



October 3, 2022

VIA ELECTRONIC SUBMISSION

Secretary Xavier Becerra
U.S. Department of Health and Human Services
Herbert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

RE: Docket ID HHS-OS-2022-0012-0001, RIN 0945-AA17, Nondiscrimination in Health Programs and Activities

Dear Secretary Becerra:

Physicians for Reproductive Health (PRH), joined by health care providers across the country, is pleased to have the opportunity to submit comments to the Department of Health and Human Services' (HHS) regarding its Notice of Proposed Rulemaking on "Nondiscrimination in Health Programs and Activities" (Proposed Rule). PRH is a physician-led national advocacy organization that organizes, mobilizes, and amplifies the voices of medical providers to advance sexual and reproductive health, rights, and justice. Our programs combine education, advocacy, and strategic communications to ensure access to abortion care and equitable, comprehensive health care. We believe that this work is necessary for all people to live freely with dignity, safety, and security.

Section 1557 of the Affordable Care Act is a groundbreaking anti-discrimination provision that prohibits discrimination in health care on the basis of race, color, national origin, age, disability, and sex, including pregnancy, gender identity, and sex stereotyping. Health insurers, hospitals, clinics, and any other entities that receive federal funds are covered by this law. Importantly, Section 1557's prohibition of discrimination on the basis of sex, protects women, people who are pregnant, people who have had abortions, are transgender, and those who are gender expansive from discrimination when accessing the health care they need. Section 1557 is unique as it acknowledges people often experience varying forms of oppression around their identities and allows for patients to bring claims based on multiple and intersecting forms of discrimination. For example, Section 1557 is designed to add protection for someone who is experiencing discrimination because they are both pregnant and transgender or someone who is both Black and an immigrant. It recognizes that experiencing oppression at the intersection of marginalized identities can shape an individual's life course.

As health care providers we have witnessed first-hand the harm discrimination has on our patients and the communities we care for overall. But we must also acknowledge the role providers have played in perpetuating discrimination. There is a growing body of research that demonstrates the negative health consequences of discrimination on an individual's [overall health and well-being](#). For example, experiences of racism and discrimination has been shown to cause psychological distress, including depression and increased anxiety, [hypertension and adverse cardiovascular events](#), and poor maternal health outcomes, [particularly for Black women](#). The continued presence of discrimination in our health care systems also interferes with



the trust necessary for the patient-provider relationship. Instances of discrimination discourage people from seeking essential care and can have long-term consequences harming the health and well-being of individuals, families, and communities. Discrimination in health care is an ongoing problem. For example, according to research conducted by the [Commonwealth Fund](#), Black people were most likely to report racial discrimination in a health care setting, with 44 percent of all Black people reporting this [happens often or very often](#), regardless of gender. It is also well documented that structural racism and discrimination in our health care settings contributes to increased maternal mortality, with Black women [three to four times more likely](#) to die from a pregnancy related cause than white women. For LGBTQ+ people, pervasive discrimination also discourages a significant number of patients from seeking health care. According to data from the [Center for American Progress](#), 8 percent of all LGBTQ+ people and 14 percent of those who had experienced discrimination on the basis of their sexual orientation or gender identity in the past year – avoided or postponed needed medical care. Among transgender people 22 percent reported such avoidance. The pervasive discrimination in our health care systems must be addressed through robust implementation and enforcement of Section 1557.

Furthermore, as we grapple with the fallout of the Supreme Court’s decision in *Dobbs v. Jackson Women’s Health Organization*, it is essential for the Administration’s Proposed Rule to robustly protect patients from discrimination related to pregnancy, including for having or seeking abortion care. Even before the fall of *Roe v. Wade*, many patients were unable to access abortion care because of medically unnecessary barriers imposed by anti-abortion politicians. Now with states moving quickly to ban abortion and the consequences of these state abortion bans rippling across the country, people of color, people with low incomes, people who are immigrants, young people, people with disabilities, and LGBTQ+ people are facing numerous logistical and legal barriers to accessing care with an increased threat of arrest and prosecution in places where abortion is illegal. It is critical that the Administration’s Proposed Rule clearly and consistently includes abortion care as part of the prohibition on discrimination based on pregnancy or related conditions throughout the final rule.

PRH enthusiastically supports the Administration’s efforts to strengthen Section 1557 of the Affordable Care Act and makes the following recommendations to further guarantee the robust implementation of this law.

- I. **In the wake of *Dobbs v. Jackson Women’s Health Organization*, HHS must clarify the scope of Section 1557’s protections against discrimination related to pregnancy and for LGBTQ+ people**
 - a. **LGBTQ+ Discrimination**

PRH welcomes the explicit recognition that Section 1557’s prohibition on sex discrimination includes discrimination on the basis of sex stereotypes, sexual orientation, gender identity and sex characteristics, including intersex traits. This follows settled federal law and it is critical the final rule consistently includes these bases. 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. Therefore, explicit language is needed to prevent this discrimination



and consistency throughout the final rule is important. We recommend also including “transgender status” in § 92.206(b)(1), (b)(2) and (b)(4), and in §92.207(b)(3).

RECOMMENDATION: Include “transgender status” after “sexual orientation” in § 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.

b. Discrimination related to pregnancy or related conditions

Abortion is health care. The [American College of Obstetricians and Gynecologists \(ACOG\)](#), along with many other medical societies, identifies abortion as an essential health care service that requires timely access to care. Many of these same medical societies also recognize the importance of addressing racism, bias, and discrimination in health care in order to ensure patients are able to get the comprehensive care they need, including abortion. As outlined above, given the moment we are in and the continued fallout from the Supreme Court’s decision, it is essential for HHS to strengthen its approach to defining sex discrimination related to pregnancy or related conditions 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. Additionally, HHS does not define sex discrimination consistently in the proposed rule: it notes that sex discrimination includes “pregnancy or related conditions” at § 92.101(a)(2), but only “pregnancy” under § 92.101 and § 92.10. We urge HHS to be consistent throughout the final rule.

RECOMMENDATION: HHS must add abortion 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.

In addition, HHS should ensure that sex discrimination is defined consistently throughout final regulations 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.

c. Intersectional Discrimination

As discussed above, one of Section 1557’s most groundbreaking aspects was its creation of protections against intersectional discrimination. While we appreciate HHS’ discussion of intersectional discrimination in the preamble, HHS must clarify Section 1557’s intersectional protections throughout the regulatory text. HHS should strengthen the text of proposed § 92.101(a)(1) to this effect.



RECOMMENDATION: Amend the text of proposed § 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. Addressing Critical Gaps in the Forms of Prohibited Sex Discrimination Enumerated in the Proposed Rules

We appreciate HHS' enumeration of specific forms of sex discrimination that are prohibited in the Proposed Rule. Section 92.206 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 to a patient based on a personal or religious belief that such care is never clinically appropriate. The restoration of protections for gender-affirming care is an essential component of the proposed rule, as denials of access to and insurance coverage for such care are among the most common manifestations of discrimination against the LGBTQ+ community. Below, we suggest strengthening the language of § 92.206(b) and 92.207(b) to prevent covered entities from using state or local laws that ban or restrict access to gender-affirming care, as well as broader reproductive and sexual health care, as a justification to deny such care.

In light of *Dobbs*, we also urge you to add specific examples of discrimination related to pregnancy and related conditions. 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, Latina/x, Asian American and Pacific Islander, and all people of color, 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. People with disabilities often experience [multiple barriers](#) to sexual and reproductive health care. For example, among subspecialty provider offices, [44% of gynecology](#) offices were inaccessible due to factors such as lack of equipment or transfer assistance, leaving wheelchair users unable to access abortion or maternity care. In addition, discrimination persists for many people when attempting to access 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 erecting 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 LGBTQ+ community (especially [transgender people](#)), and more. For example, all people, but particularly people with disabilities, are increasingly denied or subjected to unconscionable [barriers](#) to methotrexate, which is regularly used to treat cancer and autoimmune conditions. We expect that under *Dobbs*, people with disabilities will face



increasing discriminatory denials of and barriers to the vast array of medications and treatments prescribed for their conditions that happen to prevent, complicate, or end pregnancies or fertility.

RECOMMENDATION: Accordingly, we urge you to amend proposed § 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 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.

In addition, HHS must strengthen the language pertaining to providers complying with a state or local law as a justification for denying gender-affirming care, abortions, or other reproductive or sexual health care to state unequivocally that Section 1557, as federal law, preempts any such state or local law restricting access to this care.

III. Sex Discrimination Coverage

U.S. health insurance and other health-related coverage have long discriminated against applicants and enrollees on the basis of sex and intersecting identities. For example, some insurance companies [refuse to cover](#) certain types of care that are traditionally used by women, such as in vitro fertilization (IVF). Private and public insurers often discriminate based on relationship status and sexual orientation with policies that require single people or those in non-heterosexual relationships to pay out of pocket for a predetermined number of failed intrauterine insemination cycles before providing them coverage when different-sex couples do not have to meet the same standard. The high cost and lack of coverage for fertility treatment, including IVF, are large barriers for people who experience multiple and intersecting forms of bias and discrimination, including provider bias and harmful preconceptions about their desire and need for fertility



treatment. Women of color have a long history of forced sterilization and reproductive coercion in this country and [continue to report](#) that providers do not take their fertility concerns seriously, instead “emphasiz[ing] birth control over procreation.”

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.

PRH agree with HHS’ 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’ 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.

RECOMMENDATION: We urge HHS to amend proposed § 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 patients that may prevent, complicate, or end fertility or pregnancies.



IV. Discrimination based on Personal or Religious Beliefs

As health care providers we strongly oppose any health care entity or individual provider that refuses to provide based on their personal beliefs the comprehensive care a patient needs, including abortion, contraception, fertility care, and gender affirming care. A provider's personal or religious beliefs should never dictate the care a patient receives. The very purpose of Section 1557 is to address long standing discrimination in health care that has created numerous barriers to quality care for communities of color, people with disabilities, the LGBTQ+ community, and others, 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+ care, and actively exacerbate health inequities. Rural communities, people with low-incomes, and communities of color often rely on religiously affiliated health care entities as they make up a large part of the U.S. health care system and are often located in communities that have been marginalized from care. In fact, [women of color](#) disproportionately give birth in Catholic hospitals and are therefore refused many facets of comprehensive sexual and reproductive health care. We are pleased the proposed rule does not incorporate Title IX's religious exemption which would undermine Section 1557's protections for patients and result in refusals of care. We also appreciate the Department's recognition that any request for an exemption should be an individualized inquiry.

a. The Danforth Amendment

The application of the Danforth Amendment, also known as Title IX religious refusals exception and abortion exception, is inappropriate in the health care context and HHS correctly proposes to repeal 45 CFR 92.6(b). HHS correctly determined that the 2020 rule improperly applied these provisions to Section 1557. Application of these provisions to Section 1557 via the 2020 rule has been enjoined in court, largely because applying these provisions to the health care context could have life-threatening implications. Delays in abortion care due to questions of compliance with this provision would put providers in impossible situations and put patients receiving this life-saving care at risk.

As discussed above abortion care is a normal and important part of the spectrum of reproductive health care and those seeking this care must be able to get evidence-based information, referrals, and services to the greatest extent possible. Applying the Danforth Amendment in the health care context would cause life-threatening situations and hinder a person's equal access to a health program or provider based upon their pregnancy related condition.

V. Enforcement Mechanisms

PRH supports strong enforcement of Section 1557 and welcome HHS' recognition in the preamble that the law protects people who experience intersectional discrimination. HHS must therefore make explicit at § 92.301 and throughout implementing regulations that Section 1557 creates a health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff's protected identity or identities. Ensuring strong enforcement and clear mechanisms for intersectional discrimination in this way would also enable a person to state a claim under



Section 1557 on a disparate impact theory for discrimination based on race. This approach is necessary to avoid inconsistent application of Section 1557, and to ensure Section 1557 provides adequate redress for those living at the intersection of multiple identities.

In conclusion, PRH, and the many health care providers signing in support of this comment letter, commend HHS for taking the important step of undoing the harmful Trump Administration regulations and strengthening the nondiscrimination protections of the ACA to ensure more equitable access to health care. Please do not hesitate to reach out to MiQuel Davies, Assistant Director of Public Policy, mdavies@prh.org to provide further information.

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