenters — many of whom identified themselves as religious — opposed any religious exemption on the basis that it would potentially allow for discrimination on the bases prohibited by Sec. 1557 or for the denial of health services . . . .

81 Fed. Reg. 31,379. As a result, in 2016, HHS appropriately declined to add a religious exemption, stating that a religious exemption "could result in a denial or delay in the provision of health care to individuals and in discouraging individuals from seeking necessary care, with serious and, in some cases, life threatening results." 81 Fed. Reg. 31,380. HHS likewise refused some commenters' requests to incorporate Title IX's abortion provision and funding exemption into the 2016 Final Rule, emphasizing the importance of protecting "an individual's right to access health programs and activities free from discrimination" and recognizing that the rule already contained protections for those with objections to providing or covering abortion. 81 Fed. Reg. 31,388.

Four years later, HHS reversed course without adequately analyzing, or even acknowledging, the potential impact of a religious or abortion provision and funding exemption on health care or coverage. In response to the 2019 Notice of Proposed Rule Making, which suggested adding Title IX's abortion provision and funding exemption and blanket exemption for religiously affiliated entities to the Sec. 1557 regulations, a large number of commenters once again expressed their concerns with the serious harm and discrimination that could result. Despite this, HHS finalized the 2020 Rule with both exemptions, and in subsequent litigation, federal courts concluded that HHS failed to comply with the Administrative Procedure act because it did not "'adequately consider the effect of' a blanket religious exemption on the ability for individuals to access care on a prompt and nondiscriminatory basis."[34]

[34] *Whitman-Walker v. U.S. Dep't of Health & Human Servs., 2020 WL 5232076, at *26* (D. D.C. Sept. 2. 2020).

The Leadership Conference

Many religiously affiliated organizations and entities who choose not to provide the full scope of care to all patients specifically refuse to provide reproductive and pregnancy-related care and LGBTQ+ affirming care

The harm of permitting religious and abortion provision and funding exemptions to Sec. 1557 on access to health care cannot be overstated. Providers have invoked personal beliefs to deny access to health insurance and an increasingly broad range of health care services, including birth control, sterilization, certain fertility treatments, abortion, transition-related care for transgender individuals, and end of life care. In particular, allowing these exemptions in the health care context poses a significant risk of discrimination, harm, and denial of care to LGBTQ+ individuals and women, including people seeking reproductive care — groups which the ACA and Sec. 1557 specifically intended to protect.

LGBTQ+ individuals are too often denied health care because of their sexual orientation or gender identity. A 2018 survey conducted by the Center for American Progress found that 8 percent of LGBQ respondents said that in the past year a doctor had refused to see them because of their actual or perceived sexual orientation, while 29 percent of transgender respondents reported being refused care in the past year. In addition, this survey showed that many LGBTQ people avoid seeing a medical provider, even when they are in need of care, because they do not want to be discriminated against.

Similarly, objections to providing comprehensive reproductive health services pose a significant risk to people who can get pregnant, by preventing access to needed care which can have immediate serious and even life threatening consequences and cause long-term negative health effects. Health care denials that result in a delay in accessing care have the effect of increasing the overall cost of an abortion, as well as raising the cost of each step of obtaining an abortion. There are serious physical and socioeconomic consequences for patients who are denied wanted abortions. A recent landmark study following participants for five years found that women[35] who were denied wanted abortions and gave birth had statistically poorer long-term health outcomes (including serious complications like eclampsia and death) than women who received their abortions. Women denied abortion services were also more likely to stay tethered to abusive partners, suffer anxiety and loss of self-esteem, and less likely to have aspirational life plans for the coming year compared to those who were able to access an abortion.

Denials of care based on personal objections compound existing disparities in health care, and people with intersecting marginalized identities are disproportionately impacted. Due to systemic discrimination and bias, women of color are more likely to be uninsured, receive inadequate prenatal care, and are at risk of poorer outcomes during pregnancy and delivery than white women. Research has shown that women of color disproportionately receive their reproductive care at Catholic hospitals and, despite their health disparities, are exposed to restrictions that put religion over medical best practices. People of color have

[35] Although an estimate is only available for women at this time, more inclusive data are needed to reflect all people who use abortion care in their lifetimes, including women, trans, gender non-conforming, non-binary, and intersex people.

experienced historic and ongoing coercion within the medical system, denials of care further undermine the trust that is the foundation of the patient-provider relationship and deepen health disparities.

APPLICATION/COVERED ENTITIES: Prohibit health care professionals from opting out of providing medically necessary services which disregards evidence-based standards of care

Religiously motivated denials of care and abortion exemptions are in conflict with medical ethics and professional oaths

Doctors and health care providers are held to high standards of ethics, including the first and foremost ethical directive to "First, Do No Harm." However, by turning away patients in need of care or failing to provide the full scope of care, health care providers inflict harm on those who rely on them for health care. Additionally, religious and abortion refusals come into conflict with the ethical standards that require health providers to put their patient's best interest first and to allow their patients to make decisions about their own health and treatment.

Crucial to the ability of patients to exercise autonomy over their health care decisions is the practice of informed consent, which requires medical providers to provide adequate disclosure and explanation of the full range medically appropriate treatment options before the patient and provider settle on a course of treatment. (*See* guidance on informed consent from ACOG and AMA.) Informed consent requires providers to disclose relevant and medically accurate information about treatment choices and alternatives so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether. In contrast to these principles, the current religious and abortion exemptions in the 2020 Rule undermine open communication between providers and patients, interfere with providers' ability to provide care according to medical standards, and ignore the reality that many providers want to provide comprehensive care. By allowing providers, including hospital and health care institutions, to refuse to provide patients with information, the exemptions make it impossible for patients to have full information regarding treatment options.

Allowing providers' personal objections to dictate the scope of services departs from the standard of care and denies patients needed care for non-medical reasons

Religious and abortion exemptions also disregard standards of care established by the medical community by allowing providers to opt out of providing medical care. Medical practice guidelines and standards of care establish the boundaries of medical services that patients can expect to receive and that providers should be expected to deliver. Yet, religious and abortion exemptions seek to allow providers and institutions to ignore the standards of care.

For example, Catholic hospitals determine the scope of health care services they will provide based on the Ethical and Religious Directives (ERDs). The ERDs are issued and enforced by the U.S. Conference of Catholic Bishops and explicitly prohibit the provision of certain reproductive health services, including contraception, sterilization, abortion, infertility services, and end of life care supporting death with dignity, and which have been interpreted to limit LGBTQ+ inclusive care such as gender-affirming care. Researchers have documented numerous instances in which the ERDs at Catholic hospitals have led

hospital administrators to prohibit doctors from treating patients in line with evidence-based standards of care.

An example is the case of Jionni Conforti, a transgender man whose scheduled hysterectomy was canceled by a Catholic hospital because of his gender identity. While the hospital originally scheduled his procedure — despite the fact that any hysterectomies would technically violate the ERDs — they ultimately canceled his appointment because he was transgender. Similarly, there have been numerous documented instances of Catholic hospitals citing the ERDs and failing to meet medical standards of care for pregnant people with emergency health needs, including treatment of ectopic pregnancies and miscarriage management — even when the patient's life is at risk. Additionally, we have seen cases where pharmacists with religious objections have refused to fill birth control prescriptions, delaying access to care and in some instances making it impossible for people to obtain emergency contraception in time to prevent pregnancy.

The proliferation of religiously affiliated health providers in the U.S. means that allowing refusals of care will have a large impact and cause significant harm

Catholic health facilities are the largest group of nonprofit health care providers in the United States, with one in six hospital beds in the country being located in a Catholic hospital. Researchers have found that most patients are unaware of the restrictions Catholic hospitals place on care with one study showing that 37% of women surveyed whose hospital is Catholic did not know that it was. In a recent Community Catalyst report, Catholic health systems are also expanding outside the hospital setting with "the 10 largest Catholic health systems operat[ing] 864 urgent care centers, 385 ambulatory surgical centers, and 274 physician groups, along with other operations, such as clinics in retail pharmacies."

As a result, individuals who face religious refusals cannot simply "go somewhere else" to obtain needed care. In particular, individuals living in rural communities report a dearth of care providers and often have to travel long distances to access care. In the Center for American Progress's 2018 survey, 18 percent of LGBTQ+ people and 41 percent of LGBTQ people living outside a metropolitan area reported that it would be difficult or impossible for them to find the same service at a different location. Similarly, one half of rural women live within a 30-minute drive to the nearest hospital offering perinatal services. Given that rural women are also disproportionately lower-income, may not have their own cars, and live in areas with poor public transit, they may face serious obstacles to obtain care. If people make significant efforts to reach health care providers and are then refused care because of a provider's personal or religious beliefs, there may be no other sources of health or life-preserving medical care.

The Leadership Conference

APPLICATION/COVERED ENTITIES: Prohibit religious and moral exemptions that would harm any third party and are barred by the Establishment Clause of the First Amendment

Creating religious exemptions to nondiscrimination rules in health care is unconstitutional

To be constitutional, religious accommodations (1) must lift substantial, government-imposed burdens on the exercise of religion, and (2) they must not impose undue burdens on third parties.[36] Courts have long ruled that the Establishment Clause of the First Amendment bars the government from preferring one religion over another, or religion over nonreligion. This includes religious exemptions that harm third parties.In *Estate of Thornton v. Caldor*,[37] the U.S. Supreme Court held that a state law giving employees an "absolute and unqualified right not to work on their sabbath" violated the Establishment Clause because the law burdened employers and other employees. The Court wrote that the "unyielding weighting in favor of Sabbath observers over all other interests contravenes a fundamental principle of the Religion Clauses."

Religious exemptions have serious and harmful implications. They were thought of as a way to preserve religious freedom and independence. However, they often come as a societal cost that can impact other community members. Impacts of a religious exemption cannot be siloed from other areas of society.

1. Access to Health Care

As discussed above, the prioritization and exploitation of religious exemptions at the expense of patient care has resulted in physical, socioeconomic, and dignitary harm to individuals who are refused or experience delays in accessing health care, especially reproductive health care and LGBTQ+ inclusive health care. Because the long-term supports and services that people with disabilities need in order to live in the community are often funded through Medicaid, religious refusals by these health care providers can also affect the day-to-day lives of people with disabilities. These long-term supports and services are increasingly provided by organizations with religious affiliations. People with disabilities already face many barriers to accessing the health care services they need, including long-term supports and services. Religious exemptions make health care, particularly reproductive health care and LGBTQ+ inclusive health care, even more difficult for people with disabilities to access and obtain.

2. Impact of Religious Exemptions on Public Health

As the COVID-19 pandemic has highlighted, broad religious exemptions have had hazardous, wide-spread public health consequences. The government must take into consideration the significant concerns of the "third party harms" that result from any religious exemption, particularly in the health care context.

---

[36] *City of Allegheny v. ACLU Greater Pittsburgh Chapter,* 492 U.S. 573, 613 n.59 (1989); *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 709-10 (1985).
[37] 472 U.S. 703 (1985).

OCR should decline to extend religious exemptions to the health care context unless they are unambiguously required to do so.

The Establishment Clause prohibits certain religious exemptions from otherwise generally applicable non-discrimination rules

The First Amendment of the U.S. Constitution not only limits religious exemptions, it *prohibits* them when the exemption would create an appearance of endorsing a particular religion, or of endorsing religion over nonreligion.

When the Civil Rights Act was enacted, the Supreme Court denied a restaurant owner's claim that he was entitled to a religious exemption so that he could deny service to African Americans.[38] The same analysis applies to organizations that claim religious exemptions to anti-discrimination provisions of the ACA. Including religious exemptions in rulemaking invites legal challenges to this precedent.

[38] *Newman v. Piggie Park,* 390 U.S. 400 (1968).

The Leadership Conference

Enforcement

- Clarify that the same scope of claims and remedies exist under Section 1557 regardless of the type of discrimination, or stay silent on this question
- Explicitly articulate a cause of action for claims of intersectional discrimination
- Ban forced arbitration of consumers' claims Section 1557 complaints
- Require a yearly report from OCR including information about all complaints filed and resolutions; information should be disaggregated by the bases for the complaints (e.g. race, color, national origin, sex, disability, age), the number of investigations initiated, the number of complaints resolved, the number of complaints closed without resolution
- Substantially reform and improve OCR's complaint handling process and provide the public with detailed guidance through written decisions and otherwise

ENFORCEMENT: Clarify that the same scope of claims and remedies exist under Sec. 1557 regardless of the type of discrimination, or stay silent on this question

OCR should make explicit in regulation that Sec. 1557 created a "health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff's protected class status."[39] In revising the regulation, OCR should build on the language in the 2016 Rule that adopted a uniform legal standard applied to all forms of discrimination prohibited by Sec. 1557 and explicitly include claims of intersectional discrimination based on multiple protected identities. OCR must once again recognize the existence of a single private right of action to challenge prohibited discrimination in court, regardless of to which of the classes protected by Sec. 1557 the person belongs. That is, OCR must clarify that the full range of enforcement mechanisms and remedies is available to any person pursuing a discrimination claim under Sec. 1557, regardless of their protected class. For example, a person may state a claim under Sec. 1557 on a disparate impact theory for discrimination based on race, despite the fact that a disparate impact theory is not recognized under Title VI. Similarly, a person may recover compensatory damages on a showing that a covered entity illegally discriminated against them based on their age, even though such damages may not be available under the Age Discrimination Act. This approach is necessary to avoid inconsistent application of the enforcement mechanisms in the statutes incorporated by Sec. 1557, and to make clear that the enforcement mechanisms available under Sec. 1557 must be adequate to redress discrimination for those living at the intersection of multiple identities.

Clarifying in regulation that Sec. 1557 creates one cause of action with one set of remedies, regardless of the protected class to which a plaintiff belongs, is consistent with the statutory context, structure, and text. Sec. 1557 incorporates four civil rights laws specifically to delineate "the ground[s] prohibited under" it.[40] Sec. 1557 does not set forth separate remedies, legal standards, and burdens of proof applicable to each prohibited basis of discrimination based on the statutes from which each was incorporated.[41] To the contrary, Congress specified that "[t]he 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."[42] The use of the disjunctive "or" indicates that the enforcement mechanisms applicable under any of the incorporated statutes are available to every claim of discrimination under Sec. 1557, regardless of the particular type of discrimination triggering the claim. "In its elementary sense, the word 'or,' as used in a statute, is a disjunctive particle indicating that the various members of the sentence are to be taken separately."[43] Thus, applying standard rules of construction, all the enforcement mechanisms

---

[39] *Rumble v. Fairview Health Servs*., No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, *11 (D. Minn. Mar. 16, 2015) (citation omitted).
[40] 42 U.S.C. § 18116(a).
[41] *See* Sarah G. Steege, *Finding A Cure in the Courts: A Private Right of Action for Disparate Impact in Health Care*, 16 Mich. J. Race & L. 439, 462 (2011) ("[T]here is no indication in Sec. 1557 that each listed statute's enforcement mechanisms apply only to its own protected classes.").
[42] 42 U.S.C. § 18116(a).
[43] 73 Am. Jur. 2d Statutes Sec. 147; *see also United States v. Woods*, 134 S. Ct. 557, 567 (2013) ("ordinary use [of the word 'or'] is almost always disjunctive"); *In re Espy*, 80 F.3d 501, 505 (D.C. Cir. 1996) (per curiam) ("Canons of construction ordinarily suggest that terms connected by a disjunctive be given separate meanings and a statute

provided for and available under each of the generally incorporated statutes in Sec. 1557 are available to every claim of discrimination under Sec. 1557.

Moreover, clarifying that Sec. 1557 creates one cause of action with one set of remedies is necessary to avoid confusion. For example, allowing disparate impact actions for some plaintiffs but not others, compensatory damages for some but not others, or associational discrimination claims for some but not others, all depending on their protected class, would create troubling inconsistency and leave courts with no clear standard for relief when a plaintiff alleging discrimination belonged to more than one protected class.

If OCR is not inclined to clarify in regulation that Sec. 1557 creates one cause of action with one set of remedies, we strongly urge OCR to stay silent on this question and leave the matter to the courts to interpret. The 2016 regulation, for example, contributed to confusion over whether Sec. 1557 creates a single claim by interpreting the statute to create one cause of action, but only permit remedies available under the referenced statutes, depending on the protected class to which a plaintiff belonged. Not only did OCR's prior interpretation muddy the waters as to whether a plaintiff could assert an intersectional claim under Sec. 1557, and if so, what remedies would apply, but it also interpreted the statute inconsistently, providing confusing guidance to stakeholders about the scope of protection afforded by Sec. 1557. The question of the scope of the claim and remedies created by Sec. 1557 is being actively litigated in the courts. If OCR is not inclined to interpret the statute in a way that affords the most expansive protection possible for individuals who experience discrimination in health care, we urge OCR not to weigh in on this area at all, and instead allow litigants to put forward their interpretation of the statute in court. In that case, OCR should simply affirm in regulation that Sec. 1557 provides a private right of action and clarify that the standard four year statute-of-limitations applies to Sec. 1557 cases.

ENFORCEMENT: Explicitly articulate a cause of action for claims of intersectional discrimination

Currently, there are no clear remedies nor a consistent standard of proof for intersectional discrimination claims. In revising Sec. 1557 regulations, OCR must articulate a clear cause of action for claims of intersectional discrimination to avoid future rejection of claims based on discrimination on the basis of a combination or the intersection of multiple characteristics protected against discrimination under law. Sec. 1557 is one of the newest civil rights laws, and in addition to its new prohibition against discrimination on the basis of sex (which includes sexual orientation and gender identity per *Bostock*) in health care, it incorporates other statutes prohibiting such discrimination on the basis of race, ethnicity, age, disability and language. Yet, the previous Sec. 1557 regulations did not articulate a specific cause of action for claims of intersectional discrimination. This has left individuals to silo their experiences and the courts to grapple with these issues, which has resulted in some uncertainty (see below).

---

written in the disjunctive is generally construed as setting out separate and distinct alternatives.") (internal citations and quotations omitted).

The Sec. 1557 regulations should specifically recognize an intersectional cause of action to ensure that the law reflects the complex reality of people's lived experiences. The law is intended to protect individuals from discrimination in health care on the basis of all the protected categories listed above. And yet the obvious fact that people often experience discrimination based on more than one protected category has been largely ignored in the past. For example, if an older Black woman experiences discrimination in seeking health care, it may be impossible to separate out only one of these identities as the basis of discrimination. Yet, as the current regulation says an individual can only base a complaint on one protected identity. This is further complicated by the fact that each statute has unique requirements and sometimes differing remedies. OCR now has the opportunity to establish regulations that better recognize that people holding multiple marginalized identities can and do experience discrimination on the bases of all, or at least a combination of some, of those protected identities. This would mean explicitly articulating a cause of action that includes multiple causes of discrimination under one standard with common remedies and ensuring that all complaint processes are updated to reflect this new cause of action.

In addition to an explicit cause of action, below are recommendations for incorporating intersectional discrimination specifically into the existing Sec. 1557 infrastructure:

- All OCR complaint procedures should allow for reporting of intersectional discrimination claims. This may require updating complaint intake forms and administrative complaint procedures, including ensuring all complaints of intersectional discrimination and subsequent decisions are publicly recorded and available.
- The full range of enforcement mechanisms and remedies should be available to those experiencing discrimination on the basis of multiple protected identity classes.

These provisions reflect the view of a majority of federal courts, which have correctly recognized that discrimination on the basis of a combination or the interrelationship of multiple protected characteristics is actionable under federal nondiscrimination laws. These courts recognize that "where two bases of discrimination exist, the two grounds cannot be neatly reduced to distinct components" because they often "do not exist in isolation."[44] For example, "African American women are subjected to unique stereotypes that neither African American men nor white women must endure."[45]
The Biden Administration and relevant federal agencies have already noted the importance of addressing intersectional discrimination. OCR should look to the following resources for guidance on this matter:

- Section 15 of the EEOC Compliance Manual – "Title VII prohibits discrimination not just because of one protected trait (e.g., race), but also because of the intersection of two or more protected bases (e.g., race and sex). The law also prohibits individuals from being subjected to

[44] *Shazor v. Prof'l Transit Mgmt.*, 744 F.3d 948, 957-58 (6th Cir. 2014).
[45] *Id*; *see also*, *e.g.*, *Harris v. Maricopa County Superior Court*, 631 F.3d 963, 976 (9th Cir. 2011); *Jefferies v. Harris Co. Community Action Ass'n*, 615 F.2d 1025, 1032 (5th Cir. 1980); *Lam v. University of Hawaii*, 40 F.3d 1551, 1562 (9th Cir. 1994); *Jeffers v. Thompson*, 264 F. Supp. 3d 314, 326 (D. Md. 2003).

discrimination because of the intersection of their race and a trait covered by another EEO statute – e.g., race and disability, or race and age."

- EEOC Enforcement Guidance on National Origin Discrimination – "Title VII also prohibits 'intersectional' discrimination, which occurs when someone is discriminated against because of the combination of two or more protected bases (e.g. national origin and race). Employment discrimination motivated by a stereotype about two or more protected traits would constitute intersectional discrimination."
- Executive Order on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation – "Discrimination on the basis of gender identity or sexual orientation manifests differently for different individuals, and it often overlaps with other forms of prohibited discrimination, including discrimination on the basis of race or disability."

Nonetheless, it is important to note that some courts have failed to fully recognize this principle.[46] If OCR is unable to fully incorporate an explicit cause of action for intersectional discrimination along with the accompanying suite of remedies in the newly revised regulations, the matter should be allowed to continue to percolate in the courts.

[46] *See*, *e.g.*, *Giordano v. Pub. Serv. Co.*, 2020 U.S. Dist. LEXIS 83395, at *13-*14 (D.N.H. May 12, 2020); *Chaikin v. Methodist Med. Ctr. of Ill.*, 2018 U.S. Dist. LEXIS 166752, at *4-*5 (C.D. Ill. Sept. 27, 2018) ; *Judge v. Marsh*, 649 F. Supp. 770, 780 (D.D.C. 1986) *De Graffenreid v. General Motors Assembly Div.*, 413 F. Supp. 142, 143 (E.D. Mo. 1976)), *aff'd in part, rev'd in part on other grounds*, 558 F.2d 480 (8th Cir. 1977).

ENFORCEMENT: Ban forced arbitration of consumers' claims arising under Sec. 1557
OCR's regulations should bar covered entities from using forced arbitration clauses to stifle claims arising under Sec.1557. Forced arbitration clauses, also known as mandatory pre-dispute arbitration clauses, legally prohibit workers from suing when they experience discrimination or other illegal treatment—thus undermining the remedial purposes of Sec.1557 and these regulations.

The widespread use of forced arbitration would make it nearly impossible for patients and enrollees to vindicate their rights under Sec. 1557, allowing insurers, hospitals, and employers to evade accountability through forced arbitration. Patients who have signed forced arbitration agreements are legally prohibited from enforcing their civil rights in court. Instead, they may only bring legal claims before a shadowy, poorly regulated private arbitrator—typically a former attorney hand-picked and paid by the defending company. Because these clauses are typically buried deep in the fine-print of contracts, the vast majority of consumers subject to forced arbitration do not realize they are barred from suing if their rights are violated. Moreover, arbitration outcomes are typically secret—allowing companies to sweep discrimination under the rug. Worse still, most arbitration clauses also prohibit consumers like patients and enrollees from joining a class-action suit, making it too costly for many people to bring a discrimination lawsuit on their own. Arbitration is systematically biased against consumers, who win only a small fraction of arbitrations. As a result, the vast majority of people subject to forced arbitration simply never bring claims at all: the Consumer Financial Protection Bureau ("CFPB") found that out of tens of millions of Americans subject to forced arbitration between 2010-11, only 52 people brought claims and only four were awarded relief by arbitrators.

Forced arbitration is ubiquitous in consumer contracts, including in the healthcare industry. A 2015 study by the CFPB of arbitration in financial product markets found that 99.0% of mobile wireless subscribers, 85.7% private student loan contracts, and at least 82.9% of prepaid card agreements were subject to forced arbitration. Major insurers and provider networks, like Anthem, BlueCross BlueShield, and Kaiser Permanente, require enrollees and patients to sign forced arbitration agreements to access care. Hospitals and providers can and do require patients to sign an arbitration agreement to be admitted or treated. If left unregulated, the widespread use of forced arbitration would make it virtually impossible for many patients facing discrimination to vindicate their rights under Sec. 1557, frustrating the purpose of this very law. For example, a transgender worker who signs a forced arbitration agreement when enrolling in employer-provided health insurance or while being admitted to a hospital for emergency care would lose the right to sue the insurer for refusing to cover gender-affirming care or the hospital if providers harass and discriminate against them.

OCR's regulations should ban covered entities from relying in any way on a pre-dispute arbitration agreement with respect to any aspect of a claim or class action that is related to Sec. 1557, including by seeking to dismiss a class action or filing a claim in arbitration against such a plaintiff unless and until the presiding court has ruled the case may not proceed as a class. Any pre-dispute agreements concerning arbitration or class actions should include a notice explaining that these rules do not cover discrimination claims arising from Sec. 1557. Helpful models include CMS' 2016 Requirements for Long-Term Care

Facilities Final Rule, which banned pre-dispute arbitration at Medicare- and Medicaid-funded LTC facilities, and Department of Education's 2016 Borrower Defense Final Rule.

Sec. 1557 authorizes the Secretary to promulgate regulations to implement the law's nondiscrimination guarantee, vesting the Secretary with authority to impose conditions on recipients of federal funds. Limiting forced arbitration would be a valid exercise of the federal government's broad spending power—as at least two courts have recognized in upholding ED and CMS regulations limiting forced arbitration.[47] Banning forced arbitration to ensure these rules can be enforced is reasonably related to the federal interest in the ACA and related spending. Although the Federal Arbitration Act (FAA) mandates judicial enforceability of existing arbitration agreements, nothing in the FAA prevents OCR from "conditions on the use of such agreements by voluntary participants in a federally funded program."[48] Moreover, Sec. 1557 expressly affirms that no insurer, nonprofit, or business is required to participate in the program.[49] In sum, regulations barring recipients of federal funds from subjecting consumers to arbitration have been upheld by courts as a valid exercise of agency's statutory authority and the federal government's spending clause powers.

[47] California Ass'n of Private Postsecondary Sch. v. DeVos, 436 F. Supp. 3d 333, 354 (D.D.C. 2020), vacated as moot; Northport Health Servs. of Arkansas, LLC v. Dep't of Health & Human Servs., 438 F. Supp. 3d 956, 967 (W.D. Ark. 2020). But see American Health Care Association v. Burwell, 217 F. Supp. 3d 921, 929 (N.D. Miss. 2016).
[48] Northport Health Servs., 438 F. Supp. 3d at 968; see also Dean Witter Reynolds, Inc., 470 U.S. 213, 219 ("The Act, after all, does not mandate the arbitration of all claims but merely the enforcement … of privately negotiated arbitration agreements.").
[49] 42 U.S.C. § 18115.

The Leadership Conference

ENFORCEMENT: Require a yearly report from OCR including information about all complaints filed and resolutions; information should be disaggregated by the bases for the complaints (e.g. race, color, national origin, sex, sexual orientation, gender identity, disability, age) the number of investigations initiated, the number of complaints resolved, the number of complaints closed without resolution

According to the U.S. Commission on Civil Rights, research, data collection, and reporting are one of the "seven essential elements of effective federal civil rights enforcement" however, HHS does not currently provide the type of public data collection, research and reporting needed to understand the current intersecting levels of discrimination in our health care system. Proper data reporting on complaints to OCR will create the environment needed to build more effective civil rights enforcement.

HHS OCR implemented its Complaint Portal in 2013 which collects and tracks data related to the intake and processing of civil rights complaints. While HHS collects and tracks complaint data, HHS does not make this information available to the public and provides very limited data on complaints, usually limiting publicly available information to the total number of complaints filed and information on closed complaints provided via individual Freedom of Information Act requests. Without data collection, disaggregation, and reporting on OCR's Sec.1557 enforcement activities, the government and other stakeholders are unable to fully understand experiences of discrimination in health care and coverage or asses the adequacy of the government's response to discrimination and effectiveness of programs. Collecting and reporting data on Sec. 1557 can also help the agency identify inequalities it was previously unaware of. The importance of reporting on complaint data is clear in the President's executive order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government which notes that a lack of data "has cascading effects and impedes efforts to measure and advance equity."

The rule should specify the collection and reporting of key data elements to address the insufficiencies noted above and improve enforcement. OCR should collect and report data on the total number of complaints received. Reporting should also include demographic data about complainants and types of respondents; geographic information for where the complaint occurred; the type of discrimination alleged; the resolution reached; and the time to resolution. Complaint information should be disaggregated by the bases of complaints: race, color, national origin, sex (including sexual orientation, gender identity, intersex status, pregnancy [including termination of pregnancy]) disability, age, religion, and where someone has indicated more than one form of discrimination. Race and ethnicity data should also be disaggregated. This information should be disaggregated by month/year of complaints received, beginning when the ACA went into effect. Complaint data should also be disaggregated by the filers requested language access to assist in processing their claim and which language (including ASL or Braille).

In order to improve transparency and accountability, these data must be publicly reported at least annually and released with an announcement, such as a press release. Reporting must be In alignment with the

Privacy Act of 1974 to protect personal identifying information. Report must be technologically accessible, searchable, and exportable to XLS, PDF, and CSV format.

ENFORCEMENT: Substantially reform and improve OCR's complaint handling process and provide the public with detailed guidance through written decisions and otherwise

The administrative complaint process is essential to effective enforcement of Sec. 1557. As with many if not most other federal laws and regulations, most members of the public lack the resources to litigate their rights in court. Few can afford a lawyer, and most lawyers who take contingency cases, litigate impact cases, or work or volunteer for nonprofit legal services organizations, can afford to take only a few of the potential cases that come their way. Therefore, an accessible, user-friendly, and efficient administrative complaint process is the only practical recourse for many if not most people who have experienced discrimination or other unlawful treatment. An administrative complaint process that resolves issues arising under Sec. 1557 promptly and fairly, without the expense and delay of litigation in the federal courts, would be valuable for regulated health care providers and insurers as well.

Unfortunately, OCR's processes for handling and resolving complaints arising under Sec. 1557 to date have left a great deal to be desired – even in the years prior to the Trump administration. Legal services lawyers and impact litigators who have sought administrative relief on behalf of individuals who experienced discriminatory denials of care by providers, or discriminatory refusals of insurance coverage for gender-affirming or pregnancy-related care, or who were subjected to discriminatory pricing practices for their HIV or other essential medications, have found the OCR complaint process difficult to navigate, and ineffective at providing relief from discriminatory practices:

- Complaints languished for years without resolution.
- Frequently, there was no communication with complainants or their representatives about the status of a case, except in response to an inquiry – and many inquiries were never answered.
- It has been essentially impossible to learn the status of the case or the timeline for resolution through publicly accessible information systems, or to understand how to participate meaningfully in an investigation.
- In some cases, complainants who have resorted to the courts after failing to obtain timely resolution through OCR have encountered obstacles in court due to assertions that the issues were being investigated by OCR

As a result, complainants and the public have lost confidence in the agency's process, and lawyers advising clients who have experienced treatment seemingly prohibited by Sec. 1557 have generally sought to avoid the OCR complaint process.

Apart from changes to the Sec. 1557 regulations, we urge OCR to reform, and substantially strengthen, OCR's sub-regulatory policies and procedures for handling and resolving complaints. Needed reforms include:

- Detailed, clear intake forms that notify complainants of what information to include (especially for civil rights complaints) and collect sufficient demographic data to identify trends. These forms should be offered in the top 15 languages, written at a 5th grade reading level, and offer language

assistance near the top of the form. It should also include a large print tagline as well as information about how to obtain communication assistance for people with disabilities including auxiliary aids and services.

- Timely acknowledgement of receipt of a complaint, including docket number of OCR staff assigned, and communication with complainants if additional information is requested.
- Timely response to status inquiries by complainants and respondents.
- Timetables for resolution of complaints – including deadlines for achieving voluntary resolution and for proceeding to adjudication on the merits if voluntary resolution is not achieved.
- A tracking system for complaints that can be accessed by complainants and respondents as well as by agency staff and supervisors.
- Written, publicly accessible procedures that document all of the above (on the agency's website).

Advocates experienced in representing complainants in administrative proceedings are happy to work with agency personnel, and representatives of the defense bar, to implement these recommendations. OCR should also utilize enforcement tools at its disposal in addition to complaints, including proactive compliance reviews, testing, and using technical assistance to guide providers on best practices. In addition, OCR should provide detailed written guidance to the public, to health care providers and institutions and health insurers, and to complainants and respondents in complaint proceedings. Whatever the level of detail is contained in a new Sec. 1557 rule, questions will arise as to the rule's applicability in specific cases. For instance, a health insurance plan may not contain a blanket exclusion of "sex change" procedures, but may nonetheless deny coverage of many specific gender-affirming treatments or procedures. Or an insurance plan may charge significantly higher co-pays for some drugs needed for chronic or life-threatening conditions, and the basis for those differences may be disputed. Or a medical provider may deny certain treatments requested or needed for gender-affirming care on the grounds that the provider lacks the needed expertise, and that assertion may be contested.

In such situations, it will be important for OCR to take the following measures:

- In contested cases where voluntary resolution is not achieved, OCR must issue a written summary of its investigation, its findings, and the conclusions on which it relied.
- OCR should maintain a publicly accessible, searchable database of complaints and of reported decisions, edited to protect complainant confidentiality.

OCR should issue detailed Frequently Asked Questions documents and other sub-regulatory guidance addressing commonly arising questions.