



THE STATE OF CALIFORNIA
OFFICE OF THE ATTORNEY GENERAL



XAVIER BECERRA
ATTORNEY GENERAL

MAURA HEALEY
ATTORNEY GENERAL

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Via e-filing at www.regulations.gov

Secretary Alex Azar
U.S. Department of Health & Human Services
Office for Civil Rights
Attention: Section 1557 NPRM, RIN 0945-AA11,
Hubert H. Humphrey
Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

RE: Comments on Proposed Rule, “Nondiscrimination in Health and Health Education Programs or Activities,” RIN 0945-AA11, 84 Fed. Reg. 27846 (June 14, 2019)

Dear Secretary Azar:

The undersigned State Attorneys General of California, Massachusetts, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Iowa, Kentucky, Maryland, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Vermont, Virginia, and Washington (the States) submit these comments to oppose the Proposed Rule: “Nondiscrimination in Health and Health Education Programs and Activities,” 84 Fed. Reg. 27846 (June 14, 2019) (Proposed Rule). The Proposed Rule is inconsistent with the law that it purportedly seeks to implement, Section 1557 of the Patient Protection and Affordable Care Act (ACA). Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, disability, and age in a broad range of health programs and activities.¹ The Proposed Rule does the exact opposite by licensing discrimination in our healthcare system. The Proposed Rule will inflict harm on the States’ and their residents—particularly underserved populations including individuals with disabilities, women, lesbian, gay,

¹ Specifically, Section 1557 prohibits discrimination on the basis of any protected classification covered under Title VI of the Civil Rights Act (race, color, and national origin), Section 504 of the Rehabilitation Act of 1973 (disability), Title IX of the Education Amendments (sex), and the Age Discrimination Act of 1975 (age).

bisexual, transgender, and queer or questioning (LGBTQ) individuals—by undermining legal protections that guarantee healthcare as a right.

In 2016, when the U.S. Department of Health & Human Services (HHS or Department) issued a final rule implementing Section 1557, it stressed the importance comprehensive anti-discrimination protections played in achieving the ACA’s overarching goal of expanding access to healthcare for all individuals. HHS noted that discrimination within the healthcare system contributes to poor coverage and inadequate health outcomes, exacerbates existing health disparities in underserved communities, and leads to ineffective distribution of healthcare resources. *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. 31376, 31444 (May 18, 2016) (codified at 45 C.F.R. pt. 92). The 2016 Rule has played an essential role in encouraging historically marginalized populations to seek care.

The Proposed Rule would reverse and undo this progress. It would subject consumers and patients to discrimination and make it harder for them to access their entitled benefits. The Proposed Rule narrows the scope of the statute’s protections by exempting entities that are subject to Section 1557. It also eliminates important definitions of discrimination, opening the door to discriminatory treatment of a number of groups. Specifically, the Proposed Rule rolls back protections against discrimination based on gender identity, sex stereotyping, and pregnancy termination—effectively and invidiously sanctioning discrimination against women and LGBTQ persons. The Proposed Rule would also permit discrimination against and create barriers to healthcare for non-English speakers by limiting protections against national origin discrimination that require language assistance services. For individuals with disabilities, potential changes would reduce access to healthcare and health coverage by exempting certain entities from providing auxiliary aids and services. Because the Proposed Rule relies on flawed legal analysis and does not adequately account for sweeping changes that will cause significant harm, it contravenes both the ACA and the Administrative Procedure Act.

Accordingly, we urge you to withdraw the Proposed Rule.

I. The Proposed Rule Violates the Affordable Care Act

The Proposed Rule conflicts with several provisions of the ACA, including Section 1557 itself and Section 1554. Specifically, the Proposed Rule contravenes the statute by exempting covered entities, curtailing anti-discrimination protections, and failing to recognize a well-established private right of action. These exceptions and restrictions in the Proposed Rule must be rejected because they are contrary to clear congressional intent and frustrate the policy that Congress sought to implement. *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842-44 (1984); *see also Biodiversity Legal Found. v. Badgley*, 309 F.3d 1166, 1175 (9th Cir. 2002) (no deference if agency interpretation is contrary to clear congressional intent or frustrates the policy Congress sought to implement).

A. The Proposed Rule Improperly Exempts Entities that Are Subject to Section 1557.

The Proposed Rule would fail to implement the statute’s critical consumer protections by improperly limiting the entities to which they apply.² First, under section 92.3(a)(2), the Proposed Rule applies only to programs and activities administered by the Department *under Title I of the ACA*. 84 Fed. Reg. 27891. This is a violation of Section 1557’s requirement that its protections apply to “any program or activity that is administered by an Executive Agency” as well as to “any entity established under [Title I of the ACA].”³ In accordance with Section 1557, the Proposed Rule should apply to all programs and activities administered by the Department, including Medicare and other HHS programs.

Second, under section 92.3(b)-(c), the Proposed Rule applies to the complete operations of an entity receiving federal financial assistance (FFA) only if the entity is principally engaged in “the business of health care”—which is defined narrowly to exclude health insurance issuers. *Id.* This limitation is inconsistent with Section 1557’s prohibition on discrimination by “any health program or activity” if “any part” of that program or activity receives FFA, which is extremely broad and clearly includes any entity that is principally engaged in “health services, health insurance coverage, or other health coverage.” *See* 81 Fed. Reg. at 31386-86; *see also* 84 Fed. Reg. 23197 (interpreting “health program or activity” to include health insurance). The Department contends that it must redefine the scope of Section 1557 to make it consistent with the narrower scope of Title VI, Title IX and other pre-existing civil rights laws. *See* 84 Fed. Reg. 27852. But this ignores the fact that Congress intended Section 1557 to create new anti-discrimination protections and within Section 1557 defined the scope of these protections. *See Rumble v. Fairview Health Servs.*, No. 14-cv-2037 (SRN/FLN), 2015 WL 1197415, at *11 (D. Minn. Mar. 16, 2015) (noting that Section 1557 “create[d] a new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff’s protected class status”). The Department cannot simply ignore the fact that Section 1557 clearly applies to health insurance, regardless of the scope of other anti-discrimination statutes.

² In contrast to the Proposed Rule, the 2016 Rule applies to (1) “every health program or activity, any part of which receives federal financial assistance provided or made available by the Department”; (2) “every health program or activity administered by the Department”; and (3) “every health program or activity administered by a Title I entity.” 81 Fed. Reg. 31465. The 2016 Rule also explicitly defines “health program or activity” to include health insurance and provides specific protections against discrimination in health insurance issuance, coverage, cost-sharing, marketing, and benefit design. *See* 81 Fed. Reg. 31467, 31471-72. By uniformly covering entities which are principally engaged in health services, including health insurers, the 2016 Rule serves the central purpose of Section 1557, which is to ensure that “entities principally engaged in health services, health insurance coverage or other health coverage do not discriminate in any of their programs and activities, thereby enhancing access to service and coverage.” 81 Fed. Reg. at 31385-86.

³ In Section 1557, a disjunctive “or” separates the phrase “any entity established under this title” from the phrase “any program or activity that is administered by an Executive Agency.” Therefore, the adjectival modifier “established under this title” applies only to “any entity” and not to “any program or activity that is administered by an Executive Agency.” Section 92.3(a)(1) of the Proposed Rule incorrectly applies “under this title” to both sides of the disjunctive “or.”

And third, the Proposed Rule applies to entities that receive FFA only if that assistance is solely (or perhaps primarily) administered by HHS. *See* 84 Fed. Reg. 27861-62. But there is nothing in the statute that permits HHS to abdicate enforcement jurisdiction over its own programs simply because another agency is involved.

By narrowing the scope of entities that fall within the purview of Section 1557, HHS would limit the contexts in which consumers and patients are protected by the statute's critical anti-discrimination protections. This withdrawal of protection places consumers and patients at greater risk of discrimination on the basis of federally protected classes, including race, color, national origin, sex, disability, and age. As HHS previously recognized, “[i]ndividuals who have experienced discrimination in the health care context often postpone or do not seek needed health care; individuals who are subject to discrimination are denied opportunities to obtain health care services provided to others, with resulting adverse effects on their health status.” 81 Fed. Reg. at 31444. This will result in a “marketplace comprised of higher medical costs due to delayed treatment, lost wages, lost productivity, and misuse of people’s talents and energy.” *Id.*

B. The Proposed Rule Is Inconsistent With Statutory Anti-Discrimination Protections.

More broadly, the Proposed Rule is inconsistent with, and undermines, the robust anti-discrimination protections provided by Section 1557. On the one hand, the Proposed Rule eliminates key definitions and protections that are necessary to effectively implement the statute. For example, Section 1557 prohibits discrimination in health programs on the basis of any ground listed under Title IX, including discrimination on the basis of sex. 42 U.S.C. § 18116(a); 20 U.S.C. § 1681 *et seq.* Both federal case law and HHS regulations have long recognized that discrimination on the basis of sex is not limited to discrimination based on “biological sex”—that is, the “physiological distinction []’ between ‘male and female,’” 84 Fed. Reg. 27856—but also includes discrimination based on other grounds, including gender identity, *see infra* at Section II(B). This was the approach taken in the 2016 Rule. Under the Proposed Rule, however, HHS would eliminate the 2016 Rule’s definition of sex discrimination as including discrimination based on gender identity, sex stereotyping, and pregnancy status (including termination of pregnancy). HHS appears instead to endorse a narrow interpretation of “sex” as referring only to “biological sex,” 84 Fed. Reg. at 27875, that is inconsistent with Section 1557 and well-established case law.

On the other hand, the Proposed Rule incorporates restrictions and exemptions that improperly limit the protections provided by Section 1557. For instance, in addition to limiting the scope of application as discussed above, the Proposed Rule imports religious and abortion exemptions from Title IX into Section 1557. But Section 1557 does not require or authorize these “blanket” exemptions, which are “limited...to educational institutions.” 81 Fed. Reg. 31379-80. And for good reason: blanket exemptions are improper in the healthcare context because they “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.” *Id.* It also undermines the physician-patient relationship when necessary care is forestalled.

C. The Proposed Rule Fails to Recognize A Private Right of Action for Disparate Impact Claims.

The Proposed Rule also fails to recognize that Section 1557 permits private rights of action for disparate impact claims. The 2016 Rule makes clear HHS's prior view that Section 1557 established an express private right of action for individuals seeking to bring healthcare discrimination claims, and the rule sets a common legal standard for Section 1557 discrimination claims, including disparate impact analysis on the basis of any of the criteria covered by the statute.

HHS's reversal on this issue is contrary to congressional intent to create a health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff's protected class status. *Rumble*, 2015 WL 119715, at *11. Under the Proposed Rule, a private claim would be dependent on a right of action in the underlying anti-discrimination statute. This interpretation "would lead to an illogical result, as different enforcement mechanisms and standards would apply to a Section 1557 plaintiff depending on whether the plaintiff's claim is based on her race, sex, age, or disability." *Id.*; see e.g., *Edmo v. Idaho Dep't of Corr.*, No. 1:17-cv-00151-BLW, 2018 WL 2745898, at *9 (D. Idaho June 7, 2018) ("[C]ross-referencing the statutes and the express incorporation of the enforcement mechanisms from those statutes is probative of Congressional intent to provide both a private right and a private remedy for violations of Section 1557."); *Esparza v. Univ. Med. Ctr. Mgmt. Corp.*, No. 17-4803, 2017 WL 4791185, at *5 (E.D. La. Oct. 24, 2017) (concluding it was "abundantly clear to the Court that Congress intended to create a private right of action to enforce § 1557"); *Doe One v. CVS Pharmacy, Inc.*, 348 F. Supp. 3d 967, 982 (N.D. Cal. 2018) (finding plaintiffs had not sufficiently alleged disparate impact); see also *Cannon v. Univ. of Chi.*, 441 U.S. 677, 703 (1979) (recognizing that Congress intended to create Title IX remedies comparable to those available under Title VI, including a private cause of action for victims of the prohibited discrimination, and finding that age and advanced degrees criteria had a disparate impact on women).

D. The Proposed Rule Undermines Section 1554 of the ACA.

The Proposed Rule also conflicts with Section 1554 of the ACA, which explicitly prohibits the Secretary of HHS from promulgating any regulation that: "(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care; [or] (2) impedes timely access to health care services..." 42 U.S.C. § 18114. The Proposed Rule would create unreasonable barriers and impede timely access to healthcare by reversing protections against discrimination of historically marginalized communities. As the Department recognized in the 2016 Rule, the impact will be to increase disparities in healthcare and many vulnerable populations will be underserved in our healthcare system. *See* 81 Fed. Reg. 31460. This violates Section 1554. *See California v. Azar*, No. 19-cv-01184-EMC, 2019 WL 1877392, at *24 (N.D. Cal. Apr. 26, 2019) (HHS likely violated Section 1554 where Title X rule "obfuscate[s] and obstruct[s] patients from receiving information and treatment for their pressing medical needs").

II. The Proposed Rule Violates the Administrative Procedure Act

A. The Proposed Rule Exceeds Agency Authority

The Proposed Rule exceeds the authority given to the regulating agency by the statutes it cites and therefore violates the Administrative Procedure Act. 5 U.S.C. § 706. Federal agencies, “literally [have] no power to act . . . unless and until Congress confers power upon” them. *La. Pub. Serv. Comm’n v. FCC*, 476 U.S. 355, 374 (1986); 5 U.S.C. § 706(2)(C). HHS was not given the power to alter Section 1557’s statutory terms, but that is precisely what the Proposed Rule would do. As discussed above, the Proposed Rule redefines which entities are subject to the protections of the statute and removes explicit nondiscrimination protections embedded in it. For example, by eliminating sex stereotyping, sexual orientation, and gender identity from HHS regulations, HHS places healthcare services for gender nonconforming men and women, LGBTQ people, and other consumers at risk without congressional authorization to make these changes. Congress enacted Section 1557 to protect individuals from discrimination, not to encourage it. *See Ragsdale v. Wolverine World Wide, Inc.*, 535 U.S. 81, 91-92, 101-102 (2002) (holding agency interpretation unreasonable where it conflicts with law’s “remedial scheme” and intent). The Proposed Rule’s reinterpretation of federal anti-discrimination protections is not supported by any federal statute and therefore cannot stand.

B. The Proposed Rule is Arbitrary and Capricious Because It Removes Critical Anti-Discrimination Protections Without Adequate Justification and Inconsistent with Precedent

HHS justifies the Proposed Rule as needed in light of the preliminary injunction issued in *Franciscan Alliance*, 227 F. Supp. 3d 660; 84 Fed. Reg. at 27849. But this case clearly does not justify the changes made in the Proposed Rule.

In *Franciscan Alliance*, the preliminarily court enjoined enforcement of the 2016 Rule’s prohibition of discrimination on the basis of gender identity and termination of pregnancy. *Id.* at 696. In the court’s view, HHS’s definition of “sex discrimination” exceeded Title IX’s authority incorporated in Section 1557 and therefore violated the APA. *Id.* at 689. In addition, the district court held that HHS’s failure to “incorporate Title IX’s religious and abortion exemptions nullifies Congress’s specific direction to prohibit only the ground proscribed by Title IX.” *Id.* at 690-691 (citations omitted).⁴

The limited scope of this ruling does not warrant the dramatic reversals contained in the Proposed Rule. Obviously, an injunction concerning “sex discrimination” does not support substantially changing, or in some cases entirely eliminating, other aspects of Section 1557, for example, which entities are covered, language access, and health insurance benefits. Nor does

⁴ Two other courts issued similar temporary injunctions, issued under seal and limited to (1) the challenged provisions of the 2016 Rule; and (2) the named plaintiffs. *See Sealed Order Staying Enforcement, Religious Sisters of Mercy v. Burwell*, No. 3:16-cv-386 (D.N.D. Dec. 30, 2016), ECF No. 23; Sealed Order Staying Enforcement, *Catholic Benefits Association v. Burwell*, No. 3:16-cv-432 (D.N.D. Dec. 30, 2016), ECF No. 23.

the case justify the Department eliminating well-established protections against sex discrimination. While HHS focuses on the decision in *Franciscan Alliance*, other federal district courts have concluded gender identity discrimination is prohibited by Section 1557. See, e.g., *Prescott v. Rady Children's Hospital-San Diego*, 265 F. Supp. 3d 1090, 1098-1100 (S.D. Cal. 2017) (finding Section 1557's plain language bars gender identity discrimination); *Tovar v. Essential Health*, 342 F. Supp. 3d 947, 957 (D. Minn. 2018) (same); *Boyden v. Conlin*, 341 F. Supp. 3d 979 (W.D. Wisc. 2018) (holding Wisconsin's use of transgender exclusions in its state employee health insurance plan constituted sex discrimination in violation of Section 1557 and Title VII); *Flack v. Wis. Dept of Health Servs.*, 328 F. Supp. 3d 931, 951 (W.D. Wis. 2018).

Indeed, federal case law has long held that the definition of “sex discrimination” in a variety of federal civil rights laws, including Title IX, includes discrimination on the basis of gender-based assumptions and stereotypes, and the vast majority of federal courts have found that disparate treatment based on gender identity constitutes unlawful discrimination in employment, education, and healthcare. *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989); *Dodds v. U.S. Dep’t of Educ.*, 845 F.3d 217, 223 (6th Cir. 2016) (transgender girl denied access to girls’ bathroom was likely to succeed on merits of Title IX sex discrimination claim); *G.G. ex rel. Grimm v. Gloucester Cnty. Sch. Bd.*, 822 F.3d 709, 721, 723 (4th Cir. 2016) (David, J., concurring), cert. granted in part, 137 S. Ct. 369 (Oct. 28, 2016) (noting the “weight of circuit authority concluding that discrimination against transgender individuals constitutes discrimination ‘on the basis of sex’”); *Kastl v. Maricopa Cty. Cnty. Coll. Dist.*, 325 F. App’x 492, 493 (9th Cir. 2009) (“After *Hopkins* and *Schwenk*, it is unlawful to discriminate against a transgender (or any other) person because he or she does not behave in accordance with an employer’s expectations for men or women.”); *Barnes v. City of Cincinnati*, 401 F.3d 729, 737, 739 (6th Cir. 2005) (transgender woman was member of protected class under Title VII); *Smith v. City of Salem*, 378 F.3d 566, 572 (6th Cir. 2004) (transgender employee suspended from job stated claim for sex discrimination under Title VII); *Schwenk v. Hartford*, 204 F.3d 1187, 1201–02 (9th Cir. 2000) (“[S]ex’ under Title VII encompasses both sex—that is, the biological differences between men and women—and gender.”).

This inclusive definition of sex discrimination has been incorporated into numerous other HHS regulations, with which the Proposed Rule is inconsistent. See 84 Fed. Reg. at 27871 (listing conflicting regulations). These regulations, many of which significantly pre-date the 2016 Rule, provide explicit protections against discrimination based on gender identity and/or sexual orientation. See, e.g., Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310 (Mar. 27, 2012) (codified at 45 C.F.R. § 155.120). The Proposed Rule eliminates these long-standing anti-discrimination protections through what it refers to as “limited conforming amendments.” The very fact that these amendments are necessary belies HHS’s claim that the definition of sex discrimination adopted in the 2016 Rule represented a novel and unsupported interpretation of federal civil rights law. 84 Fed. Reg. at 27853, 27849. To the contrary, it is the Proposed Rule that advances an outlier interpretation of sex discrimination—one that is inconsistent with years of agency interpretation and case law.

C. The Proposed Rule Fails to Address the Significant Costs and Harms It Will Impose

The Proposed Rule is also arbitrary and capricious because it fails to thoroughly consider important regulatory costs, including any significant direct or indirect health costs to consumers and to the States. Generally, the costs of an agency’s action are “a relevant factor that the agency must consider before deciding whether to act,” and is “an essential component of reasoned decision-making under the Administrative Procedure Act.” *Mingo Logan Coal Co. v. EPA*, 829 F.3d 710, 732-33 (D.C. Cir. 2016); *see also Michigan*, 135 S. Ct. at 2707-08 (“Agencies have long treated costs as a centrally relevant factor when deciding whether to regulate.”). The failure to consider significant costs, here, is particularly problematic because it results from a reversal of a prior policy that induced significant reliance interests. *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). And a more “detailed justification” is needed when “serious reliance interests” are at stake. *Id.*

1. The Proposed Rule Will Harm Women

The Proposed Rule seeks to limit protections barring discrimination against women and fails to give adequate consideration to the harm it will cause. First, by eliminating the definition of “on the basis of sex” provided in the 2016 Rule, the Proposed Rule reverses protections against discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, recovery from childbirth or related conditions. Second, the Proposed Rule eliminates protections against discrimination in the health insurance market, where discrimination against women is a continuing problem. And third, the Proposed Rule includes a “blanket” abortion and religious exemption. Together, these changes will disproportionately harm women, particularly women seeking reproductive health services.⁵ Refusal of service based on conscience objections is “particularly widespread in the area of reproductive medicine,” and can cause extreme physical and emotional harm to women.⁶ The Department previously declined to include “blanket” exemptions in the 2016 Rule. 81 Fed. Reg. at 31379-80.

⁵ Am. Coll. of Obstetricians & Gynecologists, *The Limits of Conscientious Refusal in Reproductive Medicine*, Committee Opinion No. 385, *Obstetrics & Gynecology* (Nov. 2007), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine>. (Materials cited in these footnotes are included as attachments to this letter.)

⁶ Am. Coll. of Obstetricians & Gynecologists, *The Limits of Conscientious Refusal in Reproductive Medicine*, Committee Opinion No. 385, *Obstetrics & Gynecology* (Nov. 2007), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine>; *see also* Pamela Herd, et al., *The Implications of Unintended Pregnancies for Mental Health in Later Life*, *Am. Journal of Pub. Health* (February 17, 2016), <https://ajph.aphapublications.org/doi/10.2105/AJPH.2015.302973> (experiencing unwanted pregnancies appears to be strongly associated with poor mental health effects for women later in life.); M. Antonia Biggs, et al., *Women’s Mental Health and Well-being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, *JAMA Psychiatry* (Feb. 2017), <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2592320> (women who are denied an abortion

Discriminatory denials of service related to reproductive health under the Proposed Rule will result in an increase in unintended pregnancies which are associated with poor birth outcomes and maternal health complications, including preterm birth, low birth weight, stillbirth, and early neonatal death.⁷ Women facing an unintended pregnancy are more likely than those with intended pregnancies to receive late or no prenatal care, to smoke and consume alcohol during pregnancy, to suffer from perinatal mood disorders, and to experience domestic violence during pregnancy.⁸ Also, these women are more likely to experience economic hardship and insecurity.⁹ Women's ability to achieve and maintain economic security has important health benefits, including lower risk of disease, better mental health, greater access to medical care, and longer life expectancy. And the children of these women also face negative development, health, caregiving, and socioeconomic consequences.¹⁰ By contrast, women, particularly women of color, who have access to reproductive health services are more likely to pursue educational opportunities and have greater participation in the work force.¹¹ Reproductive control enables equal participation by women in the labor market. Limited, delayed, and denied care access due to discrimination has far-reaching economic consequences. The Proposed Rule will thus harm women, their families, and society generally.

The Department does not contest that the protections eliminated by the 2016 Rule are necessary to combat continuing discrimination which can lead to poor and ineffective care experienced by women. 81 Fed. Reg. at 31428, 31444, 31459-61. Nor does the Department deny that discrimination on the basis of pregnancy, including termination of pregnancy, is a form of sex discrimination covered by Section 1557. See 84 Fed. Reg. at 27870 n.159. Rather, the

are more likely to initially experience higher levels of anxiety, lower life satisfaction and lower self-esteem compared with women who received an abortion).

⁷ Megan Kavanaugh, et al., *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers*, New York: Guttmacher Institute (July 2013), <http://www.guttmacher.org/report/contraception-and-beyond-health-benefits-services-provided-family-planning-centers>; Caitlin Gerdts, et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, Women's Health Issues (Jan.-Feb. 2016), <https://www.sciencedirect.com/science/article/pii/S1049386715001589>.

⁸ Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps* (2011), <https://www.nap.edu/read/13181/chapter/1>, at 103.

⁹ Diana Greene Foster, et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, Am. Journal of Pub. Health (Feb. 7, 2018), <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2017.304247>.

¹⁰ Diana Greene Foster, et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, *The Journal of Pediatrics* (Feb. 2019), [https://www.jpeds.com/article/S0022-3476\(18\)31297-6/fulltext](https://www.jpeds.com/article/S0022-3476(18)31297-6/fulltext); Diana Greene Foster, et al., *Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Born After Denial of Abortion vs After Pregnancies Subsequent to an Abortion*, *JAMA Pediatrics* (Nov. 2018), <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2698454>.

¹¹ Anna Bernstein et al., *The Economic Effects of Abortion Access: A Review of the Evidence*, Institute for Women's Policy Research (July 18, 2019), <https://iwpr.org/publications/economic-effects-abortion-access-report/>.

Department states that, although it is eliminating the specific protection provided by the 2016 Rule, it will continue to investigate individual claims on a case-by-case basis. *Id.* But this is the exact approach the Department concluded was ineffective: “continued discrimination demonstrates the need for further clarification regarding the prohibition of discrimination on the basis of sex.” 81 Fed. Reg. at 31460. The Proposed Rule provides no explanation for why the Department believes that this discarded approach will work now.

2. The Proposed Rule Will Harm LGBTQ Individuals

The Proposed Rule will also inflict harm on LGBTQ individuals by reversing protections against discrimination on the basis of sex stereotyping and gender identity. It is well documented that LGBTQ individuals face discrimination in healthcare settings. LGBTQ persons report experiencing barriers to receiving medical services, including disrespectful attitudes, discriminatory treatment, inflexible or prejudicial policies, and even outright refusals of essential care, leading to poorer health outcomes and often serious or even catastrophic consequences.¹² Transgender people in particular report hostile and/or disparate treatment from providers.¹³ More broadly, LGBTQ individuals experience worse physical health compared to their heterosexual and non-transgender counterparts,¹⁴ have higher rates of chronic conditions,¹⁵ and are at higher risk for certain mental health and behavioral health conditions, including depression, anxiety, and substance misuse.¹⁶ LGBTQ youth, in particular, report a greater incidence of mental health issues and suicidal behaviors, suffer bullying and victimization to a greater extent than heterosexual youth, and have difficulty addressing concerns related to their sexual identity with their medical providers.¹⁷

HHS explicitly recognized the seriousness of continuing discrimination against LGBTQ individuals, and the healthcare disparities it causes, in the 2016 Rule. 81 Fed. Reg. at 31460. HHS concluded that this continued discrimination warranted further clarification regarding the

¹² Lambda Legal, *When Health Care Isn’t Caring: Lambda Legal’s Survey on Discrimination Against LGBT People and People Living with HIV* at 5-7, https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf; see also Jennifer Kates, et al., Kaiser Family Found., *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals in the U.S.* (May 3, 2018), <https://www.kff.org/report-section/health-and-access-to-care-and-coverage-lgbt-individuals-in-the-us-health-challenges/>.

¹³ Nat’l Ctr. for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* at 97 (2016), <http://www.transequality.org/sites/default/files/docs/usts%20Full%20Report%20-%20FINAL%201.6.17.pdf>; see also Kates, *supra* note 12.

¹⁴ Kates, *supra* note 12, at 5.

¹⁵ *Id.*

¹⁶ Kates, *supra* note 12, at 8.

¹⁷ Hudaisa Hafeez, et al., *Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review*, Cureus (April 2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5478215/>.

prohibition of discrimination on the basis of sex to not only include women, but also transgender individuals. *Id.* In light of this, the 2016 Rule prohibits: (1) the blanket exclusion of transition-related healthcare services; (2) the denial or limitation of coverage of services used for gender transition when those services would normally be covered when treating a non-transition related health condition; and (3) the refusal to cover treatment that is typically associated with a particular gender because an individual identifies with another gender or is listed as having another gender in their medical records. 81 Fed. Reg. at 31471-72. And if an insurance company provided coverage for a particular treatment of any condition, the carrier cannot refuse to cover the same treatment because it is requested by a transgender or gender-nonconforming individual, or because it is being utilized in a manner consistent with their gender identity, including in access to healthcare facilities. *Id.* at 31435.

HHS's proposed reversal of these critical gains for the LGBTQ community will result in precisely the consequences HHS warned against in detail in the 2016 Rule. As a result of the Proposed Rule, LGBTQ individuals will face unreasonable barriers in obtaining appropriate medical care by postponing or avoiding seeking healthcare services. Such outcomes will lead to negative health consequences and exacerbate health disparities. 81 Fed. Reg. at 31460. Furthermore, HHS's attempts to sanction discrimination against the LGBTQ community in the provision of healthcare will require the States and their public health systems to fill the predictable void left by the Proposed Rule. The Proposed Rule will also impede State efforts, including for example New Jersey's commitment, to end the HIV epidemic and to eliminate significant barriers to needed preventative care for those at higher risk and to treatment for those living with HIV.¹⁸

Far from taking adequate account of these harms, in its Regulatory Impact Analysis, HHS counts the reduced costs of investigating discrimination complaints as a "benefit." HHS predicts that HHS's Office for Civil Rights (OCR) long-term caseload would have increased 5% under the 2016 Rule (rather than the 1% estimated in 2016), with 60% of that increase attributable to sex discrimination claims based on gender identity and sex stereotyping. 84 Fed. Reg. at 27883. Based on that premise, HHS also assumes covered entities have experienced a 3% increase in costs from grievance claims based on gender identity and sex stereotyping. *Id.* However, HHS provides no support for these assertions and admits its numbers are speculative given that *Franciscan Alliance* enjoined enforcement of claims based on the 2016 Rule's definition of sex discrimination. *Id.* Further, HHS calculates that covered entities will save 1.5% of the annual median wage of a medical and health services manager because of the decrease in grievance caseload (assuming 50% of entities will continue to accept and handle grievances based on the current rule's definition of sex discrimination). *Id.* at 27883-84. This "cost savings" or "value" estimate is likely too high, given that most medical and health services managers appear to have many job duties apart from handling grievances (whereas HHS seems to assume they spend 100% of their work time on grievances).

¹⁸ <https://nj.gov/health/news/2018/approved/20181130a.shtml>.

3. The Proposed Rule Will Harm People With Limited English Proficiency

Over 66 million people in the United States speak a language other than English at home and approximately 25 million do not speak English “very well” and may be considered Limited English Proficient (LEP).¹⁹ Language-related barriers severely limit an individual’s opportunity to access healthcare services, assess options, express choices, follow medication instructions, ask questions, and seek assistance.²⁰

HHS has long recognized that Congress, in enacting the ACA, sought to better understand the causes of disparities in healthcare and to find effective means to eliminate them, including through the use of language services.²¹ Consistent with this understanding, in the 2016 Rule, HHS recognized that national origin discrimination includes discrimination based on the “linguistic characteristics of a national origin group.” 81 Fed Reg. 31467, 31470-71. And in order to “ensure that [health programs and activities] aimed at the American public do not leave some behind simply because they face challenges communicating in English,” *id.* at 31410, HHS provided specific protections to guarantee meaningful access to healthcare for LEP individuals, *id.* at 31470-71.

The Proposed Rule fails to take adequate account of the effect that eliminating the definition of national origin discrimination, and related specific anti-discrimination protections, will have on LEP individuals. For example, HHS fails to explain its reversal from a patient-centered rule to one almost exclusively focused on costs incurred by the provider. The Proposed Rule revises the test for compliance with the “meaningful access” provision from a two-factor test that emphasizes the individual’s needs to a four-factor test that emphasizes impact on the covered entity. 45 C.F.R. § 92.201(b). The 2016 Rule uses a compliance test that evaluates and gives substantial weight to the nature and importance of the health program and the particular communication at issue and takes into account other relevant factors including whether the entity has developed and implemented a language access plan. *Id.* This test properly prioritizes individual patients’ needs to ensure that LEP individuals are able to communicate with their healthcare service and coverage providers clearly. The Proposed Rule would codify a four-factor test that considers: (1) the number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come in contact with the program; (3) the nature and importance of the program, activity, or service

¹⁹ U.S. Census Bureau, *Characteristics of People by Language Spoken at Home, American Community Survey 1-Year Estimates* tbls. S1601, S1603 (2017), <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml>.

²⁰ Nat'l Health Law Program & Access Project, *Language Services Action Kit* at 40 (2004), https://www.commonwealthfund.org/sites/default/files/documents/__media_files_publications_fund_report_2002_may_providing_language_interpretation_services_in_health_care_settings__examples_from_the_field_lep_actionkit_reprint_0204_pdf.pdf.

²¹ U.S. Dep’t of Health & Human Servs., *ASPE Research Brief: The Affordable Care Act and Asian American and Pacific Islanders* at 2 (May 1, 2012), <https://aspe.hhs.gov/system/files/pdf/37346/rb.pdf>; U.S. Dep’t of Health & Human Servs., *HHS Action Plan to Reduce Racial and Ethnic Health Disparities* at 15, 17, 19-20, https://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

provided by the program to people's lives; and (4) the resources available to the grantee/recipient or agency, and costs. 84 Fed. Reg. at 27865. This test increases the likelihood that individuals may not be provided necessary healthcare information, a result that is particularly ill-suited to this context, where access to interpretation services can be a matter of life and death.

Under the Proposed Rule, HHS would no longer require covered entities to post notices and taglines. 84 Fed. Reg. at 27868-69. Taglines are short 1-2 sentence descriptions in a non-English language that inform an individual with LEP how to access language services. HHS fails to account for how the change will decrease access for LEP patients and keep many healthcare consumers uninformed of Section 1557's nondiscrimination protections.²² HHS acknowledged that "an unknown number of persons are likely not aware of their right to file complaints with the HHS OCR and some unknown subset of this population may suffer remediable grievances, but will not complain to OCR absent notices informing them of the process." 84 Fed. Reg. at 27883. By eliminating the notice posting requirement and designated employee to coordinate compliance and investigate complaints as currently required, HHS is only amplifying the problem. HHS calculates the savings for providers alone, and neglects the costs to consumers who will not know that they are entitled to meaningful language access or civil rights protections against discrimination.

The Proposed Rule will also reduce the quality of interpretation services LEP individuals receive in several ways. First, the proposal lowers the standards for interpreters that covered entities must provide by eliminating the word "qualified" from the definition of interpreter. 84 Fed. Reg. at 27860. Second, the Proposed Rule also eliminates the requirement that covered entities provide real-time video interpretation services just as they must for American Sign Language (ASL) interpretation, instead creating a lower standard for remote interpretation that only requires the provision of audio interpretation services. *Id.* at 27868. These proposed changes will reduce the quality of the interpreters covered entities may use as well as the quality of the provision of remote interpretation services. Third, by eliminating the definitions section of

²² In fact, this proposed change is the centerpiece of the Proposed Rule's regulatory impact analysis, with HHS estimating it will result in \$3.16 billion in savings for covered entities over five years. *Id.* at 27873. Of this amount, pharmacy-related communications constitute a significant portion (\$2.9 billion) of HHS's estimated number, which it conveniently used to justify sweeping changes to critical consumer protection rules. *Id.* at 27880-81. In weighing regulatory actions, agencies cannot "put a thumb on the scale" by undervaluing key effects and overvaluing others. *Ctr. for Biological Diversity v. Nat'l Highway Traffic Safety Admin.*, 538 F.3d 1172, 1198 (9th Cir. 2008); *see also California v. BLM*, 277 F. Supp. 3d 1106, 1123 (N.D. Cal. 2017) (agencies impermissibly considered only "one side of the equation" by calculating benefits and ignoring costs). Here, HHS seems to do just that by undervaluing the human impact of the Proposed Rule and focusing solely on purported cost savings for covered entities. In fact, the Supreme Court highlighted that it would generally be irrational not to consider the "harms that regulation might do to human health." *Michigan v. EPA*, 135 S. Ct. 2699, 2707 (2015). HHS's analysis is particularly irrational given that it failed to consider any alternatives to the complete removal of the tagline requirement, such as whether significant cost savings could result simply by issuing guidance to covered entities clarifying which communications HHS considers "significant." Many covered entities currently include taglines in every communication to ensure they do not run afoul of the tagline regulations, a practice that is likely not required under the 2016 Rule.

the 2016 Rule, including the definition of national origin that expressly includes “manifestation of the . . . linguistic characteristics of a national origin group,” HHS has improperly undermined the very rationale for providing language services.

4. The Proposed Rule Will Harm Persons Living With Disabilities

Persons with disabilities face a variety of barriers to healthcare access, including lack of sign language interpretation, appointment times that are too short, inaccessible facilities and equipment, and problematic provider attitudes.²³ And while disability affects people from all backgrounds, this does not mean that impairment occurs uniformly throughout the population.²⁴ Disability is identified in differing ways among surveys, but national data indicates that disability prevalence is highest among African Americans, who report disability at 34.9 percent compared to 31.5 percent for non-Latino whites, 24.6 percent for Latinos and 20.1 percent of Asian Americans.²⁵ Thus, people with disabilities are likely to fall into more than one protected category, creating a cumulative impact on healthcare disparities.

Recognizing these disparities, Section 1557 and the 2016 Rule prohibit discrimination based on an individual’s disability. The 2016 Rule contains important provisions to address these disparities in health outcomes and barriers to healthcare access. For this reason, the National Health Law Program “strongly support[ed]” the inclusion of accessibility standards and the adoption of the 2010 American Disabilities Act (ADA) Standards of Accessible Design.²⁶

Under the 2016 Rule, all covered entities must provide auxiliary aids and services to individuals with disabilities, regardless of the entity’s size. *See* 81 Fed. Reg. at 31470-71. The 2016 Rule includes detailed standards for the provision of ASL interpretation, including standards for video quality during remote interpretation. *Id.* The 2016 Rule also requires that new construction or alteration of buildings or facilities subject to Section 1557 must comply with the 2010 ADA Standards for Accessible Design. *Id.* The Rule allows departures from these standards only where other methods provide substantially equivalent or greater access to and usability of the building. *Id.*

HHS seeks comment on exempting entities with fewer than 15 employees from having to provide auxiliary aids and services. Such an exemption would reduce access to healthcare and health coverage for individuals with disabilities in contravention of one of the goals of the ACA. Moreover, it has been OCR’s policy for over a decade not to exempt such entities. *Id.* at 31407.

²³ Silvia Yee, *Disability Discrimination in Health Care*, Disability Rights Education & Defense Fund, <https://dredf.org/public-policy/health-access-to-care-old/disability-discrimination-in-health-care/>.

²⁴ Danielle Taylor, U.S. Census Bureau, *Americans With Disabilities: 2014, Current Population Reports* at 2 (Nov. 2018), <https://www.census.gov/content/dam/Census/library/publications/2018/demo/p70-152.pdf>.

²⁵ *Id.* at 5-6.

²⁶ Nat’l Health Law Program, Comment Letter on Proposed Rule on Nondiscrimination in Health Programs and Activities at 47 (Nov. 9, 2015), <https://www.regulations.gov/document?D=HHS-OCR-2015-0006-0827>, at 75-76.

The longstanding policy reflected in the 2016 Rule provides consistency with Title III of the ADA. That Title obligates privately operated public accommodations, regardless of their size, to provide appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities. *Id.* Under Title III, entities seeking exemption must demonstrate that providing such services would fundamentally alter the nature of their program, services or activities, or would result in undue financial and administrative burdens. *Id.* A blanket exemption for smaller covered entities is unnecessary and would adversely affect access to healthcare and health coverage for individuals with disabilities. Requiring all entities to provide auxiliary aids and services furthers consistency among disability discrimination laws. *Id.*

Finally, HHS seeks comment on whether to add an undue hardship exemption to § 92.205, which requires covered entities to make reasonable modifications to policies, practices, or procedures when necessary, to avoid discrimination on the basis of disability, except if the modification would fundamentally alter the nature of the health program or activity. This provision is derived from regulations implementing Title II of the ADA promulgated by the Department of Justice and imposed on all public entities, 28 C.F.R. § 35.104, and is consistent with the U.S. Supreme Court’s decision interpreting Section 504 in *Alexander v. Choate*, 469 U.S. 287 (1985). Adopting an undue hardship exemption would inappropriately put covered entities’ costs above the needs of persons with disabilities and run contrary to Congressional intent and provide official sanction for discrimination.

5. The Proposed Rule Will Harm Public Health and Impose Direct Costs on States

Finally, by eliminating protections necessary to improve access to adequate coverage and healthcare, the Proposed Rule will negatively affect public health and impose significant costs on States. The direct public health effects of eliminating anti-discrimination protections are obvious: an increase in “poor and inadequate health care” leading to worse health outcomes for individuals and “exacerbate[d]...health disparities in underserved communities.” 81 Fed. Reg. 31444 (describing effects of “discrimination in the healthcare context”). HHS previously recognized that individuals who have experienced discrimination in healthcare often postpone or do not seek needed healthcare, resulting in adverse health outcomes. 81 Fed. Reg. at 31444. This, in turn, results in a “marketplace comprised of higher medical costs due to delayed treatment, lost wages, lost productivity, and misuse of people’s talents and energy.” *Id.* These harms would be especially severe in rural areas where patients may confront only a limited number of providers.

Individuals denied coverage and healthcare as a result of discrimination will turn to government-funded programs that act as both providers and insurers of last resort. This includes care provided at public healthcare facilities and paid for through State-funded programs, including Medicaid. *See California v. Azar*, 911 F.3d 558, 572 (9th Cir. 2018) (recognizing HHS rule that causes women to lose contraceptive coverage and healthcare services will “inflict economic harm to the states” because women “will turn to state-based programs or programs reimbursed by the state”); *Massachusetts v. U.S. Dept. of Health & Human Servs.*, 923 F.3d 209, 216-17 (1st Cir. 2019) (same); *Pennsylvania v. President United States*, No. 17-3752, 2019 WL

3057657, at *6–8 (3d Cir. July 12, 2019) (same). Affordability presents a disproportionate barrier to care for lower-income residents.

For example, by failing to protect women from discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, recovery from childbirth or related conditions, the Proposed Rule will inevitably harm public health by resulting in women being denied comprehensive reproductive healthcare services. Denial of services related to reproductive health will result in an increase in unintended pregnancies with resulting increased costs to the States. Fifty-one percent of all U.S. births in 2010 were paid for by public insurance through Medicaid, the Children’s Health Insurance Program, and the Indian Health Service.²⁷ In California, for example, 64.3% of unplanned births are publicly funded, primarily by Medi-Cal, the state’s Medicaid program, in Massachusetts, 56.4% of unintended pregnancies are publicly funded, and in New Jersey, 52.4% of unplanned births are publicly funded.²⁸ In 2010, California spent \$1.8 billion on unintended pregnancies, of which \$689.3 million was paid for from state coffers, and New Jersey spent \$477.1 million on unintended pregnancies, of which \$186.1 million of public costs were borne by the State of New Jersey.²⁹ The average cost of an unintended pregnancy is \$15,364. And a recent study found that carrying an unwanted pregnancy to term quadrupled the odds that a new mother and her child would live below the federal poverty lines.³⁰ And families living below the poverty line often are forced to resort to more government social benefit programs, including state and federal programs.

Further, States will experience increased costs if self-insured ERISA plans stop offering gender transition care due to the discriminatory Proposed Rule because state laws that may guarantee comprehensive insurance coverage to transgender individuals do not extend to these plans.³¹ For example, 5,497,758 Californians had coverage through self-insured plans in 2018.³²

²⁷ Adam Sonfield, et al., *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, Guttmacher Inst. (Feb. 2015), https://www.guttmacher.org/sites/default/files/report_pdf/public-costs-of-up-2010.pdf.

²⁸ *Id.* at Table 3; *see id.* for additional States.

²⁹ *Id.* at Table 3; *see id.* for additional States.

³⁰ Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407, 412-413 (Mar. 2018), <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304247>.

³¹ There are an estimated 1.4 million transgender people living in the United States, and many more who do not conform to gender norms. Twenty states and the District of Columbia are estimated to have a higher percentage of transgender-identified adults than the national average, with the top three being the District of Columbia, Hawaii, and California. *See* Andrew R. Flores, et al, *How Many Adults Identify as Transgender in the United States*, The Williams Institute (June 2016), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf>.

³² California Department of Insurance, Health Insurance Covered Lives Report as of December 31, 2018, <https://www.insurance.ca.gov/01-consumers/110-health/coveredlivesprt.cfm>; California Department of

In Massachusetts, approximately 56% of people—about 2.3 million primary members—have self-insured plans.³³ A recent survey also indicates that 61 percent of all workers are enrolled in self-funded plans, including 81 percent of workers at firms with 200 or more workers.³⁴

The Proposed Rule will also result in increased costs to the States for uncompensated care. In the 2016 Rule, the Department specifically found that expanded anti-discrimination protections would lead to a decrease in these uncompensated care payments. 81 Fed. Reg. 31461 (recognizing that anti-discrimination protections under the 2016 Rule will contribute to a decrease in payments by the federal government for uncompensated care costs). Eliminating these same protections will inevitably lead to an increase in the more than \$19 billion dollars States pay each year to reimburse providers for uncompensated care.³⁵ In fact, state and local governments fund approximately 36.5 percent of government funded uncompensated care costs.³⁶

The Proposed Rule will also cause indirect public health effects. These are likely to include an increase in “violence against affected individuals;” an increase in “depression and suicide attempts among the affected populations;” and an overall increase “in substance abuse, smoking and alcohol abuse rates” and worsening “mental health.” 81 Fed. Reg. at 31461. As the Department has recognized, these negative public health outcomes have a significant economic impact on States. *Id.* at 31460 (discussing “a State of California economic impact assessment of State practices prohibiting gender discrimination in health care”).³⁷

Finally, the Proposed Rule also fails to account for increased costs to state regulatory agencies from an uptick in complaints alleging discrimination in healthcare. This will be particularly true in States that have civil rights laws and regulations that explicitly prohibit discrimination on the basis of gender identity and sexual orientation in healthcare. *See, e.g.,* Cal. Gov’t Code § 11135; 775 ILCS 5/1-103(O-1); 775 ILCS 5/5-102.1(a); M.G.L. c. 272, § 98; N.J. Stat. Ann. § 10:5-12(f).

Managed Health Care, Enrollment Summary Report - 2018,
<https://www.dmhc.ca.gov/DataResearch/FinancialSummaryData.aspx>.

³³ Center for Health Information and Analysis, Enrollment Trends 3 (2015), available at <http://www.chiamass.gov/assets/Uploads/enrollment/2018-feb/Enrollment-Trends-Feb-2018-Report.pdf>

³⁴ Kaiser Family Foundation, Employer Health Benefits 2018 Annual Survey, <https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/>.

³⁵ See Kaiser Family Found., *Uncompensated Care for the Uninsured in 2013: A Detailed Examination* at 4 (2014) (cited at 81 Fed. Reg. 31461 n. 380).

³⁶ See Teresa A. Coughlin, et al., Health Affairs, *An Estimated \$84.9 Billion In Uncompensated Care Was Provided In 2013; ACA Payment Cuts Could Challenge Providers* (May 2014), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.1068> at 812-13.

³⁷ See also California Department of Insurance, *Economic Impact Assessment Gender Discrimination in Health Insurance* (April 13, 2012), <https://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf>.

D. The Proposed Rule’s Illogical Contrast to the Refusal Rule Is Evidence of Flawed Reasoning that Renders It Arbitrary and Capricious

The Proposed Rule, when compared to the recently promulgated Refusal Rule (“Protecting Statutory Conscience Rights in Health Care; Delegations of Authority,” 84 Fed. Reg. 23170 (May 21, 2019)), takes a markedly different approach on enforcement, notice and postings (whether associated costs are justified), and whether definitions are needed for clarity. While the Proposed Rule eliminates the definition of key terms and specific protections provided by the 2016 Rule, the Refusal Rule states that this approach limits “knowledge of, compliance with, and enforcement of” the law and includes specific definitions and protections that go far beyond what is required by the text of federal conscience laws. *Id.* at 23175, 23263-64; *see also Am. Fed’n of Gov’t Employees, Local 2924 v. Fed. Labor Relations Auth.*, 470 F.3d 375, 380 (2006). And whereas the Proposed Rule seeks to eliminate the purported burden and high costs imposed by the 2016 Rule’s requirement that regulated health entities distribute non-discrimination notices³⁸ and taglines to customers, the Refusal Rule encourages such notices in order to establish compliance with that rule. 84 Fed. Reg. at 23270. Moreover, the two rules create confusion by adopting very different definitions of the same term: while the Proposed Rule defines “health program or activity” narrowly to eliminate anti-discrimination protections including in the health insurance market, the Refusal Rule interprets the term broadly to extend conscience protections to cover any entity providing any “service related to health or wellness” including “health related-insurance coverage.” Compare 84 Fed. Reg. at 27891 (§ 92.3(3)(b)), with 84 Fed. Reg. at 23197. In addition, the two rules adopt very different approaches to programs funded and administered by other agencies. Here, HHS refuses to apply Section 1557 to programs funded or administered by other agencies; but in the Refusal Rule, HHS appears to assert control over statutes and funding administered by U.S. Departments of Labor and Education. Compare 84 Fed. Reg. at 27861, with 84 Fed. Reg. at 23172, 23265-66, 23272 (implementing the “Departments of Labor, HHS, Education and Related Agencies Appropriation Act”).

The Refusal Rule is itself flawed for many reasons, but these stark differences in approach and specificity highlight the faulty reasoning behind the Proposed Rule and call into question HHS’s motivations. When HHS wants to promote a rule like the Refusal Rule, it adopts explicit definitions and notice requirements. Here, however, it is doing exactly the opposite by removing definitions and weakening communications provisions. This suggests that the reasons proffered in support of the Proposed Rule are pretextual. If an agency’s decision is “illogical on its own terms,” that decision is arbitrary and capricious. *Am. Fed’n of Gov’t Employees*, 470 F.3d at 380. That is the case with the Proposed Rule.

³⁸ As elsewhere, while the Department stresses the costs of notice requirements, 84 Fed. Reg. 27878-82, its analysis of the harm to consumers of eliminating them is cursory, *id.* at 27883.

III. Conclusion

The Proposed Rule is not only unlawful, it will have damaging, irreparable, and unnecessary repercussions for vulnerable patient populations including women, LGBTQ persons, individuals with disabilities, LEP persons, and others. In particular, the Proposed Rule demonstrates a reckless disregard for the healthcare needs of LGBTQ individuals. The administration's hostility toward this community, as evidenced by this rule, the "Refusal Rule," and a number of other proposals—such as those to ban transgender people from the military, allow discrimination in federally-funded shelters, and limit adoption opportunities—feed further discrimination, stigma, and ostracism. These policies affect this community's health outcomes, not only to the detriment of the affected citizens and their families, but also the States and their public health systems.³⁹ In sum, these policies and proposals seek to deprive these citizens in particular of "equal dignity in the eyes of the law." *Obergefell v. Hedges*, 135 S. Ct. 2584, 2608 (2015).

For these and the reasons set forth above, the States strongly oppose the Proposed Rule and urge that it be withdrawn.

Sincerely,



Xavier Becerra
California Attorney General



Maura Healey
Massachusetts Attorney General



Will
Connecticut Attorney General



Kathleen Jennings
Delaware Attorney General



Karl A. Racine
District of Columbia Attorney General



Clare E. Connors
Hawaii Attorney General

³⁹ Kates, *supra* note 12.

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Kwame Raoul
Illinois Attorney General

Tom Miller
Iowa Attorney General

Andy Beshear
Kentucky Attorney General

Brian E. Frosh
Maryland Attorney General

Dana Nessel
Michigan Attorney General

Keith Ellison
Minnesota Attorney General

Aaron D. Ford
Nevada Attorney General

Gurbir S. Grewal
New Jersey Attorney General

Hector Balderas
New Mexico Attorney General

Letitia James
New York Attorney General

Joshua H. Stein
North Carolina Attorney General

Ellen F. Rosenblum
Oregon Attorney General

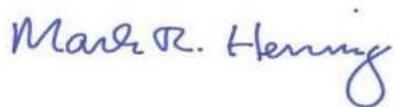
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Josh Shapiro
Pennsylvania Attorney General



T.J. Donovan, III
Vermont Attorney General



Mark R. Herring
Virginia Attorney General



Bob Ferguson
Washington Attorney General