LEGAL MOMENTUM®
The Women's Legal Defense and Education Fund

September 29, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Ms. Lisa J. Pino
Director, Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Docket HHS-OS-2022-0012, RIN 0945-AA17, Nondiscrimination in Health and Health Education Programs and Activities (Section 1557 NPRM)

Submitted via www.regulations.gov

Dear Secretary Becerra and Ms. Pino:

Legal Momentum, the Women's Legal Defense and Education Fund, appreciates the opportunity to comment on the proposed rule (NPRM) regarding Section 1557 of the Patient Protection and Affordable Care Act (ACA) (hereinafter Section 1557).

Legal Momentum is the nation's first and longest serving legal advocacy organization dedicated to advancing gender equality for women. For more than 50 years, we have used strategic litigation, innovative public policy, and educational initiatives to ensure that all women are protected under the law. We have litigated or appeared as amici in all of the foundational cases interpreting the scope of discrimination on the basis of sex set out in the various civil rights statutes affording such protections, including Title IX and Title VII.

As an organization committed to upholding the civil rights of all persons, we strongly applaud the NPRM provisions which seek to expand protections for women, people experiencing pregnancy and related conditions, individuals with limited English proficiency, LGBTQI+ persons, and persons with disabilities and chronic conditions.

I. PROTECTIONS AGAINST SEX DISCRIMINATION

a. Definition of sex discrimination

The scope of Section 1557's protected classes and characteristics extend broadly. Congress's intent that Section 1557 build and expand upon existing civil rights laws, while providing broad protection against discrimination in health care,

is clear. The plain text of Section 1557 and the proposed regulations establish the broad scope of its nondiscrimination protections in accordance with legislative intent. The proposed regulations appropriately include a broad definition of sex to ensure protection against sex-based discrimination. We applaud the proposed definition of discrimination on the basis of sex to include sexual orientation and gender identity and HHS's view that discrimination based on anatomical or physiological sex characteristics is inherently sex-based. The proposed rule properly expands upon the definition to specifically include sex stereotypes, sex characteristics, sexual orientation, and gender identity as bases for sex discrimination.

b. Intersectionality

Sex discrimination takes many forms and has the potential to occur at every step in the health care system—from obtaining insurance coverage to receiving a diagnosis and treatment by a provider. Such discrimination has serious adverse impacts on the lives of women, causing them to pay more for health care and to risk receiving improper diagnoses and less effective treatments. The effects of sex discrimination for women of color may be compounded by other forms of discrimination they face, including racial discrimination and discrimination based on limited English language proficiency. Section 1557 must address not only protections for each protected class covered, but the intersection of those protections. Section 1557's protections extend to discrimination on the basis of race, color, national origin (including language access), sex, age, and disability by building on existing civil rights laws.[1] It is the first federal law to ban sex discrimination in health care.

While we appreciate HHS's discussion of intersectional discrimination in the preamble, HHS must clarify Section 1557's intersectional protections throughout the regulatory text. We must emphasize that individuals may be part of multiple protected classes and may face discrimination because they belong to one or more of these classes. Legal Momentum suggests strengthening the text of § 92.101(a)(1) to read as follows:

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

II. PREGNANCY AND RELATED CONDITIONS

We strongly support the proposed regulation's definition of sex to include discrimination on the basis of "pregnancy or related conditions." This definition is consistent with the longstanding interpretation of sex discrimination under Title IX, including HHS's Title IX implementing regulation,[2] and other civil rights statutes. These laws prohibit discrimination based on pregnancy itself, as well as pregnancy-related conditions. However, the proposed rule does not define sex discrimination consistently as including pregnancy and related conditions—"pregnancy or related conditions" is included at § 92.101(a)(2), but only "pregnancy" is included under § 92.101 and § 92.10. We urge that the final rule define sex discrimination to include "pregnancy or related conditions" consistently throughout.

[1] Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.), Title VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000e et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Section 794 of Title 29, or the Age Discrimination Act of 1975 [42 U.S.C. § 6101 et seq.].
[2] 45 CFR § 86.21(c)(2), (3); § 86.40(b)(1), (4), (5); § 86.51(b)(6); § 86.57(b)(d) (Title IX regulation).

a. Termination of pregnancy

Abortion is a critical part of the spectrum of reproductive health care. Due to a culture that stigmatizes abortion care and a coordinated effort by anti-abortion policymakers to restrict access to abortion care and coverage, many were not able to access abortion care even prior to the *Dobbs* decision. In the fallout of the *Dobbs* decision, individuals, especially people of color, people with low incomes, immigrants, young people, people with disabilities, and LGBTQI+ individuals are facing numerous logistical and legal barriers to accessing care with an increased threat of arrest and prosecution as states seek to criminalize abortion care.

In the wake of *Dobbs*, it is critical that abortion care is clearly and consistently included with "pregnancy or related conditions" throughout the final rule. Thus, we encourage HHS to strengthen its approach to defining sex discrimination related to pregnancy or related conditions at § 92.101(a)(2) and throughout the regulatory text. In the preamble, HHS notes that although it does not propose restoring the 2016 language that the 2020 rule eliminated, the protections still apply because of the underlying Title IX regulations. We agree that the Title IX definition applies but given the pervasive nature of discrimination related to termination of pregnancy, particularly post-*Dobbs*, we urge HHS to specifically include termination of pregnancy in this definition.

Specifically, Legal Momentum suggests strengthening the proposed rule by adding termination of pregnancy to the definition of prohibited sex discrimination at § 92.101(a)(2) as follows:

> "Discrimination on the basis of sex includes, but is not limited to, discrimination on the basis of sex stereotypes; sex characteristics, including intersex traits; ***pregnancy or related conditions, including termination of pregnancy***; sexual orientation; **transgender status,** and gender identity."

Likewise, we urge HHS to ensure that sex discrimination is defined consistently throughout final regulations at § 92.8 and § 92.10 and includes "pregnancy or related conditions, including termination of pregnancy." Consistency is of particular importance given that HHS does not currently include a definition of sex discrimination proposed in § 92.4. We urge HHS to be consistent throughout the final rule.

b. Equal program access of the basis of sex

We also urge HHS to add enumerated specific forms of discrimination related to pregnancy and related conditions, in light of *Dobbs*. In this section of our comments, we offer analysis on how discrimination related to pregnancy and related conditions undermines program access and recommend amendments to the proposed regulatory text. In our suggestions related to § 92.207, we build on this analysis and recommend amendments to address discrimination related to pregnancy and related conditions in health insurance and other health-related coverage.

Sex discrimination related to pregnancy and related conditions is pervasive in our health care system. Access to sexual and reproductive health care, such as contraception, fertility care, abortion, gender-affirming care, and maternity care, is often barred by discriminatory policies or practices. For example, pregnant Black, Indigenous, Latinx, Asian American and Pacific Islander, and all people of color, and others who live at the

intersections of Section 1557's protected identities, are often subjected to discrimination throughout pregnancy and the postpartum period, including mistreatment during labor and delivery. Discrimination persists for many people when accessing infertility diagnosis, treatment, and services, including assisted reproductive technology. It is essential that the final rule explicitly name this as prohibited sex discrimination.

When the Supreme Court overturned the constitutional right to abortion in *Dobbs*, it provoked covered entities to begin discriminatorily denying or creating barriers to medications and treatments that can prevent, complicate, or end pregnancies. Covered entities are struggling to understand their compliance with rapidly changing state laws. The impacts of *Dobbs* are compounding preexisting barriers to abortions, contraception, miscarriage management, fertility care, and other sexual and reproductive health care, particularly for communities of color, people with disabilities, the LGBTQI+ community, especially transgender people.

Accordingly, Legal Momentum urges to amend § 92.206(b) as follows:

> (3) Adopt or apply any policy or practice of treating individuals differently or separating them on the basis of sex in a manner that subjects any individual to more than *de minimis harm*, including by adopting a policy or engaging in a practice that prevents an individual from participating in a health program or activity consistent with the individual's gender identity***, or subjects pregnant people to discriminatory treatment during childbirth, including rough handling, harsh language, or undertreatment of pain***;**
>
> (4) Deny or limit health services sought for purpose of gender transition or other gender-affirming care**, *fertility care, or any health services,*** that the covered entity would provide to an individual for other purposes if the denial or limitation is based on a patient's sex assigned at birth, gender identity, or gender otherwise recorded.
>
> ***(5) Deny or limit services, or a health care professional's ability to provide services, on the basis of pregnancy or related conditions, including termination of pregnancy, contraception, miscarriage management, fertility care, maternity care, or other health services;***
>
> ***(6) Deny or limit services based on an individual's reproductive or sexual health care decisions or history, including termination of pregnancy, miscarriage, or adverse pregnancy outcome; and***
>
> ***(7) Deny or limit services, or a health care professional's ability to provide services, that could prevent, cause complications to, or end fertility or pregnancies, including medications or treatments for disabilities or emergency medical conditions under 42 U.S.C. § 1395dd.***

c. Nondiscrimination in health insurance coverage and other health-related coverage

As the *Dobbs* case eliminated the constitutional right to abortion, it also undermined the right to privacy and concurring opinions attacked related rights to contraception, consensual sexual contact, and same-sex marriage. Many individuals already struggled to get full coverage or services for contraception, but especially emergency contraception. Some state legislatures have banned emergency contraception from their

state family planning programs and contraceptive coverage mandates. This results in discrimination against people of color and people with low-incomes who face higher rates of unintended pregnancy and adverse reproductive health outcomes due to these barriers. Robust enforcement of Section 1557 is necessary to ensure health entities and providers do not perpetuate discriminatory policies against contraceptive care.

We agree with HHS's judgment that the statutory text of Section 1557 is clear—Congress intended that the law apply to these entities and address these issues. Thus, we strongly support HHS's restoration of and improvements to § 92.207, including its inclusion of specific forms of prohibited discrimination. However, as with proposed § 92.206, HHS must strengthen the text of proposed § 92.207 to address sex discrimination related to pregnancy or related conditions, such as discrimination related to abortion, fertility care, and contraception.

Accordingly, Legal Momentum urges to amend § 92.207(b) as follows:

> (4) Have or implement a categorical coverage exclusion or limitation for all services related to gender transition or other gender-affirming care, ***termination of pregnancy, contraception, fertility care, miscarriage management, pregnancy loss, maternity care, other reproductive and sexual health services, or any health services,*** if such denial, limitation, or restriction results in discrimination on the basis of sex;
>
> (5) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost-sharing or other limitations or restrictions on coverage, for specific health services related to gender transition or other gender-affirming care, ***termination of pregnancy, contraception, fertility care, miscarriage management, pregnancy loss, maternity care, other reproductive and sexual health services, or any health services,,*** if such denial, limitation, or restriction results in discrimination on the basis of sex; or
> . . .
>
> ***(7) Deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations on coverage for health services that may prevent, cause complications to, or end fertility or pregnancies, if such denial, limitation, or restriction results in discrimination on the basis of sex.***
>
> In addition, we urge HHS to specify in the preamble that the health services addressed in our proposed § 92.207(b)(7) include both the full spectrum of reproductive and sexual health services and treatments and medications for people with disabilities or other medical conditions that may prevent, complicate, or end fertility or pregnancies.

d. Prohibition on sex discrimination related to marital, parental, or family status

We appreciate HHS's request for comment on whether pregnancy or related conditions discrimination should be addressed in § 92.208, in a separate stand-alone provision, or elsewhere in the final rule. We do not believe that § 92.208 is the appropriate place to do so. Instead, HHS should address these issues in § 92.206 and § 92.207 as discussed above. In addition to those recommendations, we would also support a separate stand-alone provision.

Primarily addressing the prohibition on discrimination of "pregnancy or related conditions, including termination of pregnancy" under § 92.208 could cause policies that are biased against single people experiencing discrimination based on obtaining or having obtained an abortion. While this provision is welcome for ensuring robust enforcement against sex being used to determine eligibility for a health program in specific instances, primarily including discrimination on the basis of abortion in this context could cause confusion that a person facing discrimination because they have had an abortion only occurs in a marital, parental, or family context. Entities writing policies will have clearer guidance by including discrimination based on obtaining an abortion in the broader definition of § 92.101(a)(2) with examples listed in § 92.206(b) and § 92.207(b).

III. LGBTQI+

As noted in the preamble to the NPRM, LGBTQI+ people face both health disparities and barriers to accessing health care. The National Academies of Sciences, Engineering, and Medicine reports that discrimination against sexual- and gender-diverse persons in obtaining health insurance, and in the terms of insurance coverage, has long been a barrier to accessing health care, which has contributed to significant health inequalities.[3] Much of this can be attributed to well-documented discrimination. In a study published in Health Affairs, researchers examined the intersection of gender identity, sexual orientation, race, and economic factors in health care access. They concluded that discrimination, as well as insensitivity or disrespect on the part of health care providers, were key barriers to health care access.[4] These problems persist in 2022. Data in a new report from the Center for American Progress "reveal that LGBTQI+ communities encounter discrimination and other challenges when interacting with health care providers and health insurers, underscoring the importance of strengthening nondiscrimination protections through Section 1557 of the Affordable Care Act."[5] The report finds that fifteen percent of LGBQ respondents, including twenty-three percent of LGBQ respondents of color, reported experiencing some form of care refusal by a doctor or other health care provider in the year prior.[6]

Twenty-nine percent of transgender individuals were refused to be seen by a health care provider on the basis of their perceived or actual gender identity and the same percent experienced unwanted physical contact from a health care provider.[7] Additionally, thirty percent of transgender or nonbinary respondents, including forty-seven percent of transgender or nonbinary respondents of color, reported experiencing one form of denial by a health insurance company in the past year.[8] We commend the proposed rule for clearly stating that discrimination based on sex stereotypes or gender identity constitutes discrimination on the basis of sex. Title IX and other civil rights statutes have consistently been interpreted to bar discrimination based

[3] NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, UNDERSTANDING THE WELL-BEING OF LGBTQI+ POPULATIONS (2020).
[4] NING HSIEH & MATT RUTHER, DESPITE INCREASED INSURANCE COVERAGE, NONWHITE SEXUAL MINORITIES STILL EXPERIENCE DISPARITIES IN ACCESS TO CARE (2017).
[5] CAROLINE MEDINA & LINDSAY MAHOWALD, ADVANCING HEALTH CARE NONDISCRIMINATION PROTECTIONS FOR LGBTQI+ COMMUNITIES (2022).
[6] *Id.*
[7] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress, (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discriminationprevents-lgbtq-people-accessing-healthcare/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-fordiscrimination&email_referrer=&email_subject=rx-for-discrimination.
[8] CAROLINE MEDINA & LINDSAY MAHOWALD, ADVANCING HEALTH CARE NONDISCRIMINATION PROTECTIONS FOR LGBTQI+ COMMUNITIES (2022).

on sex stereotyping concerning appearance, behavior, and family role, among other traits, and Section 1557 must be understood to ban such discrimination.

Moreover, it is well-established that sex discrimination encompasses discrimination based on sex stereotypes. Three decades ago, the Supreme Court held that Title VII prohibits discrimination against workers for their failure to conform to sex-based stereotypes in *Price Waterhouse v. Hopkins*.[9] In cases since then, courts have concluded that Title VII's nondiscrimination protections on the basis of sex applies to gender identity and sexual orientation, including the U.S. Supreme Court decision in *Bostock v. Clayton County*.[10] Since *Bostock*, two federal circuits have concluded that the plain language of Title IX prohibition on sex discrimination must be read similarly.[11] Additionally, the Civil Rights Division of the U.S. Department of Justice issued a memorandum concluding that the Supreme Court's reasoning in *Bostock* applies to Title IX. As made clear by the ACA, Section 1557 prohibits discrimination "on the grounds prohibited under . . . Title IX."[12] And the Department of Education recently issued a proposed rule aligning the Title IX implementing regulations with this settled interpretation.[13] We strongly support the proposed regulation's prohibition on discrimination on the basis of sex to be consistent with *Bostock* and Title IX to include gender identity and sexual orientation.

We suggest strengthening the language in section 92.101(a)(2) to explicitly include transgender status. While the terms "gender identity" and "transgender status" are often used interchangeably, there have been instances in which those seeking to permit discrimination against transgender people have justified it by pressing distinctions between the two concepts. It is therefore preferable to enumerate both in the regulatory text.

Legal Momentum suggests amending § 92.101(a)(2) as follows:

> "Discrimination on the basis of sex includes, but is not limited to, discrimination on the basis of sex stereotypes; sex characteristics, including intersex traits; **pregnancy or related conditions, including termination of pregnancy**; sexual orientation; ***transgender status,*** and gender identity."

a. Equal program access of the basis of sex

We strongly support the inclusion of this section, which will help to address the countless forms of harmful discrimination described above. It importantly clarifies that while providers may exercise clinical judgment when determining if a particular service is appropriate for an individual patient, they may not refuse gender-affirming care based on a personal belief that such care is never clinically appropriate. We suggest strengthening the language pertaining to providers complying with a state or local law as a justification for denying gender-affirming care to state unequivocally that Section 1557, as federal law, preempts any such state or local law restricting access to this care.

Consistent with our recommendation regarding section 92.101(a)(2) above, we suggest that "transgender status" be added to sections 92.206(b)(1), (b)(2) and (b)(4). We also believe that section (b)(2) would be clearer if shortened as indicated below. In addition, we recommend deleting the indicated language in (b)(4), as a provider could engage in a

[9] 490 U.S. 228, 251 (1989) ("As for the legal relevance of sex stereotyping, we are beyond the day when an employer could evaluate employees by assuming or insisting that they match the stereotype associated with their group.")
[10] 140 S. Ct. 1731 (2020).
[11] *See Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 616 (4th Cir. 2020); *Adams v. Sch. Bd. of St. Johns Cnty.*, 968 F.3d 1286, 1305 (11th Cir. 2020).
[12] 42 U.S.C. § 18116(a).
[13] 87 Fed. Reg. at 41571 (proposed 34 C.F.R. § 106.10).

discriminatory denial of care even if a claimant cannot show that the care in question was on other occasions provided for other purposes. These suggested changes would be reflected in 92.206 as follows:

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

b. Nondiscrimination in health insurance coverage and other health-related coverage

It is essential that this provision be adopted in the final rule to clarify that, pursuant to the text of the ACA, the protections of 1557 do apply to insurance. Consistent with our recommendations above, we suggest adding "transgender status" to section 92.207(b)(3) as follows:

> "A covered entity must not, in providing or administering health insurance coverage or other health-related coverage: . . .
>
> (3) Deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, to an individual based upon the individual's sex at birth, gender identity, ***transgender status,*** or gender otherwise recorded."

We recommend a slight modification to section 92.207(b)(4), which bars categorical coverage exclusions of services related to gender transition or other gender-affirming care. As drafted, it could be misconstrued to apply only if an insurer excludes "all" health services related to gender transition or other gender-affirming care, whereas we believe the true intent is to proscribe exclusions of "any" such services. Thus we urge deletion of the word "all" from this paragraph such that the final text reads as follows:

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

Lastly, we recommend shortening Section 92.207(b)(5) for clarity, such that the final text reads as follows:

> "A covered entity must not, in providing or administering health insurance coverage or other health-related coverage: . . .
>
> (5) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition or other gender-affirming care ~~if such denial, limitation, or restriction results in discrimination on the basis of sex~~."

c. Nondiscrimination on the basis of association

We applaud that the NPRM's restoration of explicit protections against discrimination on the basis of association in § 92.209. This is consistent with longstanding interpretations of other antidiscrimination laws, which cover discrimination based on an individual's own characteristics or those of someone with whom they are associated or with whom they have relationship. As noted in the NPRM preamble, certain protected populations, including LGBTQI+ people, are particularly susceptible to discrimination based on association. An individual in a same-sex relationship or marriage could be subjected to discrimination based on their own and their spouse or partner's sex, whereas that same individual might not be similarly mistreated were they not in a same-sex relationship.

d. Notification of views regarding application of Federal conscience and religious freedom laws

The federal government has a compelling interest in preventing discrimination in health care. The very purpose of Section 1557 is to address long-standing discrimination in health care that has created numerous barriers to quality care for the LGBTQI+ community, communities of color, people with disabilities, and more, but especially those who sit at the intersections of these identities. Religious exemptions have been used to discriminate against sexual and reproductive health care, LGBTQ+ competent care, and actively exacerbate health disparities. Rural communities, people with low-incomes, and communities of color often rely on religiously affiliated health care entities which make up a large part of the U.S. health care system. In fact, women of color disproportionately give birth in Catholic hospitals and report being refused many facets of comprehensive sexual and reproductive health care, such as limiting miscarriage-related procedures.[14] This denial of vital health care may lead to significant complications such as extreme blood loss, cognitive injury, and acute kidney injury.[15] This is incredibly concerning noting that Black women are roughly three times as likely to die from a pregnancy-related cause as white women.[16]

Under the Religious Freedom Restoration Act (RFRA), if a regulation places a substantial burden on religious exercise the government must prove they have a compelling interest and are using the least restrictive means possible. In the context of discrimination in health care, the government has the strongest compelling interest to not only prevent discrimination but ensure taxpayer dollars are not used to further discrimination. By participating in a federal health program and receiving federal funding

[14] Katherine Stewart, *Why Was a Catholic Hospital Willing to Gamble With My Life?*, N.Y. TIMES (Feb. 25, 2022), https://www.nytimes.com/2022/02/25/opinion/sunday/roe-dobbs-miscarriage-abortion.html.
[15] *Id.*
[16] *Id.*

recipients must be held to the highest anti-discrimination standard so people can access the sexual and reproductive health care they need and deserve.

To adhere to Section 1557's goals and ensure patient well-being is paramount, the review process for exemptions must address this compelling interest in each case-by-case analysis. Determinations must clearly explain how any exemption granted does not further discrimination and any exemption denied would have undermined the goals of Section 1557. Additionally, determinations of discrimination cannot be unduly delayed as people harmed by health care discrimination are often dealing with increased negative health outcomes or have been forced to forgo care entirely.

IV. PROTECTIONS AGAINST DISCRIMINATION OF PEOPLE WITH DISABILITIES

We appreciate the opportunity to comment on the impact of the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* for implementation of Section 1557 and the proposed rule with respect to how this affects people with disabilities. Studies show that there is no significant difference in pregnancy and abortion rates between disabled and non-disabled women in the US, yet people with disabilities face unique hurdles to equitably accessing healthcare.

A deeper understanding of intersectional discrimination and the life circumstances for many disabled persons reveals that abortion access has distinct importance to people with disabilities. People with disabilities have fought for the right to self-determination and bodily autonomy through a long history of eugenics, forced medical treatment, and limited or no access to reproductive care. Moreover, people with disabilities are much more likely to be sexually assaulted and twice as likely to live in poverty than people without disabilities. Having low income and disabilities that can interfere with employment capacity means that people with disabilities have a greater likelihood of health coverage through Medicaid or Medicare, both of which are federally-funded health care programs that are subject to abortion restrictions under the Hyde Amendment. Some disabled persons have complex medical conditions that can make pregnancy dangerous or life-threatening. When people seeking abortion are forced to travel out-of-state, some disabled persons can face the additional barrier of inaccessible transportation. People with disabilities need access to abortion, and failure to provide disabled persons with meaningful access to abortion has devastating consequences. Moreover, the reasoning used in *Dobbs* threatens privacy and many other substantive areas of law in ways that deeply implicate people with disabilities and their right to make decisions about their own bodies.

People with disabilities have also confronted new barriers to medication access after *Dobbs*. When the Supreme Court overturned the constitutional right to abortion, it also provoked physicians and pharmacists to deny people with disabilities who have the capacity to become pregnant access to medications and treatments for chronic health conditions. For example, disabled persons have been unjustifiably denied or subjected to unconscionable barriers to methotrexate, which is regularly used to treat cancer and autoimmune conditions, because the medication can also be used in medical abortions. We expect that under *Dobbs*, people with disabilities who have the capacity to become pregnant will face increasing discriminatory denials of and barriers to an array of medications and treatments prescribed for their conditions, sometimes uniquely so because of drug interactions or the need to minimize side effects, just because the medication happens to complicate or end pregnancies or fertility. This demonstrates the critical need to make expressly clear the intersectional application of Section 1557.

The discrimination in health care fueled by *Dobbs* generally, as well as the particular implications of that discrimination for people with disabilities, demands robust implementation of

the proposed rule. HHS should address these issues in § 92.206 and 92.207. To proposed § 92.206(b), HHS should add provisions affirming that Section 1557 prohibits covered entities from denying, limiting access to, or otherwise placing "special" caps, costs, or additional procedural requirements on medications or treatments needed by people with disabilities, irrespective of whether those medications/treatments can also be used to end or complicate pregnancies or fertility. The additional provisions should also address the discriminatory denial of medications and treatments used to provide abortions, manage miscarriages, and resolve ectopic pregnancies. HHS should similarly amend the text of proposed § 92.207(b)(4) and (5) to clarify that Section 1557 prohibits covered entities that provide or administer health insurance coverage or other health-related coverage from having or implementing categorical exclusions or limitations related to, otherwise denying or limiting coverage of or coverage of a claim for, or imposing additional cost sharing or other restrictions on coverage on abortions, as well as broader medications or treatments that can complicate or end pregnancies or fertility.

V. PROTECTIONS AGAINST LANGUAGE ACCESS DISCRIMINATION

Language proficiency should not determine whether people have access to care or the quality of a person's care. For individuals who are Limited English Proficient (LEP), communication barriers make it more difficult to navigate an already complicated health care system and exacerbate existing inequities in access to culturally and linguistically appropriate care. Moreover, these barriers are often compounded by discrimination based on national origin, immigration status, race, ethnicity, sexual orientation, and gender/gender identity. Discussions about sexual and reproductive care can be sensitive and raise issues of privacy and confidentiality. For example, where a patient is not afforded language access services they may need to request the assistance of an English-speaking family or community member denying them privacy in those interactions with their healthcare provider. It is critical that individuals have access to adequate language services, in a private and confidential setting, allowing for information about and access to sexual and reproductive health care to be available in a culturally and linguistically competent manner.

Due to the nature and importance of health care and the consequences that can result from language barriers, the proposed regulations appropriately include specific requirements to ensure that covered entities understand their obligations to ensure meaningful access and have clear instructions on how to comply with those obligations. We support this approach as it builds on yet is consistent with Title VI and existing HHS LEP Guidance. We also emphasize that, consistent with the current rule, discrimination on the basis of national origin, including LEP, creates unequal access to health. LEP is often compounded with the "cumulative effects of race and ethnicity, citizenship status, low education, and poverty," resulting in more barriers to access.[17]

a. Policies and procedures

Protections around language access have long included recommendations around development of language access plans to help covered entities meet the needs of people with LEP. The 2016 final rule did not require covered entities to develop language access plans but said if an entity has a language access plan, HHS must consider it when evaluating compliance. The proposed rule eliminates recommendations that entities develop language access plans, and instead requires that entities implement written policies and procedures in its health programs and activities that demonstrate compliance with Section 1557 language access requirements.

[17] Kaiser Family Foundation, *Overview of Health Coverage for Individuals with Limited English Proficiency*, at 3, http://kff.org/disparities-policy/fact-sheet/overview-of-health-coverage-forindividuals-with/.

Requiring development of policies and procedures, and then requiring relevant staff to receive training, will hopefully ensure that covered entities are better able to meet the requirements of Section 1557. We are unclear, however, whether the requirements to develop policies and procedures incorporate advance planning to identify what services might be required. We suggest that HHS either clarify this or specifically require covered entities to develop a communication and accessibility plan. For example, the proposed rule discusses the need for "language access procedures" which discusses how to schedule an interpreter, how to identify whether an individual is LEP, etc. but no requirement exists for a covered entity to think in advance of what types of language services the entity may need to have available. That is, without gathering data about the populations in its service area and their communication needs, the entity may not be able to develop effective policies and procedures.

Legal Momentum suggests to modify § 92.8 to clarify that covered entities must affirmatively develop a communication and accessibility plan before developing relevant policies and procedures. In the alternative, a new provision could be added requiring the development of a communication and accessibility plan prior to the development of policies and procedures. Additionally, a "model access plan" should be included, and explain how covered entities should develop one, in its Section 1557 rule, similar to the language access plan included in its 2013 LEP Guidance. It is imperative that covered entities have proactive insights into the particular needs of the community they're serving and develop procedures to meet those needs.

b. Notice of availability of language assistance services and auxiliary aids and service

We strongly support § 92.11 of the proposed rule, and the requirements for when this notice must be made available. The regulatory requirements as outlined in the proposed rule provide a helpful and important minimum standard and list of specific electronic and written communications that must be accompanied by the notice; however, more guidance is needed to ensure the notice of availability requirements effectively raise awareness of the right to access language assistance and auxiliary aids and services.

We recommend that the top 15 languages requirement not be aggregated between states and take into consideration the language needs of the particular state within which an entity is operating. We recommend that if a covered entity operates across multiple states, that the covered entity has to provide the notice in not merely the top 15 languages in the aggregate (that is, adding to the top 15 languages across all the states) but rather the top 15 languages in each state.

IV. NOTICE OF NONDISCRIMINATION

We strongly support the requirements related to a notice of nondiscrimination. When this provision was removed in prior rulemaking, many individuals never received information about their rights, did not know how to access language services to understand their rights, and did not know how to file a complaint or a grievance.

In addition to the current requirements, we also recommend including a requirement that any entity receiving a religious exemption under proposed section 92.302 include the existence and scope of such exemption in its required notices. It would be misleading and inaccurate to require entities to tell participants and beneficiaries and the public generally that the entity does not discriminate if the entity does in fact discriminate in certain circumstances and has been granted permission to do so.

Thank you for your consideration of these comments. Please contact Jennifer Becker, Legal Director, (jbecker@legalmomentum.org) with any questions.

Respectfully submitted,

Legal Momentum, the Women's Legal Defense and Education Fund