



March 27, 2018

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: RIN 945-ZA03
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

By electronic submission

**RE: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority,
Proposed Rule (RIN 0945-ZA03 and Docket No. HHS-OCR-2018-0002)**

Dear Director Severino:

The Leadership Conference on Civil and Human Rights and its Health Care Task Force appreciate this opportunity to provide comments in response to the Department of Health and Human Services' (HHS) Notice of Proposed Rulemaking (NPRM), which would create protections for health care workers who refuse to administer services that violate their religious or moral beliefs. The Leadership Conference on Civil and Human Rights is a coalition charged by its diverse membership of more than 200 national organizations to promote and protect the civil and human rights of all persons in the United States. The Leadership Conference's Health Care Task Force is committed to eliminating health disparities and ensuring that all people in the United States can access quality, affordable health care, without discrimination. The Department's proposed rule would greatly expand current "conscience" protections and religious refusals, allowing employees in health care settings to discriminate against patients and deny care.

As discussed in more detail below:

- The proposed rule is contrary not only to HHS' mandate, but also to the Office for Civil Rights (OCR) mandate to protect against discrimination.
- The proposed rule is arbitrary and capricious, not otherwise in accordance with law, and in excess of the statutory authority of the laws that it seeks to enforce.
- HHS and OCR should be putting their resources to protecting patients from discrimination, not attempting to make it easier for providers to discriminate.

I. The proposed rule is contrary not only to HHS' mandate, but also to the Office for Civil Rights (OCR) mandate to protect against discrimination.

OCR has a long and storied record of combating discrimination, protecting patient access to care, and eliminating health disparities. As one of its first official acts in 1967, the Office of

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Equal Health Opportunity undertook the massive effort of inspecting 3,000 hospitals to ensure they were complying with Title VI'sⁱ prohibition against discrimination on the basis of race, color, or national origin. The change not only in hospital policies but in actual practice, as verified by an army of volunteer inspectors, was dramatic. In less than four months, private hospitals went from being among the most segregated institutions in the United States to being among the most integrated.

Integration had a profound effect on patient care. Black patients were no longer relegated to basement wards or separate "charity" hospitals. And for the first time, those who needed the most medical care received the most medical care.ⁱⁱ One study estimated that between 1965 and 1975, integration of hospitals saved the lives of over 5,000 Black infants in the rural South and 25,000 through 2002.ⁱⁱⁱ

After this auspicious start, the Office of Equal Health Opportunity, which would eventually become OCR, would go on to ensure that the health programs and activities it regulated complied with key anti-discrimination laws including:

- Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, and national origin by recipients of federal funds;^{iv}
- Title IX of the Education Amendments of 1972, which prohibits discrimination on the basis of sex in education programs;^v
- Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of disability by recipients of federal funds;^{vi}
- The Age Discrimination Act of 1976, which prohibits discrimination on the basis of age;^{vii}
- Title VI and XVI of the Public Health Service Act, which requires health facilities that receive certain federal funds to provide certain services to members of its designated community;^{viii} and
- Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, age, and disability and marks the first time sex discrimination was broadly prohibited in health care.^{ix}

Through robust enforcement of these laws, OCR has worked to reduce discrimination in health care by ending overtly discriminatory practices such as race segregation in health care facilities, segregation of people with disabilities in health care facilities, categorical insurance coverage denials of care for transition related services, and insurance benefit designs that discriminate against people who are HIV positive, among other things.^x OCR has also sought to ensure compliance with civil rights statutes by requiring hospitals and covered entities to provide auxiliary aids and services to ensure effective communication for individuals with disabilities and taking steps to ensure that individuals with limited English proficiency have meaningful access to health facilities, such as providing interpreters free of charge.^{xi} These actions have gone a long way towards combating discrimination and disparities in health care.

Nevertheless, further work needs to address discrimination and disparities in health care. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. For example, according to one study, over half of the racial disparity in survival for heart attack patients can

be attributed to the lower performance of hospitals that serve predominantly people of color.^{xii} Bias also contributes to providers treating patients differently because of their race or gender.^{xiii}

In addition to racial disparities, women have long been the subject of discrimination in health care and the resulting health disparities.^{xiv} Black women, for example, are three to four times more likely than White women to die during or after childbirth.^{xv} Further, the disparity in maternal mortality is growing rather than decreasing.^{xvi} Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.^{xvii} Eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a doctor or other health care provider had refused to see them because of their actual or perceived sexual orientation in the year before the survey.^{xviii}

The Department and OCR have an important role to play in ensuring equal health opportunity and ending discriminatory practices that contribute to health disparities. Yet this proposed rule represents a dramatic, harmful, and unwarranted departure from OCR's historic and key mission of ending discrimination that harms patients and contributes to health inequality. The proposed rule appropriates language from civil rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended. By taking the language of civil rights laws and regulations out of context, the proposed rule creates a regulatory scheme that not only does not make sense but is affirmatively harmful.

The regulations for the civil rights statutes such as Title VI and Section 1557, for example, were written to improve access to health care, consistent with the purpose of both the statutes. By issuing the proposed rule along with the newly created "Conscience and Religious Freedom Division," the Department seeks to use OCR's limited resources to prioritize allowing institutions, insurance companies, and almost anyone involved in patient care to use their personal beliefs to deny people needed health care.

Rather than protecting access to health care, however, the proposed rule will limit access not only to health care but even to information about basic health care services. That OCR is prioritizing allowing health care providers and institutions to deny health care services to patients is particularly problematic, given that informed consent law protections were put in place to address the longstanding practices in which researchers experimented on people of color without their consent. In the "US Public Health Study of Syphilis at Tuskegee," 399 men who tested positive for syphilis were not told of their diagnosis nor were they provided treatment so that researchers could study the effects of syphilis.^{xix} OCR has a responsibility to ensure that such denials never happen again. Yet, the proposed rule has the potential to expand upon not just denials of care but also information about that care, including a patient's diagnosis.

Discrimination in health care against women, transgender persons, and people of color has been exacerbated by providers invoking religious beliefs to deny access to health insurance and an increasingly broad range of health care services, including birth control, sterilization, certain infertility treatments, abortion, transition-related medical care for transgender patients, and end of life care.^{xx} The reach of religious refusals to provide care was growing with the proliferation of both the types of entities using religious beliefs to discriminate^{xxi} and the number of religiously affiliated entities that provide health care and related services.^{xxii} The harms of these refusals do not fall equally on all. One recent study, for

example, found that women of color are more likely than White women to give birth at Catholic or Catholic-affiliated hospitals that impose religious restrictions on the health care that can be provided.^{xxiii}

OCR's work should address these disparities, yet the Proposed Rule seeks to prioritize the expansion of existing religious refusal laws beyond their statutory requirements and create new religious exemptions where none had previously existed rather than using already limited resources to protect patient access to health care. The Proposed Rule will harm patient care and is antithetical to what should be OCR's mission – eliminating discriminatory practices that contribute to persistent health inequality.

II. The proposed rule is arbitrary and capricious, not otherwise in accordance with law, and in excess of the statutory authority of the laws that it seeks to enforce.

Although agencies have broad authority to engage in rulemaking, that authority is not without limits. Under the Administrative Procedure Act, “agency action, findings, and conclusions found to be... arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,” “contrary to a constitutional right,” or “in excess of statutory jurisdiction, authority, or limitations” shall be held unlawful and set aside.^{xxiv} An agency must provide “adequate reasons” for its rulemaking, in part by “examin[ing] the relevant data and articulat[ing] a satisfactory explanation for its action including a rational connection between the fact found and the choice made.”^{xxv} Further, an agency can only change an existing policy if it provides a “reasoned explanation” for disregarding or overriding the basis for the prior policy.^{xxvi}

In promulgating this NPRM, HHS has plainly failed to meet the basic requirement of providing a satisfactory explanation for its action. As stated in the NPRM itself, between 2008 and November 2016, the Office for Civil Rights received 10 complaints alleging violations of federal religious refusal laws; OCR received an additional 34 similar complaints between November 2016 and January 2018. By comparison, during a similar time period from fall 2016 to fall 2017, OCR received *more than 30,000 complaints* alleging either civil rights or HIPAA violations. These numbers demonstrate that rulemaking to enhance enforcement authority over religious refusal laws is not warranted. HHS also relies in part on comments submitted during the 2011 rulemaking process objecting to full rescission of the prior 2008 rule as grounds for the NPRM. However, those comments are inapposite and reliance on them misplaced, given that the 2011 Rule ultimately only partially rescinded the 2008 Rule and retained enforcement authority for Coats-Snowe, Weldon and Church Amendments with OCR (which it still has to date). Further, the NPRM far exceeds the parameters of the 2008 Rule and no rationale has been given for this new or enhanced regulatory language.

Finally, HHS asserts that because some courts have held, in the context of the Church Amendments and the Coats-Snowe Amendment, that there is no private right of action, the role of the agency in providing “adequate governmental enforcement mechanisms” is somehow more critical with regards to all of the statutes over which it now claims enforcement authority. Not only is this assertion baseless, but HHS uses these justifications to expand enforcement authority far beyond what would be “adequate,” removing basic – and constitutionally-mandated – due process requirements for those against whom a complaint has been filed. No rational connection exists between these facts and ad hoc justifications and HHS’ decision

to regulate to expand the scope of its enforcement of religious refusal laws. Therefore, HHS is acting in an arbitrary and capricious manner, and this NPRM should be rescinded.

Further, the proposed rule is not in accordance with law, in that much of its language exceeds the plain parameters and intent of the underlying statutes it purports to enforce. For example, the Church Amendments prohibit federal funding recipients from discriminating against those who refuse to perform, or “assist in the performance” of, sterilizations or abortions on the basis of religious or moral objections, as well as those who choose to provide abortion or sterilization.^{xxvii} The statute does not contain a definition for the phrase “assist in the performance.” Instead the NPRM creates a definition, but one that is not in accordance with the Church Amendments themselves. As Senator Church stated from the floor of the Senate during debate on the Church Amendments:

“The amendment is meant to give protection **to the physicians, to the nurses, to the hospitals themselves**, if they are religious affiliated institutions. There is no intention here to permit a frivolous objection from someone unconnected with the procedure to be the basis for a refusal to perform what would otherwise be a legal operation.”^{xxviii}

Instead, the NPRM proposes to define “assist in the performance” as meaning “to participate in any activity with an articulable connection to a procedure, health service or health service program, or research activity.” This overly broad definition opens the door for religious and moral refusals from precisely the type of individuals that the amendment’s sponsor himself sought to exclude. This arbitrary and capricious broadening of the amendment’s scope goes far beyond what was envisioned when the Church Amendment was enacted.

This is just one example of a trend throughout the NPRM, where HHS repeatedly includes text that is not in accordance with, and exceeds the statutory authority of, the underlying statutes. On these grounds, the NPRM constitutes arbitrary and capricious agency action and should be rescinded.

III. HHS and OCR should be putting their resources to protecting patients from discrimination, not attempting to make it easier for providers to discriminate.

OCR should devote its resources to protecting patients’ ability to access health care and providers’ ability to provide that health care. This includes full and robust enforcement of Section 1557, the anti-discrimination provision of the Affordable Care Act (ACA). Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in health programs or activities that receive federal financial assistance or are administered by an executive agency or any entity established under Title I of the ACA. Section 1557 protects individuals from discrimination “on the ground[s] prohibited under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973.”^{xxix}

The work of OCR is essential to ensuring that all people can lead healthy lives free of discriminatory barriers. OCR’s efforts are important because discrimination in health care prevents many individuals

from getting the care they need to stay healthy and directly contributes to health care disparities in the communities we represent.

Sex discrimination takes many forms and occurs at every step in the health care system—from obtaining insurance coverage to receiving proper diagnosis and treatment. This discrimination seriously harms women, transgender patients, and other patients who face sex-based discrimination and threatens their health, causing them to pay more for health care and to risk receiving improper diagnoses and less effective treatments.

Some examples of discrimination against women in health programs and activities and their impacts include:

- Studies have found that women receive inadequate care when gender bias inappropriately influences medical decision-making. Although physical differences may account for some differences in treatment received by men and women, non-biological or non-clinical factors—including overt or unconscious gender bias—also affect clinical decision-making.^{xxx} For example, although women disproportionately experience chronic pain^{xxxii} and certain chronic pain conditions occur primarily in women,^{xxxii} women experience disparities in pain care that result from gender bias, “neglect, dismissal and discrimination from the health care system.”^{xxxiii}
- Some health plans continue to exclude maternity coverage from the benefits provided to certain female plan participants. Treating pregnancy differently, such as by excluding pregnancy care from an otherwise comprehensive insurance plan, is sex discrimination under civil rights laws such as Title IX and Title VII, and also sex discrimination under Section 1557.^{xxxiv}
- Providers, hospitals, or clinics that refuse to provide reproductive health services to a woman who is not married or because she does not conform to sex stereotypes force women to seek care elsewhere or forgo it completely.^{xxxv}
- Female health care providers experience discrimination in employment. New research shows a gap in earnings between male and female physicians has persisted over the last 20 years.^{xxxvi} In 1987-1990, male physicians earned \$33,840 (20 percent) more in annual salary than their female counterparts. By 2006-2010, the gender gap was \$56,019 (25.3 percent).
- While progress has been made, past and current exclusion of women in medical research continues to negatively affect advances in women’s health.^{xxxvii}

Some examples of discrimination against LGBT individuals in health programs and activities and their impacts include:

- Studies have found that transgender people are frequently turned away by providers who refuse to treat them because of personal disapproval of who they are and deny them medical care—both

care related and unrelated to gender dysphoria — or who subject them to abusive or degrading treatment.^{xxxviii}

- Despite the medical consensus that treatment for gender dysphoria is medically necessary, many religiously affiliated hospitals have not only refused to provide treatment related to gender dysphoria, but have also prevented physicians who otherwise have admitting privileges to treat transgender people in the hospital.
- Many health plans refuse to cover treatments related to gender dysphoria, and many have even refused to cover treatments unrelated to gender dysphoria simply because a beneficiary is transgender.
- The regulation could also lead a physician to refuse to provide fertility treatments to same-sex couples, single women, or interfaith couples.

The burdens of costly health care fall disproportionately on communities of color. These communities are more likely to experience higher rates of unemployment, to have jobs that do not have health insurance, and have lower incomes that put higher insurance premiums out of their financial reach. Additionally, these communities are less likely to receive preventative care. Some examples of discrimination against people of color include:

- Racial and ethnic minorities are much more likely to be uninsured than Whites. Even after enactment of the ACA, they constitute about one-third of the U.S. population, but make up more than half of the over 27 million people who are uninsured. Twelve percent of African Americans and 17 percent of Hispanics were uninsured in 2016, compared to 8 percent of non-Hispanic Whites.^{xxxix}
- The uninsured have higher rates of illness and suffer the effects of lost educational, employment, and other social and civic opportunities. Better health status in childhood is associated with higher incomes, higher wealth, more weeks worked, and a higher growth rate in income.^{xl} Conversely, being uninsured correlates with poor education outcomes, such as failing to graduate from high school or to enroll in college. The uninsured often amass significant debt as a result of unforeseen medical expenses, leading to a downward, destabilizing financial spiral, including poor credit, bankruptcy, lost wages, lower annual earnings, and unemployment. These associated effects of being uninsured are more likely to affect racial minorities.
- African Americans have poorer quality of care than Whites for about 50 percent of quality measures.^{xli} A significant proportion of Hispanics (24 percent) and African Americans (21 percent) often did not see a doctor or delayed routine and preventive care for reasons other than cost (28 percent and 27 percent respectively).^{xlii} In addition, Hispanics, Blacks, and American Indians and Alaska Natives are more likely than Whites to rely on a clinic or other provider rather than a doctor's office as their source of care.^{xliii}

- Even after enactment of the ACA, Hispanics and Blacks are less likely to have utilized health or dental care in the past year compared to Whites. In addition, the percent of Asians reporting a health care visit and the percent of American Indians and Alaska Natives reporting a dental visit are lower than Whites. And Black children are less likely than White children to be immunized.^{xliv}

Discrimination on the basis of national origin, which encompasses discrimination on the basis of limited English proficiency (LEP),^{xlv} creates unequal access to health. LEP is often compounded with the “cumulative effects of race and ethnicity, citizenship status, low education, and poverty,” resulting in more barriers to access.^{xlvi} In the United States today, there are about 25 million individuals with LEP.^{xlvii} About 9 million LEP adults are uninsured.^{xlviii} The affirmative obligation to provide language assistance services under Section 1557 is as important now as it was decades ago when Title VI was passed, as increased complexity in medical information and program bureaucracy have made navigating systems for limited English proficient individuals more difficult.^{xlix}

- Language assistance services are especially critical for individuals with LEP who are unfamiliar with our complex healthcare system. Visiting health care facilities and agencies that administer health programs and activities are often uncomfortable for individuals with LEP who are “unfamiliar with [the system’s] cultural norms, vocabulary, and procedures.”¹ Unfamiliarity with the health care system often results in inaction that could compromise a basic standard of living for individuals and families. Furthermore, the lack of language assistance services negatively impacts communities at large, not just LEP individuals. When interpreter services are inadequate, children often serve as language brokers for their parents.ⁱⁱ
- Older adults who did not grow up in the United States are particularly susceptible to discrimination based on national origin because they may be more likely than younger individuals to have limited English proficiency, different mannerisms, or dress. Furthermore, older adults may be less likely or able to advocate for themselves because of language barriers and the complexity of the health care system. If an individual cannot communicate with a provider who is unwilling to get an interpreter or is refused care because of her perceived national origin, the consequences could be harmful, even deadly. About 5 million of America’s older adults are limited English proficient,ⁱⁱⁱ including over 4 million Medicare beneficiaries.^{liii}
- Older adults who are LEP already face difficulties finding providers, especially for in-home supports and services, who speak their preferred language and often are forced to rely on family members to interpret for them.^{liv} These issues can result in delayed care in any context, but can be especially problematic in long-term care where older adults and persons with disabilities make important decisions about their own care are therefore more reliant on the relationship and effective communication with their providers.

People with disabilities experience significant health disparities and barriers to health care, as compared with people who do not have disabilities.^{lv} In fact, people with disabilities are 2.5 times more likely to have unmet health care needs than non-disabled peers. Individuals with all types of disabilities report

discriminatory physical, programmatic, and attitudinal barriers to accessing health care in hospitals, clinics, diagnostic facilities, and practitioners' offices of all sizes throughout the country.^{lvi}

- Some of the barriers to comprehensive, quality health care present in the physical environment include cramped waiting and exam rooms, inaccessible bathrooms, and inaccessible equipment (such as exam tables, weight scales, and imaging and other diagnostic equipment).^{lvii} A California study reported, for example, that among more than 2,300 primary care practices, only 3.6 percent had accessible weight scales.^{lviii} Related research reveals that wheelchair users report almost never being weighed even though weight measurement is a crucial metric for many types of health care including determining anesthesia and prescription dosages, and ongoing health and fitness monitoring. The Americans with Disabilities Act requires full and equal access to healthcare services and facilities for people with disabilities, yet patients with mobility impairments are frequently denied services, receive less preventive care and fewer examinations, and report longer waits to see subspecialists despite this mandate.^{lix}
- People with disabilities often rely on Medicaid-funded Home and Community-Based Services (HCBS) for supports with daily living, including assistance with dressing, grooming, bathing, transportation to social and health-related appointments, and participating in recreational activities. These services are intensely intimate and implicate a person's right to pursue and maintain romantic relationships, build a family, and make basic decisions about one's life. Moreover, in many areas people with disabilities may have access to only one provider who is capable of meeting their needs. Allowing such providers to discriminate, or to refuse to provide certain services, would result in dramatic limitations in people's ability to exercise their right to basic self-determination.
- Failure to provide needed policy modifications and reasonable accommodations as required by current disability rights laws affects healthcare treatment decisions and outcomes. For example, lack of effective communication when Sign Language interpreters are not provided for Deaf patients or print materials are not available in alternative, accessible formats for people with visual impairments, can lead to ineffective communication about medical problems and treatment. Accommodations such as alternative formats are not offered or available even when their necessity is clinically obvious and predictable. For example, there is a high correlation between diabetes and vision loss, but printed self-care and treatment instructions in alternative formats such as Braille, large font type, CD, or audio recording, and accessible glucometers, are rarely available although the Americans with Disabilities Act of 1990 and Section 504 of the 1973 Rehabilitation Act requires the provision of auxiliary aids and services when required for effective medication.

Finally, we want to emphasize the importance of intersectionality to implementation and enforcement of civil rights laws. When The Leadership Conference worked with members of Congress to craft Section 1557, for example, we sought to create uniformity in the enforcement of antidiscrimination protections. By bringing all forms of discrimination under one civil rights provision, we sought to ensure that individuals would not face different legal results merely because of differences in the relevant underlying

civil rights law. This also recognizes that many individuals may face discrimination due to multiple factors.

For example, discrimination against an African-American woman could be discrimination on the basis of both race and sex.^{ix} Similarly, individuals with disabilities may face discrimination based on their disability as well as concurrent or additional discrimination based on other factors such as race/ethnicity or sexual orientation/gender identity. Therefore, in your implementation and enforcement activities, OCR must examine all aspects of a complainant to understand the full scope of discrimination; that discrimination may not be one-dimensional but could be cumulative based on a number of interrelated factors.

For all the reasons stated above, as well as the additional issues intersectionality raise, we urge you not to finalize the proposed rule and instead to focus OCR's attention on enforcing Section 1557 and the other civil rights statutes within its purview.

IV. Conclusion

Thank you for your attention to our comments. If you have any questions or need any further information, please contact Corrine Yu, Managing Policy Director, The Leadership Conference on Civil and Human Rights, at yu@civilrights.org.

Sincerely,

The Leadership Conference on Civil and Human Rights
American Civil Liberties Union
American Federation of State, County and Municipal Employees (AFSCME)
Asian & Pacific Islander American Health Forum
Autistic Self Advocacy Network
Center for Reproductive Rights
Families USA
Human Rights Campaign
Justice in Aging
NAACP
National Center for Lesbian Rights
National Center for Transgender Equality
National Health Law Program
National Latina Institute for Reproductive Health
National Partnership for Women & Families
National Women's Law Center

ⁱ [42 USC § 2000d](#)

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- ii David Barton Smith, The “Golden Rules” for Eliminating Disparities: Title VI, Medicare, and the Implementation of the Affordable Care Act (2015)
- iii Almond, Chay, & Greenston (2006) at 2
- iv 42 U.S.C. § 2000d et. seq.
- v 20 U.S.C. § 1681 et. seq.
- vi 29 U.S.C. § 794.
- vii 42 U.S.C. § 6101 et. seq.
- viii 42 U.S.C. § 291-300.
- ix 42 U.S.C. § 18116.
- x <https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html>.
- xi <https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/agreements/compliance-review-initiative-report-bulletin/index.html>.
- xii Skinner et al, After Acute Myocardial Infarction in Hospitals that Disproportionately Treat Black Patients (2005).
- xiii https://papers.ssrn.com/sol3/papers.cfm?abstract_id=383803.
- xiv Women have been charged more for health care on the basis of sex and have continually been denied health insurance coverage for services that only women need. *See Turning to Fairness*, NAT’L WOMEN’S L. CTR. 1, 3-4 (2012), https://nwlc.org/wp-content/uploads/2015/08/nwlc_2012_turningtofairness_report.pdf. Women’s pain is routinely undertreated and often dismissed. *See, e.g.*, Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29:1 J. OF L., MED., & ETHICS 13, 13-27 (2001). Due to gender biases and disparities in research, doctors offer women less aggressive treatment, or even no treatment, for conditions such as heart disease. *See, e.g.*, Judith H. Lichtman et al., *Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction*, 10 J. of the Am. Heart Ass’n 1 (2015).
- xv <https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why>.
- xvi *Id.*
- xvii *See, e.g., When Health Care Isn’t Caring*, LAMBDA LEGAL 5 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf. A survey examining discrimination against LGBTQ people in health care more than half of respondents reported that they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health care status; or health care professionals being physically rough or abusive. *Id.* at 5-6. Twenty-eight percent of transgender and gender non-conforming individuals already report facing harassment in medical settings, and 19 percent report being refused medical care altogether due to their transgender status. Lesbian, gay, and bisexual people also report facing continued discrimination in health care and health insurance coverage. *See* Jaime M. Grant et al., *Injustice at Every Turn: a Report of the National Transgender Discrimination Survey*, NAT’L GAY AND LESBIAN TASK FORCE & NAT’L CTR. FOR TRANSGENDER EQUALITY (2011), http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.
- xviii <https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/>.
- xix <https://www.history.com/news/the-infamous-40-year-tuskegee-study>.
- xx Directive 24 denies respect for advance medical directives. U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (5th ed. 2009), <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>. Moreover, religiously-affiliated individuals have challenged key provisions of the federal law and implementing regulations that prohibit discrimination on the basis of sex, gender identity, or sexual orientation in health care. *Health Care Refusals Harm Patients: The Threat to Reproductive Health Care*, NAT’L WOMEN’S LAW CTR. (May 2014), http://www.nwlc.org/sites/default/files/pdfs/refusals_harm_patients_repro_factsheet_5-30-14.pdf; *see also Health Care Denied*, AM. CIVIL LIBERTIES UNION (May 2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
- xxi Entities ranging from religiously-affiliated school districts and Universities, large department stores, small businesses such as bridal salons, photo studios, and even land owners have attempted to evade important anti-

discrimination laws through the assertion of religious beliefs. See *The Hobby Lobby “Minefield”: The Harm, Misuse, and Expansion of the Supreme Court Decision*, NAT’L WOMEN’S L. CTR. (2015), <https://nwlc.org/wp-content/uploads/2015/08/nwlchobbylobbyreport2015.pdf>; *Health Care Refusals Harm Patients: The Threat to Reproductive Health Care*, NAT’L WOMEN’S LAW CTR. (May 2014), http://www.nwlc.org/sites/default/files/pdfs/refusals_harm_patients_repro_factsheet_5-30-14.pdf.

^{xxiii} The government explicitly acknowledges the growth of religiously-affiliated health care entities in the RFI stating, “one in six hospital patients were cared for in Catholic hospitals in 2015.” See *Removing Barriers for Religious and Faith-Based Organizations to Participate in HHS Programs and Receive Public Funding*, 82 Fed. Reg. 49,300, 49,301 (Oct. 25, 2017). These hospitals have some affiliation with the Catholic religion and elect to follow Catholic health care teachings, which impose restrictions on the type of care that can be offered. See U.S. CONFERENCE OF CATHOLIC BISHOPS, *ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES* (5th ed. 2009), <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>. When religious and secular hospitals merge, the religious restrictions often apply to both the religiously-affiliated and secular hospitals. See *About Hospital Mergers*, MERGER WATCH (2017), <http://www.mergerwatch.org/about-hospital-mergers/>.

^{xxiii} Kira Shepherd, et. al, *Bearing the Faith, The Limits of Catholic Health Care for Women of Color* (2018).

^{xxiv} 5 U.S.C. § 706(2)(A), (B), (C).

^{xxv} *Encino Motorcars, LLC v. Navarro*, 136 S.Ct. 2117, 2125 (June 20, 2016) (citing *Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.*, 463 U.S. 29, 103 (1983)).

^{xxvi} *Id.* at 2125-26.

^{xxvii} 42 U.S.C. § 300a-7.

^{xxviii} S9597, <https://www.gpo.gov/fdsys/pkg/GPO-CRECB-1973-pt8/pdf/GPO-CRECB-1973-pt8.pdf> (emphasis added). Senator Church went on to reiterate that “[t]his amendment makes it clear that Congress does not intend to compel the courts to construe the law as coercing **religious affiliated hospitals, doctors, or nurses to perform surgical procedures** against which they may have religious or moral objection.” S9601 (emphasis added).

^{xxix} 42 U.S.C. § 18116.

^{xxx} Council on Ethical and Judicial Affairs of the American Medical Association, *Gender Disparities in Clinical Decision Making*, 266 JAMA 559 (1991).

^{xxxi} Dept. of Health & Human Servs., Ctrs. for Disease Control & Prevention, Nat’l Ctr. for Health Statistics, *Health United States*, 13, 69 (2006) (with special feature on pain), available at <http://www.cdc.gov/nchs/data/hus/hus06.pdf>.

^{xxxii} Instit. of Med., *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, 75 (2011), available at http://www.nap.edu/download.php?record_id=13172.

^{xxxiii} *Id.* at 77 (quoting (Campaign to End Chronic Pain in Women, *Chronic Pain in Women: Neglect, Dismissal, and Discrimination*, 4 (May 2010), available at <http://www.endwomenspain.org/resources>).

^{xxxiv} See, e.g., Nat’l Women’s Law Ctr., *NWLC Section 1557 Complaint: Sex Discrimination Complaints Against Five Institutions*, <http://www.nwlc.org/resource/nwlc-section-1557-complaint-sex-discrimination-complaints-against-five-institutions> (Section 1557 complaints filed against five institutions that exclude pregnancy coverage for plan beneficiaries who are dependent children of employees at institutions).

^{xxxv} See Nat’l Women’s Law Ctr., *Health Care Refusals Harm Patients: The Threat to Reproductive Health Care* (Jan. 2013), available at <http://www.nwlc.org/resource/health-care-refusals-harm-patients-threat-reproductive-health-care>.

^{xxxvi} Seth A. Seabury, et al., *Trends in the Earnings of Male and Female Health Care Professionals in the United States, 1987 to 2010* JAMA Intern Med. (Online First) (Sept. 2013).

^{xxxvii} See, e.g., K. Coleman-Phox, et al., *Recruitment and Retention of Pregnant Women for a Behavioral Intervention: Lessons from the Maternal Adiposity, Metabolism, and Stress (MAMAS) Study*, 10 Prev. Chronic Dis. (Mar. 2013), http://www.cdc.gov/pcd/issues/2013/12_0096.htm; Mary A. Foulkes, et. al., *Clinical Research Enrolling Pregnant Women: A Workshop Summary*, 20(10) J. Women’s Health 1429 (2011).

^{xxxviii} See, e.g., Sandy E. James, *The Report of the U.S. Transgender Survey* (2015), www.ustranssurvey.org/reports.

^{xxxix} Kaiser Family Foundation, *Uninsured Rates for the Nonelderly by Race/Ethnicity* (2016), <https://www.kff.org/uninsured/state-indicator/rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

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- ^{xl} James A. Baker III Institute for Public Policy of Rice University. *The Economic Impact Of Uninsured Children On America* June 2009. <http://www.bakerinstitute.org/publications/HPF-pub-HoShortUninsuredChildren-060309.pdf>.
- ^{xli} Agency for Healthcare Research and Quality, *2016 National Healthcare Quality and Disparities Report*, <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/nhqrdr16/final2016qdr-cx.pdf>.
- ^{xlii} Kaiser Family Foundation, *Key Facts on Health and Health Care by Race and Ethnicity*, 2016, <https://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-section-2-health-access-and-utilization/>.
- ^{xliii} *Id.*
- ^{xliv} *Id.*
- ^{xlv} *Lau v. Nichols*, 414 U.S. 563 (1974).
- ^{xlvi} Kaiser Family Foundation, *Overview of Health Coverage for Individuals with Limited English Proficiency*, at 3.
- ^{xlvii} U.S. Census Bureau, *American Community Survey, Selected Social Characteristics in the United States: 2011 American Community Survey 1-Year Estimates* (25,303,308 speak English less than “very well”). http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_1YR_DP02&prodType=table.
- ^{xlviii} Kaiser Family Foundation, *Overview of Health Coverage for Individuals with Limited English Proficiency*, at 2 (Figure 5) (2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8343.pdf>.
- ^{xlix} Katz, *Children as Brokers of their Immigrant Families’ Healthcare Connections*, at 37.
- ^l Vikki Katz, *Children as Brokers of their Immigrant Families’ Healthcare Connections*, at 24 (2013) (under review).
- ^{li} Katz, *Children as Brokers of their Immigrant Families’ Healthcare Connections*, at 31.
- ^{lii} Camille Ryan, U.S. Census Bureau, *Language Use in the United States: 2011*, available at www.census.gov/content/dam/Census/library/publications/2013/acs/acs-22.pdf.
- ^{liii} CMS Office of Minority Health, *Understanding Communications and Language Needs of Medicare Beneficiaries*, at 8 (April 2017), available at www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf.
- ^{liv} See, e.g., National Senior Citizens Law Center, *Improving Language Access to Keep California’s Older Adults at Home* (Feb. 2011), available at www.justiceinaging.org/wp-content/uploads/2015/08/Improving-Language-Access-in-IHSS.pdf.
- ^{lv} See, e.g.: The National Council on Disability, (2009). *The Current State of Health Care for People with Disabilities*. Retrieved from website: <http://www.ncd.gov/publications/2009/Sept302009>;
- Reis, J. P., Breslin, M. L., Iezzoni, L. I., & Kirschner, K. L. (2004). *It Takes More Than Ramps to Solve the Crisis of Healthcare for People with Disabilities*. Informally published manuscript, Rehabilitation Institute of Chicago, Chicago, IL, Retrieved from www.tvworldwide.com/events/hhs/041206/PPT/RIC_whitepaperfinal82704.pdf.
- ^{lvi} Disabilities are diverse. As the Surgeon General said in his 2005 Call to Action to Improve the Health and Wellness of Persons with Disabilities stated: “Some disabilities are visible; others are not. Some are physical, some visual or auditory, some developmental or cognitive, and some mental or behavioral. Some persons are born with one or more disabilities; others acquire a disability during the course of a lifetime No single disabling condition necessarily affects one person in exactly the same way as it does another.”
- ^{lvii} Mudrick, N.R.; Breslin, M.L.; Liang, M.; and Yee, S. (2012) “Physical Accessibility in Primary Health Care Settings: Results from California On-site Reviews,” *Disability and Health Journal*, October, Vol. 3, Issue 4, Pages 253-261.
- ^{lviii} Mudrick, Breslin, Liang, 2012.
- ^{lix} Tara Lagu et al., *Access to Subspecialty Care for Patients With Mobility Impairment*, *Annals of Internal Medicine*, 2013; 158:441–446.
- ^{lx} Section 1557 Final Rule, 81 Fed. Reg. at 31405.