



November 9, 2015

By electronic submission

Hon. Sylvia Matthews Burwell,
Secretary,
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Jocelyn Samuels
Director, Office for Civil Rights
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
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Washington, DC 20201

Attn: 1557 NPRM (RIN 0945-AA02)

Re: Nondiscrimination in Health Programs and Activities, Proposed Rule

Dear Secretary Burwell and Director Samuels:

Lambda Legal Defense and Education Fund, Inc. (Lambda Legal) appreciates the opportunity to provide comments in response to the Department of Health and Human Services (HHS or the Department)'s Notice of Proposed Rulemaking Regarding Nondiscrimination in Health Programs and Activities (NPRM or Proposed Rule). Lambda Legal is the oldest and largest national legal organization dedicated to achieving full recognition of the civil rights of lesbian, gay, bisexual, and transgender (LGBT) people and people living with HIV through impact litigation, policy advocacy, and public education. Lambda Legal has been a strong supporter of the Patient Protection and Affordable Care Act (ACA) and applauds HHS for its commitment to ensuring that all people can receive affordable and high quality health care. We are especially grateful for the Department's work to increase access to care for LGBT people and those living with HIV because barriers to care—specifically including discrimination based on gender identity, gender expression, sexual orientation, and HIV status—have been and remain serious problems in our health care system. At Lambda Legal, we have made these problems a primary focus of our work spanning the last four decades.¹ We believe enforcement of the ACA's Section 1557

¹ For example, in 2010, Lambda Legal conducted the first-ever national survey to examine the refusals of medical care, other barriers to care, and substandard treatment confronting LGBT people and those living with HIV. The report, *WHEN HEALTH CARE ISN'T CARING*, is available here: http://data.lambdalegal.org/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf. Because LGBT people



can reduce this discrimination significantly, with important corresponding improvements in health quality for the populations we serve.² Accordingly, we provide these comments in support of the Department’s efforts to achieve Congress’s purpose of enhancing public access to high quality healthcare, including by reducing invidious bias and discrimination pursuant to Section 1557.

EXECUTIVE SUMMARY

Lambda Legal’s comments address the following key points. First, we recommend that the final nondiscrimination regulations apply more broadly to all health programs and activities receiving federal funds, not just to those receiving funding through HHS. (§ 92.2 Application.) Congress authorized the Department to promulgate government-wide rules for enforcement of Section 1557 and doing so would be consistent with the ACA’s goal of ending discrimination in federally funded health programs.

Second, Lambda Legal strongly recommends against adding by regulations a religious exemption from the requirements of Section 1557. (§ 92.2 Application.) The Department has requested comment on whether the final Rule should do this, despite Congress’s decision not to include such an exemption, and if so, what parameters might be appropriate. Religious exemptions with specific parameters exist in other federal nondiscrimination statutes. Congress knows how to craft them when they are justified. The Department should respect Congress’s decision to act firmly against the harms of discrimination in federally funded health care programs and activities by forbidding such discrimination, regardless of religious motive. Respecting that legislative decision is the legally proper approach and doing otherwise likely would severely compromise the ACA’s core purposes of enhancing access to quality medical care and, consequently, enhancing overall public health.

As the Department has observed, federal law already contains numerous protections for religious concerns, including the Religious Freedom Restoration Act, 42 U.S.C.S. § 2000bb *et seq.* (RFRA), and various laws and rules allowing religion-based refusals of particular care in particular circumstances.³ The Department has no cause to expand the impacts of those exemptions by importing them into the different context of Section 1557. Moreover, with respect to RFRA, it is important to note the substantial case law confirming that wishes to discriminate for religious reasons in public contexts generally must yield because nondiscrimination laws serve compelling interests and do so in the least restrictive manner.

and those living with HIV too-often do experience discrimination in health care services, and are especially vulnerable to breaches of confidentiality in medical settings, and to violations of their personal autonomy regarding reproductive decisions, sexual health, gender expression, transition-related care, HIV care and other matters, Lambda Legal has made this a programming priority and works to address this discrimination nationally with litigation, policy advocacy, community education, and education to ensure that medical professionals and healthcare facilities understand their responsibility to treat LGBT and HIV-positive patients fairly. See <http://www.lambdalegal.org/issues/health-care-fairness>.

² We explained our reasons for believing that robust enforcement of Section 1557 can have significant ameliorative effects on the health of LGBT people and people living with HIV in our September 30, 2013 submission in response to the Department’s Request for Information (1557 RFI (RIN 0945-AA02 & 0945-ZA01) (“Lambda Legal’s September 30, 2013 RIN 0945-AA02 Submission”), available at http://www.lambdalegal.org/in-court/legal-docs/tr_hhs_20130930_discrimination-in-health-services.

³ Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54172, 54173 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

It would be especially anomalous and improper to conclude otherwise in the context of Section 1557's guarantee of equal treatment with respect to federally-funded medical care where medical ethics parallel the statute's discrimination ban, the choice to seek public funding is voluntary, and the consequences of discrimination can be dire.

Third, we appreciate and strongly recommend that the final Rule retain the explicit recognition that discrimination based on sex stereotypes or gender identity constitutes prohibited sex discrimination. (§ 92.4 Definitions.) This is a legally sound approach and will be health-enhancing and, in many instances, lifesaving. It will benefit, however, from further clarification of the protections for individuals with non-binary gender identities.

At the same time, we very strongly recommend that the final Rule include similarly explicit recognition that discrimination based on sexual orientation likewise is prohibited sex discrimination. Failing to do so discounts the decisions of numerous courts, federal agencies and Administration policies. It also is inconsistent with the Supreme Court's key teachings in relevant cases, creates analytical incoherence, is likely soon to be obsolete, and is likely in the meantime to undermine enforcement of this and other nondiscrimination laws in harmful ways.

The Department's decision on this point takes place while widespread, harmful discrimination and related health disparities persist for LGBT people, with adverse consequences affecting an exceedingly vulnerable population, many of whom experience intersectional forms discrimination based on sexual orientation, race, age, national origin, immigration status, poverty, and other factors. The practical reality for LGBT people is that others' biased perceptions and expectations concerning gender, gender identity, and sexual orientation often blend, frequently are indistinguishable, and cause unequal health care treatment with harmful consequences. Given existing case law and Congress's antidiscrimination goals – and the consistent medical ethics rules – the regulations implementing Section 1557 should prohibit these interrelated forms of sex discrimination explicitly and consistently.

Fourth, we strongly support the inclusion of explicit protection against associational discrimination based on the protected personal characteristics of others with whom an individual or entity is known or believed to have a relationship. (§ 92.200 Nondiscrimination on the basis of association) This protection is of particular importance to LGBT people both because of the social stigma and ostracism that persist as a general matter and because discrimination based on one's same-sex intimate *association* is among the ways of understanding sexual orientation discrimination, and that it necessarily is covered by the sex discrimination ban. This protection also is of great importance to people living with HIV and people with other medical conditions and disabilities due to persistent misunderstanding and resulting social stigma concerning those medical conditions and disabilities.

Fifth, regarding § 92.207 (Nondiscrimination in health-related insurance and other health-related coverage), Lambda Legal urges the Department to establish a robust enforcement scheme to ensure nondiscrimination in benefit design, including codifying the transgender-inclusive protections in the proposed rule and clarifying that Section 1557 prohibits other forms of discrimination in benefit design, such as restricting access to medications used to treat specific conditions by placing them in high cost-sharing tiers, or by using discriminatory standards to determine medical necessity for specific populations or conditions. We believe it would be very beneficial and thus request inclusion of specific illustrations in the final Rule or in other guidance and we offer potential examples with particular focus on HIV-related discrimination problems.

LAMBDA LEGAL COMMENTS ON THE PROPOSED RULE

§ 92.2 Application.

A. The limitation to recipients of HHS funding is unwarranted.

We appreciate that the Department has adopted an inclusive view as to the applicability of the regulations to every health program or activity receiving Federal financial assistance, regardless of which part of the entity is receiving the Federal financial assistance (*see* 45 CFR § 92.2 “Application.”), as this is in keeping with the definition of “program or activity” developed through the case law under other statutes. *See* Civil Rights Restoration Act of 1987, Pub. L. No. 100-259, 102 Stat. 28. However, we are dismayed that the Department has unnecessarily limited the scope of the proposed regulations to recipients of “financial assistance administered by the Department[.]” *See* 45 CFR § 92.2 (“This part applies to health programs or activities administered by recipients of Federal financial assistance from the Department[.]” Unlike the other civil rights statutes referenced in Section 1557 that called upon multiple executive agencies to issue implementing regulations (*see* 42 U.S.C.S. § 2000d-1 (empowering “[e]ach Federal department and agency which is empowered to extend Federal financial assistance to any program or activity” to promulgate rules); 20 U.S.C.S. § 1682 (same, but with respect to education program or activities); 29 U.S.C.S. § 794 (providing that “each [Executive] agency shall promulgate such regulations as may be necessary”)), Section 1557 vests sole authority for issuing implementing regulations in the Department of Health and Human Services (HHS). *See* 42 U.S.C.A. § 18116 (c) (“The Secretary may promulgate regulations to implement this section.”))

Given this sole authority—but the statute’s application to recipients of Federal financial assistance more broadly—it seems unwarranted for the Department to limit application of these regulations to recipients of Federal financial assistance *from HHS*. While the Department may need to confine certain enforcement mechanisms to Federal financial assistance within control of the Department (*see* 80 Fed. Reg. 54173 n.2), the Secretary has been entrusted with the development of regulations that would be applicable to all recipients of Federal financial assistance, regardless of source.

RECOMMENDATION

We ask that the Secretary reconsider this limitation on application of the proposed regulations in light of the clear authority vested solely in the Secretary under Section 1557.

B. Creation of additional religious exemptions would be contrary to the statute, otherwise unjustified, and harmful to LGBT people and people living with HIV.

1. Addition of any religious exemptions would be contrary to the statute and otherwise unjustified as a legal matter.

The Department has invited comment on whether the Proposed Rule should import a religious exemption or exemptions from Title IX or other statutes, and specifically whether any exemptions are warranted with respect to the prohibitions against sex discrimination. For the reasons set out below, any such exemption would be improper for multiple reasons and could significantly defeat Congress’s purpose when enacting Section 1557.

First, by framing Section 1557 without exemptions for religious or other particular reasons for wishing to discriminate, Congress enacted the nondiscrimination standards it concluded were proper for a statute the purpose of which is to improve access to quality health care. Accordingly, the Department should not undermine that explicit congressional goal by creating loopholes for harmful conduct in federally funded health services and programs. It is well established that discrimination is harmful and that religious motives for discriminatory conduct do not ameliorate those harms. Consequently, courts have concluded consistently across generations that rules forbidding discrimination are to be enforced, notwithstanding sincere religious reasons for wishing to discriminate. Cases have addressed a variety of contexts in which religious justifications were proffered for, *inter alia*, race discrimination,⁴ sex discrimination,⁵ marital status discrimination,⁶ and sexual orientation discrimination.⁷ These contexts have included medical settings and access to health care and health insurance, in which patients, those needing insurance or others are vulnerable and the consequences can be dire.⁸ Arising under diverse statutes and constitutional provisions, these cases illustrate how significantly it could undermine Section 1557's effectiveness were the Department to create an exemption for religiously motivated discrimination, contrary to the plain language of the statute.

⁴ For example, courts properly rejected claims that Christian schools should be exempt from laws against race discrimination based on their beliefs that “mixing of the races” would violate God’s commands (*see Bob Jones Univ. v. United States*, 461 U.S. 574, 580, 583 n.6 (1983)), and that such beliefs should exempt restaurant owners who refused to serve African American customers. *Newman v. Piggie Park Enters., Inc.*, 256 F. Supp. 941, 944-45 (D.S.C. 1966), *rev'd* 377 F.2d 433 (4th Cir. 1967), *aff'd and modified on other grounds*, 390 U.S. 400 (1968). Courts likewise appropriately have rejected religious objections to laws and policies against interracial relationships and marriage. *See, e.g., Loving v. Virginia*, 388 U.S. 1, 3 (1967) (invalidating state law against interracial marriage despite religious arguments for racial segregation); *Whitney v. Greater N.Y. Corp. of Seventh-Day Adventists*, 401 F. Supp. 1363 (S.D.N.Y. 1975) (firing of white clerk typist for friendship with black person was not protected exercise of religion despite church’s religious objection to interracial friendships).

⁵ *See, e.g., EEOC v. Fremont Christian Sch.*, 781 F.2d 1362 (9th Cir. 1986) (notwithstanding sincere religious beliefs, school violated antidiscrimination law by offering unequal health benefits to female employees); *Bollenbach v. Bd. of Educ.*, 659 F. Supp. 1450, 1473 (S.D.N.Y. 1987) (school not permitted to refuse to hire women bus drivers to accommodate religious objections of male student bus riders).

⁶ *See, e.g., Smith v. Fair Emp. and Hous. Comm’n*, 913 P.2d 909, 925 (Cal. 1996) (rejecting religious objection of landlord to fair housing law requiring equal treatment of potential tenants regardless of marital status); *Swanner v. Anchorage Equal Rights Comm’n*, 874 P.2d 274 (Alaska 1994) (same).

⁷ *See, e.g., Bodett v. Coxcom, Inc.*, 366 F.3d 736 (9th Cir. 2004) (rejecting religious discrimination claim of supervisor fired for harassing lesbian subordinate); *Peterson v. Hewlett-Packard Co.*, 358 F.3d 599 (9th Cir. 2004) (rejecting religious discrimination claim of employee fired for anti-gay proselytizing intended to provoke coworkers); *Erdmann v. Tranquility, Inc.*, 155 F. Supp. 2d 1152 (N.D. Cal. 2001) (rejecting religious defense of supervisor who harassed gay subordinate with warnings he would “go to hell” and by pressuring him to join workplace prayer services).

⁸ *See, e.g., Knight v. Conn. Dep’t. of Pub. Health*, 275 F.3d 156 (2d Cir. 2001) (visiting nurse proselytizing to home-bound AIDS patient); *Hyman v. City of Louisville*, 132 F. Supp. 2d 528, 539–40 (W.D. Ky. 2001) (physician refusal to employ gay people), *vacated on other grounds*, 53 Fed. Appx. 740 (6th Cir. 2002); *North Coast Women’s Care Med. Grp., Inc. v. San Diego Cnty. Superior Court (Benitez)*, 189 P.3d 959, 967 (Cal. 2008) (applying strict scrutiny and rejecting physicians’ religious objections to treating lesbian patients).

Lambda Legal also recommends that the Department resist requests to infer or import religious exemptions or limitations into Section 1557 from Title IX. The reasons for this include that, as the Department notes, the education contexts covered by Title IX are materially different from the health care contexts covered by the ACA and certain sex-based exclusions common in education would be wholly inappropriate in medical settings. Moreover, as the Department also has noted, there already are specific federal protections for particular religious concerns in health care settings and the ACA does not override or diminish them.

The Religious Freedom Restoration Act, 42 U.S.C.S. § 2000bb *et seq.* (RFRA), is among those protections and, as the Supreme Court demonstrated in *Burwell v. Hobby Lobby*,⁹ it provides protection in some circumstances for those who object on religious grounds to requirements of the ACA. However, RFRA should not be read as authorizing discrimination contrary to the commands of Section 1557. Among other reasons, this is because, in the context of challenges to the ACA’s contraception coverage rule, the Supreme Court was explicit that **RFRA does not permit discrimination**, even if “cloaked as religious practice to escape legal sanction.”¹⁰ Justice Alito’s opinion for the majority was emphatic: “Our decision today provides no such shield.”¹¹ As he explained, this is because the government has a “compelling interest in providing equal opportunity” and because discrimination bans “are precisely tailored to achieve that critical goal.”¹²

Numerous federal and state court decisions echo that nondiscrimination laws serve compelling interests.¹³ Section 1557 plainly serves, to use Justice Alito’s phrasing, the government’s “compelling interest in providing equal opportunity.” Accordingly, even with RFRA’s heightened protections for religiously motivated conduct, Section 1557’s nondiscrimination provisions should be enforced as written because they serve compelling public interests using the least restrictive means. As the Supreme Court has confirmed, this remains true even when some may have religious reasons for wishing to discriminate.

A conclusion that HHS should **not** create an exemption from the text of Section 1557 for religiously motivated discrimination will be consistent with medical ethics standards that discrimination against patients is harmful and improper, even when religiously motivated. The American Medical

⁹ *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2014 U.S. LEXIS 4505, 2014 WL 2921709 (2014).

¹⁰ *Id.* at *87.

¹¹ *Id.*

¹² *Id.* Justice Kennedy’s concurring opinion reinforced this point: “[N]o person may be restricted or demeaned by government in exercising his or her religion. Yet neither may that same exercise unduly restrict other persons, such as employees, in protecting their own interests, *interests the law deems compelling.*” *Id.* at *97 (emphasis added).

¹³ For example, the United States Supreme Court has held that nondiscrimination laws “serve interests of the highest order.” *Roberts v. United States Jaycees*, 468 U.S. 609, 624 (1984) (requiring enforcement of California’s public accommodations law); *see also Catholic Charities of Sacramento, Inc. v. Superior Court*, 32 Cal.4th 527, 565 (2004) (laws against sex discrimination serve compelling interests); *North Coast Women’s Care Med. Grp.*, 189 P.3d at 967 (California’s public accommodations nondiscrimination law serves the state’s compelling interest in protecting lesbian patients against religiously motivated denials of medical care based on their sexual orientation).

Association (AMA) has at least two dozen rules and policy statements prohibiting sexual orientation discrimination and calling for culturally-appropriate care for LGBT patients.¹⁴ Especially relevant here is AMA ethical rule E-10.05, “Potential Patients,” which instructs that any rights of religious refusal concerning particular medical treatments do *not* include rights to refuse to treat particular groups of people and are subordinated to the primary duty not to discriminate.¹⁵ Accordingly, the government’s compelling interest in forbidding discrimination in health care programs and activities that receive federal funding is fully consistent with ethical rules that already govern medical professionals.

2. Addition of religious exemptions would be harmful to LGBT people and people living with HIV.

Religion too often has been used to discriminate against LGBT people and people living with HIV, including in health care settings. This happens when individual health professionals claim a right to discriminate in a secular health care context based on the professional’s personal religious views about LGBT people and/or same-sex relationships and when religiously affiliated institutions impose discriminatory restrictions against provision of medically needed care to LGBT people, people living with HIV or others. Examples of these two categories of religion-based discrimination, and the harmful consequences, are provided here.

a. Discrimination by individual health professionals in secular health care contexts based on the professionals’ personal religious views about LGBT people or same-sex relationships.

The following selection of cases illustrates the harmful results when health professionals have invoked protections for their religious liberty as grounds for providing unequal treatment to LGBT patients. The first two concern refusal of routine services to address reproductive and sexual health care needs:

- Lambda Legal client Guadalupe “Lupita” Benitez was referred for infertility care to North Coast Women’s Care Medical Group, a for-profit clinic that had an exclusive contract with Benitez’s insurance plan. After eleven months of preparatory treatments, including medication and unwarranted surgery, Lupita’s doctors finally admitted they would not perform donor insemination for her because she is a lesbian. The doctors claimed a right not to comply with California’s public accommodations law due to their fundamentalist Christian views against treating lesbian patients as they treat others. In a unanimous decision, the California Supreme Court held that religion liberty protections do not authorize doctors to violate the civil rights of lesbian patients.¹⁶

¹⁴ See American Medical Association, LGBT Advisory Committee, *GLBT Policy Compendium*, available at <http://www.ama-assn.org/ama1/pub/upload/mm/42/glbtpolicy0905.pdf>.

¹⁵ E-10.05, *Potential Patients*, (2) The following instances identify the limits on physicians’ prerogative: ... (b) Physicians cannot refuse to care for patients based on race, gender, sexual orientation, or any other criteria that would constitute invidious discrimination. ... (3) In situations *not* covered above, it may be ethically permissible for physicians to decline a potential patient when: ... (c) A specific *treatment* sought by an individual is incompatible with the physician’s personal, religious, or moral beliefs.” (emphasis added).

¹⁶ *North Coast Women’s Care Med. Grp.*, 189 P.3d at 959.

- Washington resident Jonathan Shuffield was denied a medical prescription when his doctor in a secular medical practice claimed a personal religious right to refuse to provide care based on Jonathan’s sexual orientation. Lambda Legal negotiated a settlement on Jonathan’s behalf in which the doctor and employing medical center agreed to take steps to protect other LGBT patients, including LGBT cultural competence for training physicians and staff and amending the center’s antidiscrimination policies.¹⁷

The following cases further illustrate the range of situations in which individual health professionals have asserted claims of a right to discriminate against LGBT people or people living with HIV in a health care setting based on the provider’s religious views about LGBT people.

- Counseling student’s objections to providing relationship counseling to same-sex couples: *Keeton v. Anderson-Wiley*, 664 F.3d 865 (11th Cir. 2011) (finding student unlikely to prevail on free speech and religious liberty claims challenging her expulsion from counseling program due to her religiously based refusal to counsel same-sex couples, contrary to professional standards requiring nonjudgmental, nondiscriminatory treatment of all patients).
- Physician’s objection to working with an LGB person: *Hyman v. City of Louisville*, 132 F. Supp. 2d 528, 539-540 (W.D. Ky. 2001) (physician’s religious beliefs did not exempt him from law prohibiting employment discrimination based on sexual orientation or gender identity), *vacated on other grounds* by 53 Fed. Appx. 740 (6th Cir. 2002).
- Proselytizing to patients concerning religious condemnation of homosexuality: *Knight v. Connecticut Dep’t of Pub. Health*, 275 F.3d 156 (2d Cir. 2001) (rejecting free exercise wrongful termination claim of visiting nurse fired for antigay proselytizing to home-bound AIDS patient).
- Refusal to process lab specimens from persons with HIV: *Stepp v. Review Bd. of Indiana Emp. Sec. Div.*, 521 N.E.2d 350, 352 (Ind. 1988) (rejecting religious discrimination claim of lab technician fired for refusing to do tests on specimens labeled with HIV warning because he believed “AIDS is God’s plague on man and performing the tests would go against God’s will”).

Testimonies received in Lambda Legal’s health survey describe similar encounters with health professionals who felt free to express their religiously grounded bias toward LGBT patients:

- Kara in Philadelphia, PA: “Since coming out, I have avoided seeing my primary physician because when she asked me my sexual history, I responded that I slept with women and that I was a lesbian. Her response was, ‘Do you know that’s against the Bible, against God?’”¹⁸
- Joe in Minneapolis, MN: “I was 36 years old at the time of this story, an out gay man, and was depressed after the breakup of an eight-year relationship. The doctor I went to see told me that it was not medicine I needed but to leave my ‘dirty lifestyle.’ He recalled having put other patients in touch with ministers who could help gay men repent and heal from sin, and he even suggested that I simply needed to ‘date the right woman’ to get over my depression. The doctor even went

¹⁷ *In re Shuffield*: <http://www.lambdalegal.org/in-court/cases/in-re-shuffield>.

¹⁸ Lambda Legal, *People Speak Out*, *supra* note 1, at page 1.

so far as to suggest that his daughter might be a good fit for me.”¹⁹

Similar examples of discrimination are all too common. Such treatment demonstrably leads to a distressing encounter for the patient, inadequate care, and future medical care avoidance, with potentially dangerous health consequences. It therefore is essential that the courts continue to rule as they have in the cases cited above that protections for religious liberty do not exempt health professionals from legal duties not to discriminate against patients, any more than is true under the American Medical Association’s ethical rules.

But, were additional religious exemptions to be allowed by regulation, it would create a potentially devastatingly risk that those subject to Section 1557’s nondiscrimination standards would impose their religious beliefs even more oppressively on patients, employees and insureds. For example, some might object to provision of or insurance coverage for HIV medications, infertility care for lesbians or unmarried non-lesbian women, treatment of gender dysphoria, and many more health care options individuals should be free to consider based on medical need without improper barriers imposed due to others’ religious commitments.

b. Discrimination against LGBT people and people living with HIV by religiously affiliated service providers.

When LGBT people receive medical care in religiously affiliated facilities, they may have limited recourse against discrimination under applicable nondiscrimination laws. Accordingly, it is that much more important that institutions that accept public funding be held to the same nondiscrimination standards as others offering services to patients. Here are two examples of situations in which patients had little notice or opportunity to select a secular provider to ensure protection against discrimination.

- Melody Rose in Wisconsin required gall bladder surgery but was refused when the surgeon expressed medically baseless concerns that her HIV posed a threat to him and his surgical team. Lambda Legal represented Melody against the physician and health facility that refused her. The physician and clinic were responsible to Melody under the nondiscrimination laws. However, the court determined that Agnesian HealthCare, Inc., the religiously affiliated corporation that did business with the clinic, was exempt from any liability under the civil rights law.²⁰
- Jennifer in Folsom, CA: “I am transgender, a registered nurse and married to my same-sex spouse of 6 years. ... [W]e were involved in a car crash and taken by trauma alert ambulance to a hospital ... My spouse was more seriously hurt and we were separated at the hospital. I was denied any information about her condition despite identifying myself as her spouse and producing a certified copy of our marriage certificate. This Catholic hospital didn’t recognize my status as next of kin so they would provide no information. I had to wait several hours until I was discharged from the ER to visit her and see how she was doing for myself. ... No one at the hospital ever apologized for adding to our suffering by denying us what would be usual courtesy if we had fit their standards. Until this happened I had never experienced discrimination in health

¹⁹ *Id.* at page 2.

²⁰ Information about *Rose v. Cahee* is at <http://www.lambdalegal.org/in-court/cases/rose-v-cahee-et-al>.

care—I just couldn’t believe it happened to us.”²¹

As the Department has acknowledged, “a fundamental purpose of the ACA is to ensure that vital health care services are broadly and nondiscriminatorily available to individuals throughout the country.”²² Creating an exemption for religiously motivated discrimination would significantly undermine that purpose by allowing harmful mistreatment of patients, insureds and others to continue and even to increase.

RECOMMENDATION

Lambda Legal strongly recommends that the Department resist requests to infer or import any religious exemptions or limitations into Section 1557, including suggestions to borrow from Title IX.

§ 92.4 Definitions.

The Department has requested comment about the proposed rule’s definition of discrimination “on the basis of sex,” which, with particular relevance to LGBT people, “includes, but is not limited to” discrimination based on sex stereotyping or gender identity. As explained in more detail below, we offer three principal comments. First, we appreciate and applaud the explicit recognition that gender identity discrimination is a covered form of sex discrimination. We propose some additional revisions and explain the basis below. Second, we propose revisions to the definition of sex stereotypes. Third, we strongly recommend that the definition be revised to include explicitly that sexual orientation discrimination is a form of prohibited sex discrimination. We propose revisions to correct this omission and explain the legal and scholarly basis for doing so.

A. Gender Identity Discrimination and Sex Stereotyping Discrimination are Forms of Sex Discrimination.

We commend HHS for clearly stating that discrimination based on sex stereotypes or gender identity constitutes discrimination on the basis of sex. As many federal agencies and courts have recognized, discrimination based on gender identity—including gender expression, gender transition, and transgender status—or on sex-based stereotypes is necessarily a form of sex discrimination.²³

In 2012, for instance, the Equal Employment Opportunity Commission (EEOC) held that “intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination based on sex and such discrimination therefore violates Title VII.”²⁴ The

²¹ Lambda Legal, *People Speak Out*, *supra* note 1, at page 2.

²² Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54172, 54173 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

²³ *See, e.g., Smith v. City of Salem*, 378 F.3d 566, 572-75 (6th Cir. 2004); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act). *See also* Statement of Interest of the United States at 14, *Jamal v. Saks*, No. 4:14-cv-02782 (S.D. Tex. Jan. 26, 2015).

²⁴ *Macy v. Holder*, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, *12 (Apr. 20, 2012).

Attorney General affirmed this interpretation in a 2014 memorandum.²⁵ The Department of Labor has taken the same position in internal guidance and proposed regulations,²⁶ as has the Office of Personnel Management in its regulations.²⁷ Similarly, the Departments of Education and Justice have clarified on multiple occasions that, under Title IX, “discrimination based on gender identity, including transgender status, is discrimination based on sex,”²⁸ as is discrimination based on sex stereotyping.²⁹ The Department of Housing and Urban Development has similarly concluded that the Fair Housing Act covers claims based on sex stereotypes and gender identity.³⁰

To date, the only court to rule on the issue in the context of Section 1557 has reached the same conclusion: the ACA’s sex discrimination prohibition “necessarily” encompasses bias based on gender identity or transgender status.³¹ This is an obviously correct application of the law’s plain words. By explicitly articulating Section 1557’s application to discrimination based on gender identity and sex stereotypes, the proposed rule’s definition of sex discrimination will provide needed clarity and address a widespread and urgent problem.

Accordingly, we support the proposed definitions of gender identity and sex stereotypes. Read together, these definitions recognize that protections against sex discrimination should extend to people of all gender identities—including non-transgender and transgender men and women as well as people of non-binary genders. However, the proposed rule’s definition of sex stereotypes, while accurate, is cumbersome and may be confusing for readers not familiar with the issue. The proposed definition of gender identity should also be clarified to include an explicit reference to non-binary identities. We propose language to clarify both definitions.

²⁵ Attorney General Memorandum, *Treatment of Transgender Employment Discrimination Claims Under Title VII of the Civil Rights Act of 1964* (Dec. 15, 2014).

²⁶ Department of Labor, *Discrimination on the Basis of Sex, Proposed Rule*, 80 Fed. Reg. 5246 (Jan. 30, 2015); Office of Federal Contract Compliance Programs (OFCCP) Dir. 2015-1, *Handling individual and systemic sexual orientation and gender identity discrimination complaints* (Apr. 16, 2015); OFCCP Dir. 2014-02, *Gender Identity and Sex Discrimination* (Aug. 19, 2014).

²⁷ See 5 C.F.R. §§ 300.102-300.103, 335.103, 410.302, 537.105.

²⁸ Statement of Interest of the United States at 5, *G.G. ex rel. Grimm v. Gloucester Cty. Sch. Bd.*, No. 4:15cv54 (E.D. Va. filed June 29, 2015); Statement of Interest of the United States at 12, *Tooley v. Van Buren Pub. Sch.*, No. 2:14-cv-13466 (E.D. Mich. filed Feb. 24, 2015); Dep’t of Educ., *Title IX Resource Guide*, 1 (Apr. 2015); Dep’t of Educ., “Questions and Answers on Title IX and Sexual Violence,” 5 (Apr. 29, 2014).

²⁹ See Dep’t of Educ., “Dear Colleague,” 7-8 (Oct. 26, 2010).

³⁰ *HUD v. Toone*, Charge of Discrimination, FHEO Nos. 06-12-1130-8; 06-121363-8 (Ofc. Hear. & App. Aug. 15, 2013); Memorandum from John Trasviña to FHEO Regional Directors, *Assessing Complaints that Involve Sexual Orientation, Gender Identity, and Gender Expression* (June 2010).

³¹ *Rumble v. Fairview Health Services*, No. 14-cv-2037, 2015 WL 1197415, *2 (D. Minn. Mar. 16, 2015).

RECOMMENDATIONS

- We recommend that the definition of gender identity in § 92.4 be revised as follows:

Gender identity is an individual's internal sense of gender, **which may be male, female, neither, both, or a combination of male and female, and** which may be different from that individual's sex assigned at birth. The way an individual expresses gender identity is frequently called “gender expression,” and may or may not conform to social stereotypes associated with a particular gender. A transgender individual is an individual whose gender identity is different from the sex assigned to that person at birth; an individual with a transgender identity is referred to in this part as a transgender individual.

- We recommend revising the definition of sex stereotypes in § 92.4 as follows (incorporating the modifications recommended in the following section discussing sexual orientation):

Sex stereotypes refers to stereotypical notions of gender, including expectations of how an individual represents or communicates gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics. These stereotypes can include the expectation that gender can only be constructed within two distinct opposite and disconnected forms (masculinity and femininity), and that gender cannot be constructed outside of this gender construct (individuals who identify as neither, both, or a combination of male and female genders) **that individuals consistently identify with one and only one of two genders (male or female), and that they act in conformity with the gender-related expressions stereotypically associated with that gender. Sex stereotypes also include gendered expectations related to the appropriate roles or behavior of men and women, such as the expectation that women are primary caregivers, and aspects of an individual's sexual orientation, such as the sex of an individual's sexual or romantic partners.**

B. The Final Rule Should State Explicitly That Sexual Orientation Discrimination Is A Prohibited Form of Sex Discrimination.

1. Sexual orientation discrimination is sex discrimination.

The EEOC has ruled that an employee discriminated against based on sexual orientation has a claim under Title VII, because his or her sex necessarily was a factor in the discrimination.³² With increasing frequency, federal courts agree: before 2014, three federal courts had so held;³³ now, with recent decisions, at least eight courts – from different judicial circuits – have so ruled.³⁴ Explicitly

³² *Baldwin v. Foxx*, EEOC Appeal No. 0120133080, 2015 EEOPUB LEXIS 1905 (July 16, 2015).

³³ *Koren v. Ohio Bell*, 894 F. Supp. 2d 1032, 1038 (N.D. Ohio 2012); *Heller v. Columbia Edgewater Country Club*, 195 F. Supp. 2d 1212, 1223-24 (D. Or. 2002); *Centola v. Potter*, 183 F. Supp. 2d 403, 410 (D. Mass. 2002).

³⁴ *Isaacs v. Felder Servs., LLC*, No. 2:13cv693, 2015 U.S. Dist. LEXIS 146663 *9 (M.D. Ala. Oct. 29, 2015); *Deneffe v. SkyWest, Inc.*, No. 14-cv-00348, 2015 U.S. Dist. LEXIS 62019 (D. Colo. May 11, 2015); *Boutillier v.*

incorporating sexual orientation within the definition of sex in Section 1557 in the final rule is both consistent with this current legal doctrine and essential to ensuring that LGB individuals and families have access to the health care they need.

Last year, the Attorney General issued a memorandum setting forth the Department of Justice’s position that Title VII’s sex discrimination prohibition encompasses “gender identity *per se* (including transgender discrimination)” and not merely cases where the employee can prove that sex-stereotyping discrimination occurred.³⁵ The memorandum cited only one court case supporting that position, the thorough and thoughtful analysis in *Schroer v. Billington*;³⁶ the memorandum also relied on the EEOC’s identical holding in *Macy v. Holder*.³⁷ Rather than undertake a head count of courts, the Attorney General placed primary reliance – as did the EEOC in *Baldwin* – on two Supreme Court holdings: *Price Waterhouse*’s forbidding of “sex-based considerations” in employer decisions³⁸ and *Oncale*’s mandate that Title VII covers all cases in which an employee suffers an adverse employment action or hostile work environment that would not have happened if the employee were of a different sex, irrespective of whether Congress contemplated that particular application of Title VII.³⁹

The Department of Justice again should focus on the Supreme Court’s interpretation of Title VII generally and the rulings of the best reasoned and thus most persuasive judicial and administrative decisions. As a general matter, the cases holding that sexual orientation discrimination is not covered by Title VII reveal approaches that undermine their persuasiveness, such as assuming the issue has been definitely resolved already; focusing on the absence of the words “sexual orientation” in Title VII; relying heavily on the presumed goals of Congress in passing Title VII,⁴⁰ and the fact that Congress has

Hartford Public Schools, No. 3:13cv1303, 2014 U.S. Dist. LEXIS 134919 (D. Conn. Sept. 25, 2014); *Hall v. BNSF Railway Co.*, No. C13-2160, 2014 U.S. Dist. LEXIS 132878 (W.D. Wash. Sept. 22, 2014); *TerVeer v. Billington*, 34 F.Supp.3d 100 (D.D.C. 2014).

³⁵ Attorney General Memorandum, *Treatment of Transgender Employment Discrimination Claims Under Title VII of the Civil Rights Act of 1964* (Dec. 15, 2014).

³⁶ 577 F. Supp. 2d 293 (D.D.C. 2008).

³⁷ Appeal No. 0120120821 (EEOC April 20, 2012).

³⁸ *Price Waterhouse v. Hopkins*, 490 U.S. 228, 240-42 (1989).

³⁹ *Oncale v. Sundowner Offshore Servs.*, 523 U.S. 75, 79 (1998).

⁴⁰ As one might imagine, courts after *Oncale* that reject sexual orientation coverage generally have not expressly relied on the intent of the 88th Congress. But they often have relied heavily on cases decided before *Oncale* that based their holdings largely if not exclusively on not wanting to allow lawsuits by plaintiffs that Congress presumably had not contemplated in 1964. *E.g. DeSantis v. Pacific Tel. & Tel. Co.*, 608 F.2d 327, 330 (9th Cir. 1979) (“[I]n passing Title VII Congress did not intend to protect sexual orientation and has repeatedly refused to extend such protection.”). The *DeSantis* holding that Title VII does not cover sexual orientation has been cited by the most prominent cases with similar pronouncements or holding against coverage in the Second, Fourth, Sixth, and Eighth circuits, which in turn have been relied upon countless times. Similarly, *Ulane v. Eastern Airlines*, 742 F.2d 1081 (7th Cir. 1984), relied almost exclusively on Congressional intent and inaction in holding that transsexuals were not protected under Title VII. *Id.* at 1084-86. *Ulane*’s constricted view of whether Title VII protects LGBT people was repeated in the leading Second, Sixth, and Seventh Circuit cases on the subject of coverage of sexual orientation discrimination.

not passed any of the bills that would add the words “sexual orientation” explicitly to Title VII;⁴¹ they never answer or even consider the question “what is sex discrimination under Title VII?” On the latter point, the Supreme Court has articulated a “simple test” for sex discrimination: “treatment of a person in a manner which but for that person's sex would be different.”⁴² Again, the Court has provided the framework that should make the coverage question simple: if an employee’s dating of women would not be a problem if she were not a woman herself, any resulting adverse employment action is sex discrimination.

Is an employer using sex-based considerations by announcing a policy that precludes insurance coverage or work leave for a spouse of the same sex? That question should be exceedingly easy, given that every court for over three decades⁴³ has held that discrimination against an employee for having a spouse of a different race violates Title VII because the employer is taking the employee’s race into consideration.⁴⁴ At first blush, it seems impossible that every court would recognize that an employee is discriminated against because of his or her race if an interracial marriage was the motive, but that courts would be slow to realize that an employee is discriminated against because of her sex if she is the only employee that the employer objects to having a wife. But there is legitimate reason to believe that such asymmetry in judicial treatment may fade. One must remember that the law often treated same-sex relationships as *criminal* prior to the decision a dozen years ago in *Lawrence v. Texas*,⁴⁵ and in many

⁴¹ Reliance on congressional inaction in not passing a “sexual orientation” amendment to Title VII is wrong for at least two reasons. The holding of *Oncale* is that courts should hear all cases where the mistreatment of an employee occurred “because of such individual’s . . . sex”; a limitation in the minds of the 88th Congress – or any subsequent Congress -- that is not in the statutory words is irrelevant. Moreover, attaching significance to Congressional inaction is especially inappropriate in this instance, given that only Courts of Appeals have weighed in on the coverage question and, with one exception, only after 1991, the last significant amendment to Title VII. Thus, there was no judicial consensus or even a prevailing interpretation for Congress to countermand. Moreover, that amendment (the Civil Rights Act of 1991) specifically overruled part of *Price Waterhouse* (regarding mixed-motive liability) but left intact its holding that employers cannot punish employees for their failure to conform to prevailing gender norms.

⁴² *Manhart v. Los Angeles Dep’t of Water & Power*, 435 U.S. 702, 711 (1978); see also *Shepherd v. Slater Steels Corp.*, 168 F.3d 998, 1009 (7th Cir. 1999) (“So long as the plaintiff demonstrates in some manner that he would not have been treated in the same way had he been a woman, he has proven sex discrimination.”).

⁴³ See the thorough collection of cases in Victoria Schwartz, *Title VII: A Shift From Sex to Relationships*, 35 Harvard J. L. & Gender 209, 246 (Jan. 2012) (“In the past thirty years, every case to consider a relational discrimination claim in the context of race has held that Title VII applies to such claims.”).

⁴⁴ A few early decisions actually exonerated employers with the reasoning that the discrimination was because of the race of the employee’s spouse, not the race of the employee. E.g., *Adams v. Governor’s Committee on Postsecondary Education*, 1981 U.S. Dist. LEXIS 15346, 26 Fair Empl. Prac. Cas. (BNA) 1348 (N.D. Ga. Sept. 3, 1981). And of course, the race of the spouse was also a factor – but Title VII does not concern itself with other factors that may have led to the mistreatment but instead asks only whether it would have occurred but for the employee’s gender. See *Barnes v. Costle*, 561 F.2d 983, 991 (D. C. Cir. 1977) (it is irrelevant that the harassment “embraced something more than the employee's gender, [because] the fact remained that gender” led to the harassment).

⁴⁵ 539 U. S. 558 (2003).

jurisdictions continued to treat them as inferior before the decision this June in *Obergefell v. Hodges*.⁴⁶ Although these decisions do not bear directly on the statutory coverage question at issue, they are likely to remove legal blinders that sometimes have prevented courts from seeing the obvious: that discrimination based on a marriage to someone of a *different* race or to someone of the *same* sex necessarily involves taking into consideration the race or sex of the employee.⁴⁷

In the same way that the Attorney General’s memorandum regarding gender identity discrimination drew from the well-reasoned *Schroer* and *Macy* decisions, there is fortuitous timing in this summer’s *Baldwin v. Foxx* decision of the EEOC, which analyzed thoroughly the range of arguments on the question whether Title VII covers sexual orientation discrimination before concluding the answer must be in the affirmative. The EEOC ruled in favor of a Department of Transportation employee who alleged that he had not received a promotion because of his sexual orientation.⁴⁸ The EEOC echoed the Attorney General memorandum by focusing on the Supreme Court’s holding that Title VII prohibits employers from relying on “sex-based considerations” when making personnel decisions.⁴⁹ The EEOC concluded that antigay bias in the Department of Transportation’s decision process would violate Title VII because sexual orientation discrimination is inseparably linked to sex-based considerations. The Commission clearly stated that “sexual orientation is inherently a ‘sex-based consideration,’ and an allegation of discrimination based on sexual orientation is necessarily an allegation of sex discrimination under Title VII.”⁵⁰ The EEOC further clarified that “[a] complainant alleging that an agency took his or her sexual orientation into account in an employment action necessarily alleges that the agency took his or her sex into account.”⁵¹ The EEOC also held that sexual orientation discrimination violates Title VII

⁴⁶ 135 S. Ct. 2071 (2015).

⁴⁷ The facial classification and associational discrimination analyses of the race discrimination cases that warrant the explicit ban on association discrimination of §92.209 apply with similar force to different treatment based on one’s own sex or the sex of another with whom one is known or believed to associate.

⁴⁸ EEOC Appeal No. 0120133080, 2015 EEOPUB LEXIS 1905 (July 16, 2015). The Commission, which is the agency “responsible for enforcing federal laws that make it illegal to discriminate against a job applicant or an employee” (<http://www.eeoc.gov/eeoc/>) has consistently applied this interpretation in a long series of decisions prior to *Baldwin*. See, e.g., *Complainant v. Johnson*, EEOC Appeal No. 0120110576 (Aug. 20, 2014); *Complainant v. Cordray*, EEOC Appeal No. 0120141108 (Dec. 18, 2014); *Complainant v. Donahoe*, EEOC Appeal No. 0120132452 (Nov. 18, 2014); *Complainant v. Secretary, Dept. of Veterans Affairs*, EEOC Appeal No. 0120110145 (Oct. 23, 2014); *Couch v. Dep’t of Energy*, EEOC Appeal No. 0120131136 (Aug. 13, 2013); *Brooker v. U.S. Postal Service*, EEOC Appeal No. 0120112085 (May 20, 2013); *Culp v. Dep’t of Homeland Security*, EEOC Appeal No. 0720130012 (May 7, 2013); *Castello v. U.S. Postal Service*, Appeal No. 0120111795 (Dec. 20, 2011); *Veretto v. U.S. Postal Service*, EEOC Appeal No. 0120110873 (July 1, 2011).

⁴⁹ *Baldwin*, at *11, quoting *Price Waterhouse*, 490 U.S. at 240-42; *Macy*, *supra* at 5.

⁵⁰ *Baldwin*, at *13.

⁵¹ *Id.*

“because it necessarily involves discrimination based on gender stereotypes;”⁵² that holding is discussed in the next section.⁵³

In holding that sexual orientation discrimination necessarily involves “sex-based considerations,” the EEOC relied on federal court decisions that had recognized that male and female employees in relationships with women should be treated the same; it is sex discrimination to do otherwise. A 2002 federal court decision pointed out that an employer is engaged in unlawful discrimination if the employee would have been treated differently if she were a man dating a woman, instead of a woman dating a woman.⁵⁴ Concerning equal access to health care insurance, a federal judge reached a similar conclusion last year in *Hall v. BNSF Railway Co.*, when an employee had been denied spousal coverage on the company health plan because his spouse was a man.⁵⁵ The *Hall* court held that the plaintiff had stated a viable claim of sex discrimination under Title VII and the Equal Pay Act because he “alleges disparate treatment based on his sex, not his sexual orientation, specifically that he (as a male who married a male) was treated differently in comparison to his female coworkers who also married males.”⁵⁶ Similarly, to treat women who are in relationships with men better than men who are in relationships with men has been held to be sex discrimination in violation of Title IX⁵⁷ and the Equal Protection Clause of the Constitution.⁵⁸

⁵² *Baldwin*, at *20.

⁵³ *Baldwin* has been well-received by the courts that have analyzed the decision. See, e.g., *Isaacs v. Felder Servs., LLC*, No. 2:13cv693, 2015 U.S. Dist. LEXIS 146663 *9 (M.D. Ala. Oct. 29, 2015) (“the Commission explains persuasively why ‘an allegation of discrimination based on sexual orientation is necessarily an allegation of sex discrimination under Title VII.’”) (citation omitted); *Roberts v. United Parcel Serv., Inc.*, No. 13-CV-6161, 2015 U.S. Dist. LEXIS 97989 *40 (E.D.N.Y. July 27, 2015) (calling *Baldwin* “a landmark ruling”); see also *Burrows v. Coll. of Cent. Fla.*, No. 5:14-cv-197-Oc-30PRL, 2015 U.S. Dist. LEXIS 119940 *4 (M.D. Fla. Sept. 9, 2015) (*Baldwin* would have been “considered persuasive authority” had it been brought to the court’s attention prior to a motion for reconsideration).

⁵⁴ *Heller v. Columbia Edgewater Country Club*, 195 F. Supp. 2d 1212, 1223-24 (D. Or. 2002).

⁵⁵ *Hall v. BNSF Railway Co.*, No. C13-2160, 2014 U.S. Dist. LEXIS 132878 (W.D. Wash. Sept. 22, 2014).

⁵⁶ *Id.* at *9.

⁵⁷ See *Videckis v. Pepperdine Univ.*, No. CV 15-00298, 2015 U.S. Dist. LEXIS 51140 **20-21 (C.D. Cal., 2015) (“[D]iscrimination based on a same-sex relationship could fall under the umbrella of sexual discrimination [prohibited by Title IX] even if such discrimination were not based explicitly on gender stereotypes. For example, a policy that female basketball players could only be in relationships with males inherently would seem to discriminate on the basis of gender.”).

⁵⁸ See, e.g., *Latta v. Otter*, 771 F.3d 456, 480-96 (9th Cir. 2014) (Berzon, J., concurring); *Waters v. Ricketts*, 48 F.Supp.3d 1271, 1281 (D. Neb. 2015); *Rosenbrah v. Daugaard*, 61 F.Supp.3d 845, 860-61 (D.S.D. 2014); *Jernigan v. Crane*, 64 F.Supp.3d 1260, 1286 (E.D. Ark. 2014); *Lawson v. Kelly*, 14-0622-CV-W-ODS, 2014 WL 5810215, at *8 (W.D. Mo. Nov. 7, 2014); *Kitchen v. Herbert*, 961 F.Supp.2d 1181, 1206 (D. Utah 2013); *Golinski v. U.S. Office of Pers. Mgmt.*, 824 F. Supp. 2d 968, 982 n.4 (N.D. Cal. 2012); *Perry v. Schwarzenegger*, 704 F.Supp.2d 921, 996 (N.D. Cal. 2010); *In re Balas*, 449 B.R. 567, 577-78 (Bankr. C.D. Cal. 2011); see also *Baehr v. Lewin*, 852 P.2d 44, 64-67 (Haw. 1993) (plurality opinion); *Goodridge v. Dep’t of Pub. Health*, 798 N.E.2d 941, 971-73 (Mass. 2003) (Greaney, J., concurring).

In January 2015, the EEOC published a final determination applying this understanding of Title VII in *Cote v. Wal-Mart* a case concerning access to health care.⁵⁹ In *Cote*, the EEOC found that Wal-Mart had discriminated against a lesbian employee in violation of Title VII when it denied her the opportunity to enroll her wife in the company-provided health insurance plan. As in *Hall v. BNSF Railway*, the EEOC likewise concluded that the only way to understand the differential treatment of this employee was as discrimination on the basis of her sex.

Failure to incorporate this consistent legal trajectory into the final rule would concretize a harmful and outdated interpretation of the law and would put HHS policy out of step with both federal courts and other federal agencies, including the Office of Personnel Management, the EEOC, the Office of Special Counsel, and the Merit Systems Protection Board.⁶⁰

RECOMMENDATIONS

- We strongly recommend that the definition of “on the basis of sex” in § 92.4 be revised as follows:

On the basis of sex includes, but is not limited to, on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, ***sexual orientation***, or gender identity.

- Similarly, we recommend that language be added to § 92.4 defining sexual orientation as follows:

Sexual orientation means homosexuality, heterosexuality, or bisexuality.⁶¹

2. The relationship between sex stereotypes and sexual orientation discrimination.

To ensure that covered entities are aware of the full ramifications of Section 1557’s protections from sex discrimination, we also urge HHS to clarify the relationship between sex stereotypes and sexual orientation discrimination by adding language to the proposed definition of sex stereotypes in § 92.4 to illustrate how discrimination on the basis of sex stereotypes can target individuals not only on the basis of sex or gender identity, but also on the basis of sexual orientation.

In *Price Waterhouse v. Hopkins*, the Supreme Court held that discrimination based on sex stereotypes is unlawful under the sex discrimination protections of Title VII. In *Baldwin*, the EEOC held that sexual orientation discrimination is a form of unlawful sex stereotyping discrimination because the employee is penalized for contravening societal norms about what men and women are and what intimate relationships they should have. *Baldwin*’s robust application of protections from sex stereotyping discrimination reflects the understanding that sex stereotypes can involve not only expectations for

⁵⁹ EEOC Charge No. 523-2014-00916 (Jan. 29, 2015).

⁶⁰ Office of Personnel Management, *Addressing Sexual Orientation and Gender Identity Discrimination in Federal Civilian Employment* (2015).

⁶¹ This definition is adapted from the Equality Act (H.R. 3185, 114th Cong. § 1101, 2015).

masculine and feminine gender presentation, but also beliefs related to sexual orientation, such as the stereotype that men must date and marry women, and women must date and marry men.⁶²

A noted above, the EEOC had ample support for its holding; at least a half-dozen federal cases to date have held that employees had valid sex stereotyping claims under Title VII by alleging mistreatment based on their sexual orientation.⁶³ One of those cases, *TerVeer v. Billington*, rejected a motion to dismiss the plaintiff's claim that he had endured sex stereotyping discrimination; the court held that the plaintiff's "status as a homosexual male did not conform to [his supervisor's] gender stereotypes associated with men under his supervision and that his orientation as a homosexual had removed him from [his supervisor's] preconceived definition of male."⁶⁴

RECOMMENDATION

We recommend that the definition of sex stereotypes in § 92.4 be revised as follows (incorporating the above recommendation regarding gender identity):

Sex stereotypes refers to stereotypical notions of gender, including expectations of how an individual represents or communicates gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics. These stereotypes can include the expectation ~~that gender can only be constructed within two distinct opposite and disconnected forms (masculinity and femininity), and that gender cannot be constructed outside of this gender construct (individuals who identify as neither, both, or a combination of male and female genders)~~ **that individuals consistently identify with one and only one of two genders (male or female), and that they act in conformity with the gender-related expressions stereotypically associated with that gender. They also include gendered expectations related to the appropriate roles of men and women, such as the expectation that women are primary caregivers, and**

⁶² In *Veretto v. United States Postal Service*, EEOC Appeal No. 0120110873, 2011 WL 2663401, at *3 (Jul. 1, 2011), for example, the EEOC determined that the complainant's allegation of sexual orientation discrimination was a sufficient sex discrimination claim because the discrimination was based on the sex stereotype that "marrying a woman is an essential part of being a man" and "motivated by...attitudes about stereotypical gender roles in marriage."

⁶³ See *Isaacs* at *10 (when an employee suffers sexual orientation discrimination "based on her or his perceived deviations from 'heterosexually defined gender norms,' this, too, is sex discrimination, of the gender-stereotyping variety."); *Heller*, 195 F. Supp. 2d at 1224 ("[A] jury could find that Cagle repeatedly harassed (and ultimately discharged) Heller because Heller did not conform to Cagle's stereotype of how a woman ought to behave [because] Heller is attracted to and dates other women"); see also *Deneffe v. SkyWest, Inc.*, No. 14-cv-00348, 2015 U.S. Dist. LEXIS 62019 (D. Colo. May 11, 2015); *Boutillier v. Hartford Public Schools*, No. 3:13cv1303, 2014 U.S. Dist. LEXIS 134919 (D. Conn. 2014); *TerVeer v. Billington*, 34 F.Supp.3d 100 (D.D.C. 2014); *Koren v. Ohio Bell*, 894 F. Supp. 2d 1032, 1038 (N.D. Ohio 2012); *Centola v. Potter*, 183 F. Supp. 2d 403, 410 (D. Mass. 2002).

⁶⁴ *TerVeer*, 34 F. Supp. 3d at 116. Courts have decided similarly under Title IX. *Estate of Brown v. Ogletree*, No. 11-cv-1491, 2012 U.S. Dist. LEXIS 21968 (S.D. Tex. Feb. 21, 2012), *modified on other grounds by Estate of Brown v. Cypress Fairbanks Indep. Sch. Dist.*, 2012 U.S. Dist. LEXIS 72347 (S.D. Tex. May 23, 2012); *Schroeder v. Maumee Board of Education*, 296 F. Supp. 2d 869, 871 (N.D. Ohio 2003); *Ray v. Antioch Unified Sch. Dist.*, 107 F.Supp.2d 1165, 1170 (N.D.Cal.2000); Letter of Findings to Tehatchapi Unified School District, ED/OCR Case No. 09-11-1031, DOJ Case No. DJ 169-11E-38, at 14. (June 30, 2011).

aspects of an individual's sexual orientation, such as the sex of an individual's sexual or romantic partners.

3. Lack of explicit recognition that sexual orientation discrimination is prohibited sex discrimination will allow wrongful, damaging health care discrimination to continue, with significant adverse public health consequences.

As noted above, five years ago Lambda Legal conducted the first-ever national survey to examine health care discrimination against LGBT people and those living with HIV.⁶⁵ Of the nearly 5,000 respondents, more than half reported that they have experienced at least one of the following types of discrimination in care:

- Health care providers refusing to touch them or using excessive precautions;
- Health care providers using harsh or abusive language;
- Health care providers being physically rough or abusive;
- Health care providers blaming them for their health status.⁶⁶

Almost 56 percent of lesbian, gay, or bisexual (LGB) respondents had at least one of these experiences; 70 percent of transgender and gender-nonconforming respondents had one or more of these experiences; and almost 63 percent of respondents living with HIV experienced one or more of these types of discrimination in health care.⁶⁷ Almost 8 percent of LGB respondents reporting having been denied needed care because of their sexual orientation,⁶⁸ and 19 percent of respondents living with HIV reported being denied care because of their HIV status.⁶⁹ The picture was even more disturbing for transgender and gender-nonconforming respondents, who reported the highest rates of being refused care (nearly 27 percent), being subjected to harsh language (nearly 21 percent), and even being abused physically (nearly 8 percent).⁷⁰

Respondents of color and low-income respondents reported much higher rates of hostile treatment and denials of care. Nearly half of low-income respondents living with HIV reported that medical personnel refused to touch them, while the overall rate among those with HIV was nearly 36 percent.⁷¹ And while transgender respondents as a whole reported a care-refusal rate of almost 27 percent, low-income transgender respondents reported a rate of nearly 33 percent.⁷² People of color living with HIV and LGB people of color were at least twice as likely as whites to report experiencing physically rough

⁶⁵ LAMBDA LEGAL, WHEN HEALTH CARE ISN'T CARING, *supra* note 1.

⁶⁶ *Id.* at 5, 9-10.

⁶⁷ *Id.*

⁶⁸ *Id.* at 5, 10.

⁶⁹ *Id.*

⁷⁰ *Id.* at 10-11.

⁷¹ *Id.* at 11.

⁷² *Id.*

or abusive treatment by medical professionals.⁷³

The WHEN HEALTH CARE ISN'T CARING report explains the context of this study and its recommendations. Accompanying the report are eight supplements providing excerpts of the personal testimonies submitted by study participants and presenting findings about particular subgroups; these supplements are:

- Lesbian, Gay, Bisexual and Transgender (LGBT) People and People Living with HIV Speak Out⁷⁴
- LGBT People of Color and People of Color Living with HIV⁷⁵
- LGBT Women⁷⁶
- LGBT Older Adults and Older Adults Living with HIV⁷⁷
- LGBT Immigrants and Immigrants Living with HIV⁷⁸
- Transgender and Gender-nonconforming People⁷⁹
- People Living with HIV⁸⁰
- Low-Income or Uninsured LGBT People and People Living with HIV⁸¹

The study results showing that LGBT and HIV-positive people who also are people of color, older, immigrants and/or low income experience much more discrimination in health care settings, with correspondingly compromised health outcomes, than people who do not experience such compounding of vulnerabilities reinforce that Section 1557 must be implemented and enforced effectively. What follows is information drawn from Lambda Legal's survey, from years of experience litigating discrimination cases and developing health policy recommendations, and from other sources showing the widespread, harmful reality that is likely to persist to a much greater extent absent explicit inclusion of

⁷³ *Id.* at 12.

⁷⁴ http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-insert_lgbt-people-and-people-living-with-hiv-speak-out.pdf. Examples from these testimonies are provided in the following sections.

⁷⁵ http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-insert_lgbt-people-of-color.pdf.

⁷⁶ http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-insert_lgbt-women.pdf.

⁷⁷ http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-insert_lgbt-older-adults-and-older-adults-living-with-hiv.pdf.

⁷⁸ http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-insert_lgbt-immigrants-and-immigrants-living-with-hiv.pdf.

⁷⁹ http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-insert_transgender-and-gender-nonconforming-people.pdf.

⁸⁰ http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-insert_people-living-with-hiv.pdf.

⁸¹ http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-insert_low-income-or-uninsured.pdf.

sexual orientation discrimination within the definition of “on the basis of sex.” First is information about sex discrimination against LGB people, and then about discrimination against people living with HIV.

a. Examples of Discrimination Based On Sexual Orientation That Should Be Prevented By Enforcement Of Section 1557.

As explained below, three common forms of discrimination against LGB people are (1) refusal to respect the family relationships of same-sex couples and their children; (2) discriminatory insurance coverage and services relating to infertility and assisted reproduction; and (3) lack of respect and cultural competence concerning the non-heterosexual orientation of LGB people.

(1) Refusal to recognize same-sex family relationships in health care settings

Because this has been a pervasive problem, Lambda Legal has brought claims on behalf of surviving partners against multiple hospitals that had prevented the survivor from being at the bedside of the dying same-sex partner. Here are two examples:

- Washington State residents Janice Langbehn and her three children were kept from the bedside of Janice’s dying partner, Lisa Pond, as Lisa lay dying following a brain aneurism during the family’s vacation in Florida. Although Langbehn held Lisa’s power of attorney, hospital staff refused information from her regarding Pond’s medical history. And although a physician admitted there was no medical reason to deny visitation, staff refused her and the children access to Lisa’s room for nearly 8 hours, saying they were in an “antigay city and state” and could expect no acknowledgment as family. Lambda Legal sued Jackson Memorial Hospital on behalf of Janice and the couple’s children. The case inspired President Obama to issue new visitation guidelines requiring respect for same-sex couples in health care facilities receiving federal funding.⁸²
- Robert Daniel and Bill Flanigan were traveling from California to visit family in Maryland when Robert suddenly needed emergency care. Although Robert and Bill were registered domestic partners in California and Bill had Robert’s power of attorney, hospital personnel kept Bill from Robert’s side, telling him only family was permitted to visit and partners did not qualify. Bill could not inform doctors that Daniel wanted to forego life-prolonging measures. By the time Bill was allowed to visit hours later, Daniel had lost consciousness and doctors had inserted a breathing tube. Daniel never regained consciousness and the couple never had a chance to say goodbye. Lambda Legal represented Bill in litigation against the hospital, which spurred policy reform.⁸³

⁸² Information about *Langbehn v. Jackson Memorial Hospital*, including the complaint, is at <http://www.lambdalegal.org/in-court/cases/langbehn-v-jackson-memorial>. The memorandum issued by President Obama requiring equal treatment of same-sex partners for visitation purposes in medical facilities receiving federal funds is here <http://www.lambdalegal.org/in-court/cases/langbehn-v-jackson-memorial>.

⁸³ Information about *Flanigan v. University of Maryland Hospital System*, including the complaint, is at <http://www.lambdalegal.org/in-court/cases/flanigan-v-university-of-maryland>.

2. Unequal access to family health insurance for same-sex couples and discriminatory insurance plan terms.

Over the years, a great many same-sex couples and their children have experienced discrimination when attempting to access insurance, such as when plans have refused to offer coverage for family members absent a valid marriage, or even with one if it is not recognized in-state. The ACA reduces these problems by making it easier for individuals to obtain insurance regardless of marriage. In addition, the Supreme Court's decisions in *United States v. Windsor*, 133 S. Ct. 2675 (2013), and *Obergefell v. Hodges*, 135 S. Ct. 2071 (2015), mean same-sex married couples are to be treated the same under both state and federal law as different-sex married couples with respect to access to health insurance and applicable rules. This is a great improvement, however, issues concerning policy terms often are separate from the ability to acquire insurance.

With respect to health coverage and provision of medical services concerning infertility and assisted reproduction, LGBT people frequently encounter discrimination. Here are two examples illustrating distinct concerns of women and men, respectively:

- In many health insurance policies that cover infertility treatment, infertility in a woman is defined as the inability to achieve pregnancy through unprotected sexual intercourse with a man for at least one year. This eligibility rule discriminates against lesbians who suffer from the same medical problem as heterosexual women but are not pursuing pregnancy through intercourse with a male partner.⁸⁴
- Dennis Barros and his partner planned to have a child with the assistance of a surrogate mother who would carry an egg fertilized by Barros's sperm. But the clinic they enlisted refused to provide services to Barros, citing an FDA guideline recommending against insemination using anonymous donations from men who have had sex with men in the past five years. Lambda Legal has been representing Barros, explaining that the FDA guideline does not apply to known donors such as Barros. The clinic still refuses to provide care to Barros. The Orlando, Florida Human Rights Board has ruled that discrimination occurred; the case is now pending before the Circuit Court.⁸⁵

3. Lack of “cultural competence” – or even basic understanding and respect – for the health needs of LGB people.

The following testimonies from Lambda Legal's WHEN HEALTH CARE ISN'T CARING report show that many providers lack even basic understanding of lesbian, gay and bisexual people and what

⁸⁴ Lambda Legal consulted with the Illinois Department of Insurance on a revision of the state administrative regulation that applies to this issue, obtaining a change that permits equal treatment not only of women with a same-sex partner but also those for whom this method of demonstrating infertility is neither feasible nor fair. Information is at http://www.lambdalegal.org/news/il_20100420_illinois-department-of.

⁸⁵ Information about *Barros v. Riggall* including the complaint is available at <http://www.lambdalegal.org/in-court/cases/barros-v-riggall>.

constitutes an appropriately respectful professional interaction, let alone the “cultural competence” that enables health providers to address their health needs effectively.

- Michelle of San Jose, California reported: “When I left the U.S. Army in 1993, I moved to Georgia to go to college. As I had a disability from my active duty service, I tried to sign up for the Vocational Rehabilitation and Employment program to pay for my college tuition. In order to qualify for the program, I had to attend an evaluation with the local VA clinic psychiatrist. ... [T]he psychiatrist asked me why I had left the Army. I explained that I had come to accept that I was gay ... The psychiatrist proceeded to spend the entire rest of our hour convincing me that I was not a lesbian, just ‘misguided by some other gals’ and that he could ‘cure me of my deviancy.’ By the end of the hour, I knew my chances of signing up for the program were gone. The psychiatrist even went so far as to offer me free counseling at his ‘camp for girls like you to get better.’”⁸⁶
- Gregory of Brooklyn, New York recalled: “I had prostate cancer six years ago. The urologist was fully aware of my sexual orientation. A few years ago I went to the urologist who took over his practice when he retired, for erectile dysfunction. He asked me how hard I’d get on a scale of one to ten, if I saw a beautiful woman. I told him ‘I’m gay.’ His reaction? ‘Very funny.’ I didn’t find this particularly funny.”⁸⁷
- Torrey of Portland, Oregon explained: “I went to visit my school’s health clinic for an annual checkup. While I was filling out my health history information sheet, I was pleasantly surprised to find that there was space to indicate whether I was sexually active with male or female partners, the number of partners I’d had, and the type of birth control I used. I thought that this was a great example for LGBT-friendly medical facilities. Unfortunately, when I was called into the exam room, the nurse didn’t read the form and proceeded to ask me if I was sexually active and used condoms. When I replied no, and told the nurse that I was a lesbian, she was shocked. After that, the appointment was awkward and I felt as though the nurse was not willing to touch me because of my sexual orientation. It just goes to show you that having a LGBT-friendly form does not make a clinic LGBT-friendly.”⁸⁸
- John, a doctor in East Stroudsburg, Pennsylvania, described his treatment of an 18-year-old high school student: “He [had] moved from the West Coast ... because of trouble in school. He was having attacks of sudden shaking and weakness. His mom took him to her primary care provider, who referred him to a neurologist, suspecting temporal lobe epilepsy (a very rare condition). He underwent thousands of dollars’ worth of tests—all of which turned out normal. I saw him professionally at the request of his boyfriend. Turns out he had been gay bashed in the bathroom at his old high school. He received death threats ... None of his new physicians had asked him about his sexual orientation. It

⁸⁶ Lambda Legal, Lesbian, Gay, Bisexual and Transgender (LGBT) People and People Living with HIV Speak Out (“People Speak Out”), http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-insert_lgbt-people-and-people-living-with-hiv-speak-out.pdf.

⁸⁷ *Id.*

⁸⁸ *Id.*

quickly became apparent to me that he was having anxiety or panic attacks I treated him with small doses of Lorazepam This completely eliminated the attacks. The presumption of heterosexuality and failure of his primary care provider and consulting neurologist led to many costly and unnecessary tests and failure to correctly diagnose and treat his problem.”⁸⁹

b. Intersectional Discrimination

(1) Discrimination against LGBT youth

Under the ACA, mental health care now is among the essential covered health benefits. What constitutes appropriate mental health care for LGBT people was a matter of dispute in past generations when homosexuality was considered a mental illness and transgender identity also was not well understood. The overwhelming consensus of contemporary mental health professions now is that there is no illness in homosexuality or bisexuality *per se*, and that efforts to change a same-sex orientation through aversion or “conversion” therapy are likely to be ineffective and damaging.⁹⁰ Similarly, while medical care may be indicated for those with gender dysphoria, the treatment is to align the body with the brain’s internal sense of gender rather than to attempt to change the brain’s awareness of its gender or to train the person to display the behavior society expects based on the person’s external appearance.

Due to continuing social stigma, however, LGBT people continue to seek or be subjected to mental health counseling represented as having the potential to cure same-sex attraction or gender-variant behavior, despite the evidence that such aversion counseling often is damaging. Consequently, two states have prohibited subjecting minors to these practices, deeming it “unprofessional conduct” warranting discipline from the state licensing board,⁹¹ and other states are considering similar legislation.

California’s law was challenged and recently upheld by the Ninth Circuit Court of Appeals.⁹² Lambda Legal submitted an amicus brief in the litigation on behalf of organizations that serve LGBT youth. The brief presents numerous examples of the harms to young people of being subjected to counseling based on the false and discriminatory premise that they should and can change these innate personal characteristics.⁹³ In its decision upholding the statute, the Ninth Circuit noted that the legislature had relied on the “well-documented, prevailing opinion” amongst the country’s major medical

⁸⁹ *Id.*

⁹⁰ See APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation*, at 121 (2009), available at www.apa.org/pi/lgbt/resources/therapeutic-response.pdf; Joy S. Whitman, *et al.* *Ethical Issues Related to Conversion or Reparative Therapy* (2006), available at <http://www.counseling.org/news/updates/2013/01/16/ethical-issues-related-to-conversion-or-reparative-therapy>.

⁹¹ California Senate Bill 1172, 2012 Cal. Stat. 835; New Jersey’s A3371, P.L.2013, c.150.

⁹² *Pickup v. Brown*, 2013 U.S. App. LEXIS 18068, 2013 WL 4564249 (9th Cir. Cal., Aug. 29, 2013).

⁹³ Brief of *Amicus Curiae* Children’s Law Center of California, *et al.*, available at <http://www.lambdalegal.org/in-court/cases/pickup-v-brown-and-welch-v-brown>.

and psychological authorities that these practices are ineffective and pose a risk of “serious harm to those who experience it.”⁹⁴

The harms of anti-LGBT aversion counseling are discussed here because, for purposes of Section 1557 implementation, *they should be recognized as a prohibited form of sex discrimination*. The only persons targeted for such aversion counseling are those who exhibit or claim a same-sex sexual orientation or other gender-nonconforming behavior. Persons who present with a different-sex sexual orientation and other gender-*conforming* behavior are not counseled that there is something wrong with them that they should attempt to change through an unpleasant, at best, course of medical intervention.

In addition to the personal accounts in Lambda Legal’s *amicus* brief of the adverse effects for many young people of aversion counseling, an established body of research shows a link between parental reactions to a child’s same-sex sexual orientation or gender non-conforming behavior and that child’s subsequent health outcomes. This research on family rejection or acceptance shows:

- There is a predictive link between specific, negative family reactions to a child’s minority sexual orientation and serious health problems for these adolescents in young adulthood – such as depression, illegal drug use, risk for HIV infection, and suicide attempts.⁹⁵
- LGB young adults who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse, compared with peers that reported no or low levels of rejection by their families.⁹⁶
- Accepting behaviors of parents and caregivers towards LGBT children are protective against mental health risks, including depression, substance abuse, and suicide.⁹⁷

According to this leading research in this field, Latino male youth report the highest number of negative family reactions to disclosure of a youth’s minority sexual orientation in adolescence.⁹⁸ A subsequent survey similarly found that Latino LGBT youth identified the need for family acceptance as

⁹⁴ *Id.* at *13-*14, citing the legislature’s reliance on position statements and reports by, among others, the American Psychological Association, the American Psychiatric Association, The American School Counselor Association, the American Academy of Pediatrics, the American Medical Association, the National Association of Social Workers, the American Counseling Association, the American Psychoanalytic Association, the American Academy of Child and Adolescent Psychiatry, and the Pan American Health Organization.

⁹⁵ Caitlin Ryan, PhD, ACSW, *et al.*, *Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay and Bisexual Young Adults*, PEDIATRICS, Vol. 123, No. 1, pages 346 -352 (Jan. 1, 2009) (doi: 10.1542/peds.2007-3524), available at <http://pediatrics.aappublications.org/content/123/1/346.full>.

⁹⁶ *Id.*

⁹⁷ Caitlin Ryan, PhD, ACSW, *et al.*, *Family Acceptance in Adolescence and the Health of LGBT Young Adults*, J. Child & Adolescent Psych. Nursing, Vol. 23, No. 4, pages 205–213 (Nov. 2010) (doi: 10.1111/j.1744-6171.2010.00246.x), available at http://familyproject.sfsu.edu/files/FAP_Family%20Acceptance_JCAPN.pdf.

⁹⁸ Ryan, *et al.*, *Family Rejection*, *supra* note 95.

their top problem and personal priority.⁹⁹ A separate study of transgender adults showed a similar correlation between family rejection and increased rates of suicidal attempt; 32 percent of transgender respondents who had experienced acceptance from their families reported that they had attempted suicide, compared with 51 percent of respondents who reported family rejection.¹⁰⁰

Enforcement of Section 1557 to decrease discriminatory counseling and other biased health services provided to LGBT youth and their families, and to increase medically sound services, is needed urgently because LGBT youth are over-represented in youth homeless populations¹⁰¹ and in foster care systems¹⁰² with all the adverse health consequences those living situations entail. Numerous studies have determined that family rejection due to a young person's minority sexual orientation and/or gender identity is a main cause of the disproportionate numbers of LGBT youth in these situations.¹⁰³ In fact, one study found that 42 percent of LGBT youth in out-of-home care were there due to family rejection or because they had been removed from their families because of conflict over their sexual orientation and/or gender identity.¹⁰⁴

One root of the problem is that, "Unlike children and adolescents, in general, who receive services and care in the context of their families, LGB adolescents are typically served as adults as if they have no families, across a wide range of settings."¹⁰⁵ This is particularly misguided – and causes missed opportunities to facilitate family coping and to reduce likelihood of destructive behaviors within the family – because many "parents consider pediatricians and other health providers to be important sources of guidance in childrearing."¹⁰⁶ Indeed, many parents of LGBT children turn to a range of health care providers for support when trying to come to terms with their child's minority sexual orientation and/or

⁹⁹ Human Rights Campaign Foundation & League of United Latin American Citizens, *Supporting and Caring for our Latino LGBT Youth* (2013), available at <http://www.hrc.org/files/assets/resources/LatinoYouthReport-FINAL.pdf>.

¹⁰⁰ JAIME M. GRANT, PH.D., ET. AL., INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY, 76 (2011), http://transequality.org/PDFs/NTDS_Report.pdf.

¹⁰¹ Andrew Cray, et al., *Seeking Shelter: The Experiences and Unmet Needs of LGBT Homeless Youth* (Sept. 2013) available at <http://www.americanprogress.org/wp-content/uploads/2013/09/LGBTHomelessYouth.pdf>.

¹⁰² Mark E. Courtney, et al., *Midwest evaluation of the adult functioning of former foster youth: Outcomes at Ages 23 and 24* (2009), available at http://www.chapinhall.org/sites/default/files/Midwest_Study_Age_23_24.pdf.

¹⁰³ Shahera Hyatt, *Struggling to Survive: Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning Homeless Youth on the Streets of California* (2011), available at <http://cahomelessyouth.library.ca.gov/docs/pdf/StrugglingToSurviveFinal.pdf>; Laura E. Durso & Gary J. Gates, *Serving Our Youth: Findings from a National Survey of Service Providers Working with Lesbian, Gay, Bisexual, and Transgender Youth who are Homeless or At Risk of Becoming Homeless* (2012), available at <http://fortyonone.org/wp-content/uploads/2012/06/LGBT-Homeless-Youth-Survey-Final-Report-7-11-12.pdf>.

¹⁰⁴ Nico Sifra Quintana, et al., *On the Streets: The Federal Response to Gay and Transgender Homeless Youth* (June 2010), <http://www.americanprogress.org/issues/2010/06/pdf/lgbtyouthhomelessness.pdf>. See also Shannan Wilber, et al., *Child Welfare League of America (CWLA) Best practice guidelines: Serving LGBT youth in out-of-home care* (2009).

¹⁰⁵ Ryan, et al., *Family Rejection*, supra note 95.

¹⁰⁶ *Id.*

non-conforming gender identity. The American Academy of Family Physicians instructs that, “Family physicians are in an ideal position to be aware that their adolescent patients may be dealing with issues of sexual identity or orientation that impact their psychosocial and physical health. Asking open questions about sexual identity and orientation can open a dialogue on family relationships, safe sexual practices, suicide risks and other issues confronting gay, lesbian, bisexual, transgendered and questioning adolescents in a sensitive and accepting atmosphere.”¹⁰⁷ This is especially true for LGBT youth, for whom it is essential that health care be supportive and free from sex discrimination. The services they receive should not only support their own wellness but also nurture the accepting family relationships that will influence their long-term health prospects.¹⁰⁸

(2) Discrimination against LGBT youth in foster care, juvenile justice and homeless systems

a. The landscape for LGBT youth in out-of-home care

As discussed above, LGBT youth are over-represented in foster care, juvenile justice, and homeless systems. Many enter out-of-home care due to rejection by parents or kinship caregivers and are, therefore, already statistically more likely to have poor health outcomes.¹⁰⁹ Due to the rejection and discrimination that led to placement in out-of-home care settings, LGBT youth are more likely to need behavioral health services in addition to basic medical care.¹¹⁰

Although some jurisdictions have nondiscrimination policies and regulations in place to protect LGBT youth in care, many still face harassment and discrimination by child welfare workers, congregate care staff, and others.¹¹¹ As a result, LGBT youth are forced out of homes and facilities or flee for their own safety and are less likely to have stable placements while in care. In child welfare cases, LGBT are less likely to return home or to be adopted and as result remain in impermanent situations. For youth

¹⁰⁷ Am. Acad. of Family Physicians, *AAFP Policy Statements: Adolescent Healthcare, Sexuality and Contraception* (1987, 2011 COD), available at <http://www.aafp.org/about/policies/all/adolescent-sexuality.html>.

¹⁰⁸ Indeed, the American Academy of Pediatrics’ Task Force on the Family highlights the importance of family support for adolescent development and recommends that pediatricians include assessment of family relationships and behaviors in their practice. Edward L. Schor, MD, *et al.*, *American Academy of Pediatrics, Report of the Task Force on the Family*, PEDIATRICS, Vol. 111, No. Suppl. 2, pages 1541– 1571 (June 1, 2003), available at http://pediatrics.aappublications.org/content/111/Supplement_2/1541.full.html. See also Caitlyn Ryan & Donna Futterman, *Lesbian and gay youth: Care and counseling*, J. ADOLESC. MED., Vol. 8, No. 2, pages 207– 374 (June 1997) (abstract available at <http://www.ncbi.nlm.nih.gov/pubmed/10360017>) (asking LGB adolescents about their family relationships and experiences with rejection can help providers assess the adolescent’s risk profile and how to guide their parents to support the child’s health and development).

¹⁰⁹ Ryan, *et al.*, *Family Rejection*, *supra* note 95; Heather M. Berberet, *Putting the Pieces Together for Queer Youth*, 85 Child Welfare 261 (2006).

¹¹⁰ National Alliance on Mental Illness, *Mental Health Risk Factors Among GLBT Youth* (2007), available at http://www.nami.org/texttemplate.cfm?section=fact_sheets1&template=/contentmanagement/contentdisplay.cfm&contentID=48112.

¹¹¹ <http://www.nrcyd.ou.edu/lgbtq-youth>.

involved with the juvenile justice system, moves from detention to home to congregate care can result in multiple medical and behavioral health care providers and inconsistent treatment. Each move to a new foster home, a different homeless shelter, or, in the worst cases, to living on the street, can mean a disruption in health care or a failure to establish a primary physician at all.

Youth of color are over-represented in child welfare, juvenile justice, and homeless systems and LGBT youth of color often experience multiple forms of discrimination while in care. In a Massachusetts study, LGBT youth of color stated they access health care from LGBT-focused facilities because they feel providers in these settings are more knowledgeable about their needs.¹¹² Youth in the study expressed reluctance to engage in behavioral health care services because of the lack of health care providers' personal knowledge of LGBT people of color.¹¹³

Transgender and gender non-conforming (TGNC) youth in out-of-home care systems face particular challenges. In group care facilities, transgender youth are often denied supportive counseling, appropriate evaluations, and other medically necessary transgender-related treatments.¹¹⁴ In some cases, facilities have refused to fill prescriptions from a transgender youth's treating physician. Transgender youth who are denied appropriate treatment are at risk for serious negative health and social consequences, including depression, suicide attempts, and self-treatment (using street hormones and engaging in other medically unsupervised activities for gender transition).¹¹⁵

Currently, health care for transgender youth in out-of-home care is a patchwork across the country because youth in care are eligible for Medicaid, but coverage varies widely from state to state. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.¹¹⁶ States are required to provide any additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered regardless of whether the service is covered in a state's Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis.¹¹⁷ This case-by-case basis approach to coverage is a breeding ground for discrimination against transgender youth where so much stigma and misunderstanding persists around their experiences and needs. When procedures that have been recommended by a physician as medically necessary are not

¹¹² <http://www.bostonalliance.org/wprs/wp-content/uploads/2012/02/GLBT-Youth-of-Color-Community-Health-Assessment.pdf>.

¹¹³ *Id.*

¹¹⁴ <http://www.bostonalliance.org/wprs/wp-content/uploads/2012/02/GLBT-Youth-of-Color-Community-Health-Assessment.pdf>www.villagecounselingcenter.net/A_GUIDE_FOR_GROUP_CARE_FACILITIES.pdf.

¹¹⁵ *Id.*

¹¹⁶ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html>.

¹¹⁷ *Id.*

covered by the child welfare agency, it puts transgender health care in a unique class as the only type of medically necessary treatment not covered for youth in care.

Because of broader societal changes more youth are now openly identifying as LGBT.¹¹⁸ Medical and behavioral health care providers and the out-of-home care systems serving youth across the country must improve their competency in working with these young people or they will continue to face discrimination and have significant unmet health needs.

b. Examples of discrimination in health services experienced by LGBT youth in out-of-home care

The following two stories, drawn from Lambda Legal's work with these youth, illustrate all-too-common forms of health care discrimination faced by transgender youth, particularly those being raised in foster care systems.

- S.T., a transgender youth of color in foster care, was diagnosed with gender identity disorder. Following WPATH standards, her doctor recommended breast augmentation in addition to a social transition. S.T.'s foster care agency supported her in her social transition and also paid for hormone treatment. However, breast augmentation was not covered by state Medicaid and, therefore, the procedure could only be paid out of discretionary agency funds. S.T. waited nine months for the agency to decide whether to pay for the procedure. Her request ultimately was denied. The agency cited S.T.'s instability and a concern that she might be ill-suited to make such an important decision. S.T.'s attorney asked the family court to require payment and the agency is fighting her request. The agency is now requiring a second opinion by a doctor of its choice and will not allow S.T. or her attorney to provide collateral information or even to speak with the doctor outside of S.T.'s consultation. The agency says S.T. must comply with the second doctor's recommendation even though it has not questioned the qualifications of S.T.'s primary doctor. The agency's decision makers have neither met S.T. nor spoken to her doctor. S.T. is now waiting for a second opinion and the outcome of the family court litigation. Meanwhile, her transition has stopped, exacerbating the symptoms which resulted in the original gender identity disorder diagnosis and contributing to the instability the agency now uses against her.
- P.F., a transgender girl living in the northeast, went into foster care and then later returned home to her mother where problems persisted. Months later, she entered the juvenile justice system and, ultimately, was placed in a group home. Individuals involved in her care from child welfare and juvenile justice systems were not aware of her transgender-related health needs. As a result, every time she was moved her treatment was disrupted and prior treatment recommendations were questioned. P.F. ultimately aged out the system, Medicaid coverage ended when she did, and no health coverage plan was put in place. Her treatment again was compromised.

¹¹⁸ <http://www.americanprogress.org/issues/lgbt/news/2013/05/02/62087/improving-the-lives-of-lgbt-americans-beginning-with-our-youth/>.

Accordingly, in addition to making explicit that Section 1557's sex discrimination ban covers discrimination based on sexual orientation as well as on gender identity and on sex stereotyping, the Department should make clear that this requires child welfare, juvenile justice, and homeless systems providers to be informed about the specific health care needs of LGBT youth of color and knowledgeable regarding LGBT-specific health care providers in their communities. The Department likewise should require provision of information and training on these topics. In addition, HHS should require that child welfare, juvenile justice, and homeless service providers be knowledgeable about LGBT-focused providers within communities of color and offer those services to youth. Further, the federal government should require that all providers, including behavioral health providers, have training regarding the specific experiences and needs of LGBTQ youth of color. Staff at all group homes, psychiatric hospitals, and juvenile detention facilities should be familiar with transgender medical care to ensure that a youth's treatment is not interrupted and should look to a youth treating clinician for treatment planning.¹¹⁹ Through the final rule or other guidance, HHS should require that child welfare, juvenile justice, and homeless systems providers utilize health care providers that are LGBT competent. Providers make referrals to health care providers in their community and, often, have specific contracts with local providers. HHS should require that all providers receiving federal funding are LGBT competent and affirming.

(3) Sex Discrimination against Children with Intersex Conditions/Disorders of Sexual Development

One in every 2000 children is born with some form of a disorder of sexual development (DSD), also known as intersex conditions.¹²⁰ Misinformation about treatment and inconsistency in treatment are prevalent.¹²¹ Parents are left with a confusing patchwork of policies and recommendations from medical professionals and often are ill-equipped to make fully-informed decisions regarding procedures. As a result, many children with DSD have medically unnecessary gender reassignment surgery performed at a very early age before gender identity develops. These unnecessary procedures may have life-long and profound negative health implications. Residual effects of surgery or resulting scar tissue from surgery can leave individuals incapable of reproducing or experiencing sexual pleasure.¹²² In addition, by unnecessarily deciding gender identity for a child at an age when a child cannot consent, uninformed parents and physicians are inadvertently creating the potential for gender dysphoria and other behavioral health conditions.¹²³

¹¹⁹ <http://whhttp://www.bostonalliance.org/wprs/wp-content/uploads/2012/02/GLBT-Youth-of-Color-Community-Health-Assessment.pdf>www.villagecounselingcenter.net/A_GUIDE_FOR_GROUP_CARE_FACILITIES.pdf

¹²⁰ See Advocates for Informed Choice, *What is intersex/DSD?*, <http://aiclegal.org/who-we-are/faqs/>. See also Intersex Society of North America, *How common is intersex?*, <http://www.isna.org/faq/frequency>.

¹²¹ Intersex Society of North America, *What do doctors do now when they encounter a patient with intersex?*, <http://www.isna.org/faq/concealment>.

¹²² Consortium on the Management of Disorders of Sex Development, *Clinical Guidelines for the Management of Disorders of Sex Development in Childhood* at 28, <http://www.accordalliance.org/dsdguidelines/clinical.pdf>.

¹²³ Intersex Society of North America, *What's wrong with the way intersex has traditionally been treated?*, <http://www.isna.org/faq/concealment>.

The following two examples illustrate the types of health care discrimination faced by children with DSDs, particularly those being raised in foster care systems, which should be recognized as sex-based discrimination:

- M.C. was born with an intersex condition – a reproductive or sexual anatomy that does not fit typical definitions of male or female. Children with M.C.’s condition have bodies that are not easily labeled as either male or female. Doctors referred to M.C. as a “true hermaphrodite.” M.C. was in the care of the South Carolina Department of Social Services (SCDSS) when doctors, in cooperation with social services employees, decided to perform gender reassignment surgery. Typically, children with these conditions develop as a boy or girl as they grow. Despite not knowing whether 16-month-old M.C. would develop into a man or woman, SCDSS consented to sex-assignment surgery and M.C.’s healthy phallus was removed in an attempt to make M.C. a girl. M.C., now 8, has shown signs of developing a male gender and now identifies as a boy. M.C.’s adoptive parents have filed a lawsuit on his behalf in an attempt to end this practice.¹²⁴
- R.T., a child diagnosed with a rare form of DSD, is in foster care in the northeast. His foster mother is accepting and supportive. R.T. needed extensive testing to determine the proper course of treatment, but child welfare caseworkers were uninformed about DSDs and have large caseloads. As a result of the caseworkers’ lack of knowledge and excessive workloads, R.T. and his foster mother waited months for treatment referrals, test results, and recommendations on R.T.’s needs. When the tests finally were ordered they were referred to out-of-state providers due to the limitations of state resources. Administrative hurdles regarding payment for the out-of-state testing caused further complications and delays. In the meantime, R.T.’s foster mother has been forced to assign a gender to R.T. without proper information and recommendations.

Accordingly, in addition to clarifying that individuals with intersex/DSD conditions are protected by the prohibition against sex discrimination, some form of HHS guidance should provide basic further recognition of the needs of this population. While it is not possible to recommend a uniform treatment for individuals with DSDs because every situation is unique, guidance from the federal government summarizing current recommended treatment standards, articulating uniform procedures to follow, and directing that accurate, comprehensive information be provide to parents would do a great deal to address a complicated area with profound health implications. In particular, HHS should provide guidance requiring education for staff in child welfare systems that are responsible for making health care decisions for children with DSD conditions and require legal oversight concerning non-voluntary gender reassignment surgeries.

(4) Discrimination against LGBT seniors.

For LGBT older adults, the experience of being denied the care they need is prevalent, with research showing that 13 percent of LGBT older adults report having been denied health care or provided

¹²⁴ <http://aiclegal.org/>

inferior care because they are LGBT.¹²⁵ Fear of discrimination in accessing care is widespread. For example, in a large-scale study from 2006, 19 percent of gay and lesbian baby boomers had little or no confidence that the health care system would treat them respectfully.¹²⁶ Another study showed that, because of concerns about how they will be treated, almost 25 percent of LGBT older adults have not revealed their LGBT status to their primary care physicians. This lack of disclosure often means that LGBT seniors do not sufficiently discuss their sexual health, risks of breast or prostate cancer, hepatitis, HIV risk, hormone therapy, or other risk factors with their doctors.¹²⁷ As noted by the American Medical Association, “Unrecognized homosexuality by the physician or the patient’s reluctance to report his or her sexual orientation can lead to failure to screen, diagnose or treat important medical problems.”¹²⁸ These barriers to accessing health care and the negative consequences from not being able to do so are even more pronounced for transgender seniors than for LGB seniors.¹²⁹

Specifically with regard to home-based health care, LGBT elders who fear harassment will often attempt to “de-gay” their home before a caregiver arrives, including hiding photographs or books, or asking a same-sex partner to leave temporarily. This process can have significant negative impacts on the emotional and physical health of a person who already has serious health care needs.¹³⁰

Finally, LGBT seniors experience a range of discrimination in long term care facilities, including verbal and physical harassment from both staff and other residents, refused admission or attempted discharge, refusal to accept medical powers of attorney from a patient’s same-sex spouse or partner, restrictions on visitors, refusals by staff to use the correct name or pronoun for transgender patients, and failure to provide appropriate medical care or treatment.¹³¹

A study conducted by the National Senior Citizens Law Center, Lambda Legal and others captured many stories of inadequate health care caused by anti-LGBT bias and lack of cultural competence concerning the needs of LGBT elders. Responding to the survey, Jean-Luc D. from Maybee, Michigan told the following story about his partner, Johnny Jones, who was in a skilled nursing facility for four days in 2007:

¹²⁵ K. Fredriksen-Goldsen, *et al.*, *The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults* (2011).

¹²⁶ MetLife Mature Market Institute, *Out and Aging: The MetLife Study of Lesbian and Gay Baby Boomers*, at 14 (2006).

¹²⁷ K. Fredriksen-Goldsen, *supra* note 125, *The Aging and Health Report*; R. Klitzman and J. Greenberg, *Patterns of Communication between Gay and Lesbian Patients and their Health Care Providers*, *J. of Homosexuality* 42(4) (2002).

¹²⁸ American Medical Association, Policy H-160.991, *Health care needs of the homosexual population*.

¹²⁹ K. Fredriksen-Goldsen, *supra* note 125, *The Aging and Health Report*.

¹³⁰ Services & Advocacy for GLBT Elders (SAGE) & Movement Advancement Project, *Improving the Lives of LGBT Older Adults*, at 34 (Mar. 2010).

¹³¹ Nat’l Senior Citizens Law Center, *et al.*, *LGBT Older Adults in Long Term Care Facilities: Stories from the Field*, at 9 (2011).

The first day the nursing staff “accidentally” pulled out his feeding tube. The second day they “accidentally” injured his urethra after pulling out the catheter or inserting it too forcefully. Johnny had to go to the ER twice in the four days: the first time to treat his damaged urethra and the second time after he was found unresponsive following the trip back from the ER. After that, Johnny’s family and I moved him to a bigger hospital in Ann Arbor. I don’t know whether the poor care Johnny received was because he is black, or because we are a gay couple. I was at his side all day every day, only leaving to sleep. The bad things happened at night, when I couldn’t see what was going on.¹³²

Another respondent, C. from Columbia, SC, reported:

I went for nine days without heart medication during a rehabilitation stay in a nursing home. For 17 days I received another, inappropriate, medication. Even though I had been out for many years, I was so dependent on the nurses that I became afraid. It took all the courage I could muster up to keep pushing the staff to solve the problem.¹³³

§ 92.101 Discrimination prohibited.

A uniform standard of causation. We appreciate that the Department is applying the same standard of causation across the various potential bases of discrimination identified within the statute (*see* 45 CFR § 92.101 (“[A]n individual shall not, *on the basis of* race, color, national origin, sex, age, or disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any health program or activity to which this part applies.”(emphasis added))), and we encourage the Department to make explicit its reasoning for applying this uniform standard. Such an explanation likely would be helpful to courts and others in the future given past federal court decisions that have applied a more demanding “sole basis” standard of causation for those seeking protection under Section 504 of the Rehabilitation Act because Section 504 states that: “No otherwise qualified individual with a disability . . . shall, *solely by reason of* her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance” 29 U.S.C. § 794 (emphasis added). This “solely by reason” standard is in contrast to the standard applied under the Americans with Disabilities Act, which requires merely that the discrimination be “on the basis of” disability. 42 U.S.C.S. § 12112. Though the difference may appear to be merely semantic, federal courts have applied the two standards differently, allowing “motivating factor” and “but-for” causation under the ADA, but only “sole basis” causation under the Rehabilitation Act. *See, e.g., Lewis v. Humboldt Acquisition Corp.*, 681 F.3d 312, 317 (6th Cir. 2012) (holding that sole causation “is a creature of the [RA] . . . [and] does not apply to claims under the ADA”); *Parker v. Columbia Pictures Indus.*, 204 F.3d 326, 337 (2d Cir. 2000) (finding that the ADA requires “motivating role” causation, in part, because “[t]he elimination of the word ‘solely’ . . . suggests forcefully that Congress intended the statute to reach beyond the [RA]”); *McNely v. Ocala Star-Banner Corp.*, 99 F.3d 1068, 1078 (11th Cir. 1996) (stating that the proper test for an ADA claim is “but for” causation). This

¹³² *Id.* at 15.

¹³³ *Id.*

can make it difficult for a plaintiff to succeed in court if the defendant can show that some other factor influenced its decision, regardless of how minor a role the other factor played.

The Department properly has recognized that discrimination is discrimination, and that the same standard of causation should apply regardless of whether the basis for the discrimination is the individual’s race, color, national origin, sex, age or disability (or some combination thereof). Congress’s adoption of the “on the basis of” standard of causation under the ADA, along with its use in Section 1557 of all of the other civil rights statutes using the “on the basis of” standard and juxtaposition of Section 504 with those other civil rights statutes, demonstrate that the “sole basis” standard of the Rehabilitation Act is anachronistic, based as it was on an outdated assumption that it would be more difficult to know when a claim of disability discrimination is legitimate.

RECOMMENDATION

We recommend providing explicitly the reasons why the consistent standard is proper and has been adopted, whether in an explanation accompanying publication of the final rule or in additional guidance published at a later date, in order to assist those working to further understanding of, compliance with, and enforcement of Section 1557.

§ 92.207 Nondiscrimination in health-related insurance and other health-related coverage.

A. Benefit design problems

1. Benefit design problems for people living with HIV.

We welcome the recognition that caution must be taken to ensure that health insurers cannot circumvent the nondiscrimination protections in the Affordable Care Act by employing discriminatory benefit designs or marketing practices when providing or administering health insurance or coverage. Several ways that health insurance issuers frequently discriminate against LGBT individuals and other vulnerable groups include:

- Placing entire classes of critical medications, such as those used to treat HIV, in high cost-sharing tiers in prescription drug formularies;
- Establishing narrow provider networks that exclude certain types of specialists; and
- Employing arbitrary, unreasonable, or otherwise discriminatory utilization management practices, such as transgender-specific exclusions or standards for determining medical necessity that are not based on the most up-to-date and medically sound consensus of experts in the relevant field.

We urge HHS to ensure that the final rule clearly prohibits such facially discriminatory practices, regardless of whether they are motivated by a discriminatory purpose.

Specificity is needed; HIV-related examples. We appreciate that the proposed regulations adopt as a “floor” the protections available under the civil rights statutes referenced in Section 1557 (*see* 45 CFR § 92.3 (“This part shall not be construed to apply a lesser standard for the protection of individuals from

discrimination than the standards applied under [Title VI, Title IX, Section 504, the Age Discrimination Act], or the regulations issued pursuant to those laws.”)), and also that the proposed regulations lay out categories of prohibited discriminatory conduct that arise in the context of health-related insurance and other health-related coverage (*see* 45 CFR § 92.207 “Nondiscrimination in health-related insurance and other health-related coverage.”). We are very concerned, however, that the Department has not provided enough specificity with respect to the types of discriminatory conduct that are likely to occur—and in many instances, already are occurring—in the context of health insurance and other health-related coverage for people with disabilities. We believe it would be beneficial if the Department were to provide specific examples of the types of benefit designs, marketing practices, coverage determinations, and other practices—related to disabilities in general or to HIV in particular—that the Department regards as discriminatory in this context.

The following are examples of discriminatory conduct that could be identified in the rules either with the HIV-specific illustrations outlined below or reframed to pertain generally to medical conditions falling within Section 1557’s definition of a disability:¹³⁴

- **Medical necessity definitions that are not based on physician recommendations and supported with medical justifications.** Medical necessity definitions sometimes are used by plans to limit access to essential treatment for people living with HIV and other chronic and complex conditions. For example, medical necessity definitions that deny access to otherwise covered treatment when a person’s health cannot be restored, but where the treatment will help maintain health or prevent deterioration, may serve to exclude people from necessary care. Any medical necessity definition must ensure that treatment decisions are made based on physician recommendations and medical justification. Because the definition and application of medical necessity to insurance coverage determinations is subject to immense variation within the private insurance coverage realm, we urge HHS to include analysis of medical necessity definitions along with examples of impermissible definitions in any non-discrimination compliance tools.
- **Monthly limits on prescription drugs or the exclusion of drugs recognized as the standard of care for HIV** (i.e., blanket exclusions of brand-name medications or limited drug formularies). Formularies should meet the federal HIV treatment guidelines, which are widely recognized as setting the standard of care for maintaining the health of people living with HIV.¹³⁵ Private insurers have utilized restrictive and limited drug formularies to foreclose access by people living with HIV. For chronic and complex conditions such as HIV, for which the standard of care is rapidly evolving, reference to clinical guidelines is essential to ensure that coverage decisions are based on established medically accepted guidelines.

¹³⁴ For instance, the first example could be reframed in this way: “Monthly limits on prescription drugs or the exclusion of drugs recognized as the standard of care for the disabling condition at issue. Formularies must meet treatment guidelines recognized as setting the standard of care for treating the disabling condition.”

¹³⁵ See federal guidelines, including for antiretroviral treatment and prevention and treatment of opportunistic infections at <http://aidsinfo.nih.gov/guidelines>.

- **High cost-sharing on the medications and services that are considered the standard of care for people with HIV.** Higher costs—particularly in the form of co-pays, deductibles, and coinsurance—also serve as discriminatory barriers to care for people living with HIV and other chronic conditions.¹³⁶ For instance, even with out-of-pocket caps, placing lifesaving HIV medications on specialty tiers that require 25 or 30 percent coinsurance (or more, in some instances) acts as an insurmountable barrier to that treatment by making it unaffordable. The use of cost sharing—in the form of co-payments, deductibles, and coinsurance—must be closely evaluated to ensure that cost sharing is not used to limit access to essential care and treatment for people living with HIV and other chronic conditions.
- **Utilization management techniques used primarily to deny or restrict access to care for people with chronic and complex health conditions.** For instance, requiring step therapy for HIV treatment without a medical override provision or imposing unnecessarily burdensome prior authorization requirements on HIV medications are discriminatory utilization management techniques. These plan practices—which impair a provider’s ability to prescribe appropriate medication in a timely fashion—are having and will continue to have serious negative effects on the ability of people living with HIV to access necessary care and for medical professionals to provide that care.
- **Requiring use of mail-order pharmacies.** Another growing concern in this area involves requiring people to access HIV and other “specialty” medications through mail-order pharmacies only and/or imposing significant costs for not doing so.¹³⁷ In addition to hindering timely access and adherence to medications, this utilization management technique eliminates the opportunity for consultation with one’s pharmacist; interferes with the management of drug interactions and side effects; and creates privacy and confidentiality concerns, particularly for those who must have medications delivered to a place of employment to ensure receipt.
- **Provider networks that exclude HIV-care providers or do not identify HIV-care providers in their provider directories in a way that is transparent to prospective enrollees.** Inadequate physician network size and composition also serve to exclude people living with HIV and other chronic conditions from access to insurance by excluding providers who are able to deliver quality care for people living with HIV and other chronic and complex conditions. A plan network that systematically excludes HIV-care providers both violates network adequacy standards outlined in Qualified Health Plan certification requirements and is a discriminatory plan design practice that forecloses meaningful access to care.

¹³⁶ See Douglas B. Jacobs & Benjamin D. Sommers, *Using Drugs to Discriminate—Adverse Selection in the Insurance Marketplace*, 372(5) N. Engl. J. of Med. 399 (Jan. 29, 2015).

¹³⁷ See, e.g., “Blue Cross to Allow HIV/AIDS Patients to ‘Opt-Out’ of Mandatory Mail-Order Rx Program—Blue Cross Settles Lawsuit Alleging Discrimination, Threats to Health & Privacy,” available at <http://www.consumerwatchdog.org/case/blue-cross-allow-hiv-aids-patients-%E2%80%99Copt-out%E2%80%99D-mandatory-mail-order-rx-drug-program-blue-cross-set>.

Furthermore, we urge HHS to develop and provide a list of chronic conditions that likely fall within the definition of “disability” set forth in the ADA Amendments Act and are incorporated into these regulations via Section 504 of the Rehabilitation Act (*see* 45 CFR § 92.4 (“Definitions”). While the law requires an individualized determination as to who is an “individual with a disability,” there are some conditions, such as HIV, that almost unquestionably will entitle an individual to the protections of Section 1557. A list identifying such conditions will be useful to plan participants and insurers alike, in that it will demarcate groups of individuals whose rights under the disability provisions cannot reasonably be questioned.

2. Benefit design problems for transgender people.

Specifically with regard to the issue of transgender-specific exclusions, we strongly support § 92.207(b) in enumerating and prohibiting a range of insurance carrier and coverage program practices that discriminate against transgender individuals by arbitrarily singling them out for categorical denials of coverage for procedures and services that are the same or substantially similar to those provided to non-transgender people. The multifaceted nature of insurance discrimination against transgender individuals means that the provisions at § 92.207(b)(3), (4), and (5) are *all* vital to ensuring that transgender people are able to access the health coverage and care they need. We very strongly urge HHS to preserve all three of these provisions in the final rule, with the modifications below. We also very strongly support amending § 92.207(d) to ensure that carriers cannot use standards for determining medical necessity that are themselves inherently discriminatory.

3. Benefit design problems for lesbian, gay and bisexual people.

As indicated above, numerous benefit design problems affect LGBT people. These include requirements that all women, including lesbians, prove infertility by engaging in vaginal intercourse with a man for at least a year without use of contraception. This is especially absurd and discriminatory when the physical cause of a woman’s infertility has been diagnosed and is unrelated to whether her spouse or partner is male and able to cause pregnancy through vaginal intercourse with her. Similarly, limiting plan benefits for infertility care to insemination of a woman using the semen of her husband, even if she is in a committed relationship with a woman, is discriminatory and improper.

RECOMMENDATIONS

- Maintain § 92.207(b)(3) without any changes and amend the proposed provisions at §§ 92.207(b)(4)-(5) as follows:
 - (4) Categorically or automatically exclude from coverage, or limit coverage for, ~~all~~ health services related to gender transition, *including gender reassignment surgeries and other services or procedures described in the most current version of the recognized professional standard of medical care for transgender individuals*; or
 - (5) Otherwise deny or limit coverage, or deny a claim, for specific health services related to gender transition if such denial or limitation results in discrimination against a transgender

individual. A denial or limitation results in discrimination if, inter alia, (a) a transgender individual is denied coverage for services to treat gender dysphoria even though substantially similar services are covered for treatment of other conditions, (b) a medically necessary service for treating gender dysphoria is denied solely because that service is designated as cosmetic when used to treat other conditions, (c) a transgender individual is denied access to medically necessary health services in accordance with the most current version of the recognized professional standard of medical care for transgender individuals.

- Amend § 92.207(d) as follows:

Nothing in this section is intended to determine, or restrict a covered entity from determining, whether a particular service is medically necessary or otherwise meets applicable coverage requirements in any individual case, *provided that the determination of medical necessity or meeting applicable coverage requirements is not itself discriminatory and does not result in discrimination.*

B. Benefit design monitoring and enforcement.

We appreciate and strongly support the work of HHS OCR in accepting, investigating, and addressing complaints of discrimination under Section 1557. We also recognize that there are multiple entities with overlapping responsibilities to investigate consumer complaints and initiate enforcement actions aside from OCR, including the Office of Consumer Information and Insurance Oversight, the HHS Office of the Inspector General, the Centers for Medicare and Medicaid Services, the Department of Justice, and state insurance regulators and consumer assistance programs. We welcome and applaud the work of all of these agencies and urge HHS to develop a broad, multi-pronged approach to nondiscrimination compliance monitoring and enforcement that centers around HHS OCR and involves robust coordination with other federal and state monitoring and enforcement agencies to ensure that the strongest standard of federal plus state protections applies in any instance of discrimination.

RECOMMENDATION

To ensure that coverage exclusions targeting transgender individuals do not persist in plans offered or administered by entities covered under Section 1557, we join other commenters in urging HHS to include the following language in the preamble discussing § 92.207:

To be considered in compliance with this section, all health coverage programs and plans issued or administered by a covered entity will be required to:

- Revise current health plan documents to remove benefit and coverage exclusions or limitations based on an individual's sex, gender identity, or diagnosis of Gender Identity Disorder, gender dysphoria, or related health condition (e.g., "transsexualism");
- Revise current health plan documents to omit lists of surgeries or other procedures related to gender transition that are universally excluded from coverage, that impose other

coverage limitations that are not supported by sound clinical principles, or that create clinically unsupported barriers to receiving medically necessary services related to gender transition;

- Implement protocols for determining medical necessity that are nondiscriminatory and based on the most current version of the recognized professional standard of medical care for transgender individuals; and
- Revise current health plan documents to clarify that transgender individuals seeking coverage for services will be treated in the same manner as other enrollees, including with regard to access to internal and external appeals processes.

§ 92.209 Nondiscrimination on the basis of association.

We appreciate that the Department has made clear the applicability of Section 1557 to discrimination based the protected characteristics of an individual with whom an individual is known or believed to associate. *See* 45 CFR § 92.209 (“Nondiscrimination on the basis of association.”) As noted above, this legally sound rule is one of multiple reasons that it would be anomalous were sexual orientation not included explicitly within the definition of “on the basis of sex.” In addition, we strongly support this rule because we envision its beneficial application to coverage determinations for pre-exposure prophylaxis (PrEP) (preventive HIV medications for those at higher risk), particularly for the HIV-negative partner in a serodiscordant couple. Given its direct applicability to such situations, we recommend that the Department include this example among those provided to illustrate types of coverage determinations that the Department will deem discriminatory under Section 1557.

CONCLUSION

We greatly appreciate the research and care HHS has taken in preparing this proposed rule. For the reasons set out above, we again respectfully and vigorously urge that the final rule addresses at least the following three points of critical importance to LGBT people and people living with HIV:

1. Do not undermine the purpose and effectiveness of this rule by adding a religious exemption.
2. Clarify that the scope of protections under Section 1557’s sex nondiscrimination provision includes protections on the basis of sexual orientation, as well as clarifying protections for individuals with non-binary gender identities.
3. Establish a robust enforcement scheme to ensure nondiscrimination in benefit design, including codifying the transgender-inclusive protections in the proposed rule and clarifying that Section 1557 prohibits other forms of discrimination in benefit design, such as restricting access to medications used to treat specific conditions by placing them in high cost-sharing tiers, or by using discriminatory standards to determine medical necessity for specific populations or conditions.



Thank you for considering these comments and for your work to implement the crucial civil rights protections in Section 1557 so that the benefits and protections of the Affordable Care Act can reach everyone who needs them.

Most respectfully,

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