

October 3, 2022

Office for Civil Rights
Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue, SW
Washington, D.C. 20201

Submitted Electronically

Attention: Nondiscrimination in Health Programs and Activities (Section 1557 NPRM), RIN 0945-AA17

Dear Director Fontes Rainer:

The undersigned organizations are writing in response to the Department of Health and Human Services' ("the Department") and the Office for Civil Rights' ("OCR") proposed rule changes on "Nondiscrimination in Health Programs and Activities" (Section 1557). We strongly support the Department's efforts to ensure the broad scope of Section 1557 protections is reflected within the Proposed Rule and appreciate the Department's invitation for proposals on responding to the current crisis of discrimination in reproductive health care. While clear protections against sex-based discrimination in health care have always been necessary, the need for these protections are particularly urgent following the Supreme Court's devastating *Dobbs v. Jackson Women's Health Organization* decision and the ongoing attacks on transgender and nonbinary individuals, which have exacerbated these already pervasive forms of discrimination. We urge the Department to recognize the ways discrimination in health care can appear in people's lives and to make explicit the strong federal protections against sex-based discrimination.

I. Introduction

Section 1557 of the Affordable Care Act (ACA) was enacted to remedy discrimination in health care. Section 1557 established groundbreaking reforms to health care and health insurance, prohibiting discrimination in health care on the basis of race, color, sex, national origin, age, and disability. Importantly, the scope of Section 1557 protections against sex discrimination in health care and health insurance encompasses protections for pregnancy or related care, including termination of pregnancy, and protections against discrimination on the basis of sexual orientation, gender identity, and sex characteristics. It is critical that the Department's regulatory interpretation of this groundbreaking provision reflect the full scope of protections against health care discrimination that Section 1557 encompasses.

We strongly support the proposed rule. The Department provides several critical clarifications regarding the scope of protections, including as to the entities subject to the law and the forms of health discrimination prohibited by it. The Department takes care in explaining the ways discrimination – particularly intersectional discrimination – shows up in people's lives. We also agree with and appreciate the Department's efforts to make clear the strong protections against discrimination based on sex, including the Department's decision to not incorporate additional harmful religious and anti-abortion provisions in these protections.

However, the Department must provide more clarity. We provide comment on key provisions of the proposed rule and offer concrete recommendations for how to strengthen the regulatory framework implementing Section 1557. This comment particularly focuses on the ways the Department can improve the

protections relating to sex discrimination, especially in response to the crisis in access to abortion and other reproductive health care following the *Dobbs* decision.¹ The Department correctly acknowledges that Section 1557 already protects against discrimination on the basis of termination of pregnancy, but given the crisis unraveling across the country, we urge the Department to be explicit about these protections in its regulatory framework, among other recommendations.

II. The Final Rule must standardize and explicitly recognize that protections against sex discrimination includes pregnancy or related conditions and make clear that this includes termination of pregnancy and other reproductive health care.

In the proposed rule, the Department properly recognizes that discrimination based on sex includes pregnancy and other related care, which includes reproductive health care, including abortion. We urge the Department to explicitly name these forms of sex discrimination and we suggest ways to do that in the following section.

a. The Proposed Rule properly recognizes that sex-based discrimination includes discrimination based on pregnancy or related conditions, but it must standardize the definition wherever sex discrimination is named in the regulatory text.

The Proposed Rule correctly clarifies that Section 1557 prohibits recipients of federal funding from discriminating against individuals with respect to their sex, including discrimination based on pregnancy or related conditions. Specifically, consistent with long-standing interpretations of Title IX and other civil rights statutes like Title VII,² the Proposed Rule includes “pregnancy or related conditions” in the definition of sex discrimination.³

While we support the Department’s inclusion of “pregnancy or related conditions,” the Department does not consistently use this definition in other provisions of the proposed rule. The Department should standardize how it defines sex discrimination throughout the proposed regulatory text. For example, at § 92.8(b) and § 92.10(i), the Department must add “or related conditions” after it lists “pregnancy.”

b. The Final Rule must explicitly name discrimination on the basis of termination of pregnancy as part of sex discrimination.

While the Department acknowledges that discrimination based on “pregnancy or related conditions” includes protections against discrimination based on termination of pregnancy, the Department does not make that explicit in the regulatory text. Just as the Department should standardize its definition of “pregnancy or related conditions” throughout the regulatory text, it must also make clear that “termination of pregnancy” is specifically named in that definition. There are several places where the Department should clarify and further amend the proposed rule to make clear these and other reproductive and sexual health-related protections, including § 92.101(a)(2), and § 92.206 and § 92.207 (*see* Section III(b)(v) of this comment), and in a separate stand-alone provision on pregnancy or related conditions.

¹ *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2242 (2022) (overturning *Roe v. Wade*, 410 U.S. 113 (1973)).

² For example, several court decisions make clear that Title VII’s protection against discrimination on the basis of sex, including, “pregnancy . . . or related medical conditions” reach abortion. *See, e.g., Doe v. C.A.R.S. Prot. Plus, Inc.*, 527 F.3d 358, 364 (3d Cir.), *order clarified*, 543 F.3d 178 (3d Cir. 2008); *Turic v. Holland Hosp., Inc.*, 85 F.3d 1211 (6th Cir. 1996).

³ Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, 47858 (proposed Aug. 4, 2022) (to be codified at 45 C.F.R. pt. 92), § 92.101(a)(2).

Federal law, including Title IX, recognizes that protections against sex discrimination include termination of pregnancy.⁴ Discrimination in health care based on termination of pregnancy can show up in many ways. For example, patients needing emergency abortion care have been denied care at hospitals. Patients have reported being denied medical care unrelated to abortion because their medical history includes a prior abortion. Pharmacies have refused to fill prescriptions needed to manage a miscarriage or complications from pregnancy loss because these medications can also be used to terminate a pregnancy.

Often, discrimination based on termination of pregnancy is rooted in abortion stigma.⁵ This stigma is experienced by a majority of people seeking abortion⁶ and is rooted in sex-based conventions that women are: inherently nurturing and maternal; expected by society to be chaste (which an unwanted pregnancy is seen as diametrically opposed to); and expected to biologically desire to birth children and fulfill traditional roles of homemaker and child caretaker within the nuclear family structure.⁷ The stigmatization of abortion also stems from a universal misperception that abortion is an immoral act as opposed to a personal medical decision.⁸

Abortion stigma often shapes the experiences of patients seeking all forms of medical care, simply because they present as capable of pregnancy.⁹ Sex-based discrimination in health care—including abortion care—has a disproportionate impact on women and transgender and non-binary individuals in comparison to cis men.¹⁰ These experiences are precisely the discriminatory conduct that Section 1557 protects against.

Patients need to know that they cannot be discriminated against based on termination of pregnancy, and we urge the Department to make this clear in its final rule. This is particularly urgent in light of the public health crisis unfolding across the country as large swaths no longer have access to legal abortion care. Accordingly, in the regulatory text, the Department should explicitly name “termination of pregnancy” in any text where “pregnancy or related conditions” is defined as part of sex discrimination.

For example, in § 92.101(a)(2), where the Proposed Rule defines protections against discrimination on the basis of sex to include discrimination based on “pregnancy or related conditions,” we urge the Department to incorporate “including termination of pregnancy” after “pregnancy or related conditions.” Accordingly, that specific regulatory text at § 92.101(a)(2) should read:

Discrimination on the basis of sex includes, but is not limited to, discrimination on the basis of sex stereotypes; sex characteristics, including intersex traits; pregnancy or related conditions, **including termination of pregnancy**; sexual orientation; **transgender status**,¹¹ and gender identity.

⁴ The Department of Education’s Title IX regulations prohibit discrimination related to “termination of pregnancy or recovery therefrom.” 34 C.F.R. § 106.40(b)(1).

⁵ Alison Norris et al., *Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences*, 21 WOMEN’S HEALTH ISSUES 1, 6 (2011), <https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/Abortion-Stigma.pdf>; Anuradha Kumar et al., *Conceptualising Abortion Stigma*, 11 CULTURE, HEALTH & SEXUALITY 625, 628–29 (2009).

⁶ See Paula Abrams, *The Scarlet Letter: The Supreme Court and the Language of Abortion Stigma*, 19 MICH. J. GENDER & L. 293, 328–29 (2013); M. ANTONIA BIGG ET AL., PERCEIVED ABORTION STIGMA AND PSYCHOLOGICAL WELL-BEING OVER FIVE YEARS AFTER RECEIVING OR BEING DENIED AN ABORTION 2 (Whitney S. Rice ed., 2020) (finding that most people considering abortion perceive some stigma related to their decision).

⁷ Norris, *supra* note 5, at 6; Kumar, *supra* note 5, at 628–29.

⁸ COCKRILL K ET AL., ADDRESSING ABORTION STIGMA THROUGH SERVICE DELIVERY: A WHITE PAPER 17(2013); <https://www.ibisreproductivehealth.org/publications/addressing-abortion-stigma-through-service-delivery-white-paper>.

⁹ Transgender, nonbinary, and gender-expansive people who were assigned female or intersex at birth experience pregnancy, have abortions, and are underrepresented and underserved in abortion policy discourse. See e.g. Heidi Moseson et al., *Abortion Experiences and Preferences of Transgender, Nonbinary, and Gender-expansive People in the United States*, AM. J. OBSTET GYNECOL., Sep. 2020, at 1, 1–2.

¹⁰ See Emily Paulsen, *Recognizing, Addressing Unintended Gender Bias in Patient Care*, DUKE HEALTH (Jan. 14, 2020), <https://physicians.dukehealth.org/articles/recognizing-addressing-unintended-gender-bias-patient-care>.

¹¹ This proposed addition is discussed in section V. below.

The Department should include this same text in the other places pregnancy or related conditions is named, including § 92.8(b) and § 92.10(i), as discussed in the previous section.

c. The Department should make clear the scope of Section 1557’s protections against discrimination on the basis of pregnancy or related conditions, including termination of pregnancy.

In the proposed rule’s discussion of § 92.208, the Department asks whether there should be a provision to “specifically address discrimination on the basis of pregnancy [or] related conditions.”¹² We are concerned that including such a provision under § 92.208 could cause policies that are biased against people seeking abortions. For instance, primarily including discrimination on the basis of abortion in this context could lead to biased policies against single people and confusion that a person facing discrimination because they have had an abortion only occurs in a marital, parental, or family context. However, in our comments below, we recommend that HHS add new provisions on discrimination related to pregnancy or related conditions, including termination of pregnancy, under § 92.206 and § 92.207 instead.

Further, we would support the Department’s decision to include an additional provision elsewhere in the final rule to “specifically address discrimination on the basis of pregnancy [or] related conditions” and the broad scope of protected services that fall under this form of care.

III. The Final Rule must enumerate specific forms of discrimination related to pregnancy or other related conditions, including termination of pregnancy.

Throughout the final rule, we urge the Department to specifically name and include – both in the text and preamble, including the language specified in § 92.206 and § 92.207—examples of discrimination related to the full range of reproductive health care and type of services.

a. The Final Rule must name the full range of reproductive health care protected from discrimination

Section 1557’s protection against sex discrimination includes protections against discrimination relating to all reproductive health decisions. For instance, when seeking a hysterectomy or excisions to help remedy chronic pain caused by endometriosis, patients have been refused care by doctors who believe the patient is making the wrong choice and will one day want to have children.¹³ Specifically, the Final Rule must explicitly name that Section 1557 reaches discrimination related to fertility care, contraception, mistreatment in maternity care, and sex discrimination in access to medications and treatments for disabilities and emergency medical conditions.

- i. The Final Rule must make clear that Section 1557’s protections against discrimination on the basis of sex includes discrimination against people seeking or accessing fertility treatment.

¹² Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, 47878 (proposed August 4, 2022) (to be codified at 45 C.F.R. pt. 92).

¹³ Anne Branigin, *Choosing Between not Having Kids or Pain: An Endometriosis Case is Sparking Outrage*, THE LILY (Apr. 20, 2021), <https://www.thelily.com/choosing-between-children-and-a-lifetime-of-pain-a-endometriosis-case-in-the-uk-is-sparking-outrage/>.

Despite Section 1557’s clear prohibition of sex discrimination in health care, discrimination persists in the context of accessing infertility diagnosis, treatment, and services including assisted reproductive technology. It is thus essential that the final rule explicitly name this as prohibited conduct under this provision.

Sex discrimination in the context of fertility care can take many forms. Some insurance companies refuse to cover certain types of care that are traditionally used by women (e.g., IVF).¹⁴ Even in those states that do require insurance plans to cover IVF, some insurance providers require that patients use their “spouse’s sperm” to fertilize their eggs to be eligible for IVF insurance coverage, discriminating against patients based on their sex with respect to marital status, sexual orientation, and gender identity.¹⁵ In a recent example of discrimination on the basis of sexual orientation and marital status, OSF HealthCare, a self-insured Catholic hospital system with facilities in Illinois and Michigan, recently adopted an insurance policy for its employees that limits IVF coverage to “married couple[s] of opposite sex spouses.”¹⁶

Additionally, public and private insurers often discriminate against patients based on sex by requiring that they meet outdated and heteronormative definitions of infertility before providing IVF coverage. For example, relying on a 2013 definition of infertility that has since been rescinded by the American Society of Reproductive Medicine,¹⁷ many insurers require simply that patients in different-sex relationships attest that they have unsuccessfully tried to become pregnant by having unprotected sex for six months or a year, depending on their age, but require same-sex couples and single individuals to undergo six to twelve unsuccessful cycles of intrauterine insemination (IUI) at their own expense before deeming them eligible for IVF coverage. These patients are thereby forced to absorb exorbitant costs out of pocket and are delayed or denied access to their IVF coverage benefits solely due to their sexual orientation.¹⁸ Indeed, in the last year alone, NWLC has received nearly fifty intakes from same-sex couples in seventeen states who have been denied by five different insurance companies coverage for fertility treatments that are otherwise provided for in their plan because they cannot attest to having engaged in six or twelve months of heterosexual sex.

Health care providers may also refuse to provide fertility care for discriminatory reasons. For example, Guadalupe Benitez underwent a year of invasive, costly, and medically unnecessary treatments by the sole in-network fertility care provider on her insurance plan only to then be denied the fertility treatment she needed based on the provider’s religious objections to performing the procedure because Benitez identified as a lesbian. Benitez was forced to pay for her fertility care out-of-pocket at another clinic.¹⁹ Further, studies have found that physicians may consciously or unconsciously block patients from accessing fertility treatment by making

¹⁴ GABRIELA WEIGEL ET AL., KAISER FAMILY FOUNDATION, COVERAGE AND USE OF FERTILITY SERVICES IN THE U.S. (2020), <https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s/>. These benefit exclusions disproportionately affect women of color due to racial disparities in the rate of certain diseases that may cause infertility. See Jennifer O’Hara, *Mayo Clinic Q&A Podcast: The Link Between Racial Disparities and Cervical Cancer*, MAYO CLINIC NEWS NETWORK (Jan. 10, 2022), <https://newsnetwork.mayoclinic.org/discussion/mayo-clinic-qa-podcast-the-link-between-racial-disparities-and-cervical-cancer/#:~:text=Hispanic%20women%20have%20the%20highest,Race%20is%20a%20social%20construct> (describing that Hispanic women have the highest incidence rate of cervical cancer, followed by non-Hispanic Black women).

¹⁵ E.g., HAW. REV. STAT. § 431:10A-116.5 (1987); ARK. CODE R. 054.00.1–5(B) (1991). Furthermore, Texas, which only requires insurance providers to offer IVF insurance, also includes this same eligibility requirement. See TEX. INS. CODE ANN. § 1366.005.

¹⁶ Shira Stein, *Hospital Chain Blocks Fertility Coverage for Its LGBTQ Employees*, BLOOMBERG L. (July 18, 2022), <https://news.bloomberglaw.com/health-law-and-business/hospital-chain-blocks-fertility-coverage-for-its-lgbt-employees>.

¹⁷ Compare Practice Committee of the American Society for Reproductive Medicine, *Definitions of Infertility and Recurrent Pregnancy Loss: A Committee Opinion*, 99 FERTILITY & STERILITY 63, 63 (2013) (defining infertility as “a disease defined by failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination,” with Practice Committee of the American Society for Reproductive Medicine, *Definitions of Infertility and Recurrent Pregnancy Loss: A Committee Opinion*, 113 FERTILITY & STERILITY 533, 533 (2020) (defining infertility as “a disease historically defined by the failure to achieve a successful pregnancy after 12 months or more of regular, unprotected sexual intercourse or due to an impairment of a person’s capacity to reproduce either as an individual or with her/his partner.”)).

¹⁸ See *Goidel* complaint, *supra* note TK, at ¶ 8 (describing that a patient was forced to pay out of pocket \$45,000 to achieve a successful pregnancy after she was denied coverage for the benefits in her plan because, as a queer woman, she could not attest to engaging in heterosexual sex).

¹⁹ *Benitez v. North Coast Women’s Care Medical Group, Inc.*, 106 Cal. App. 4th 978, 983 (2003).

assumptions or possessing biases about who can or deserves to be a parent and who wants or deserves fertility treatment. For example, women of color “have reported that some physicians brush off their fertility concerns, assume they can get pregnant easily, emphasize birth control over procreation, and may dissuade them from having children.”²⁰

We urge the Department to clarify in the regulatory text that such discrimination in health care, including in the context of seeking or accessing fertility care, is impermissible discrimination on the basis of sex under Section 1557, and to include examples of a broad range of impermissible sex discrimination in the context of seeking or accessing fertility care in the final rule.

- ii. The Final Rule must make clear that discrimination against those seeking contraception or specific types of contraception is prohibited under Section 1557.

In the final rule, it is imperative that the Department make clear that Section 1557 prohibits discrimination against those seeking contraception or specific types of contraception. This type of discrimination happens frequently and is becoming more widespread in the wake of the *Dobbs* decision.

On July 13, 2022, the Department issued guidance to retail pharmacies about Section 1557 protections, responding to incidents occurring after *Dobbs*. The guidance included certain types of discrimination impacting access to contraception in the retail pharmacy setting, such as an individual being refused access to hormonal contraception at a pharmacy that otherwise provides contraceptives.²¹ These examples should be reiterated in the final rule.

The Department should also include explicit clarification of other types of discrimination against those seeking contraception. Additional examples could include: a state program that otherwise provides coverage of contraceptives but excludes a specific contraceptive because of an assertion that the contraception causes an abortion²² or a provider network that would only include facilities that refuse to perform female sterilization procedures.

The Department must also specify that items or services related to contraception are also protected.²³ Additional medications or services are often needed to facilitate use of contraception, such as anesthetics for insertion of long-acting reversible contraceptives. For example, a pharmacy refusal to provide misoprostol to a patient who was prescribed it in order to make IUD insertion easier could be a Section 1557 violation.

²⁰ The Ethics Committee of the American Society for Reproductive Medicine, *Disparities in Access to Effective Treatment for Infertility in the United States: An Ethics Committee Opinion*, 116 FERTILITY & STERILITY 54, 57 (2021) (discussing the various inequitable barriers to fertility care), https://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/ethics-committee-opinions/disparities_in_access_to_effective_treatment_for_infertility_in_the_us-pdfmembers.pdf.

²¹ U.S. DEPT. OF HEALTH & HUM. SERVS., GUIDANCE TO NATION'S RETAIL PHARMACIES: OBLIGATIONS UNDER FED. C.R. L. TO ENSURE ACCESS TO COMPREHENSIVE REPRODUCTIVE HEALTH CARE SERVS. (Jul. 13, 2022), <https://www.hhs.gov/civil-rights/for-individuals/special-topics/reproductive-healthcare/pharmacies-guidance/index.html#:~:text=Pharmacies%2C%20therefore%2C%20may%20not%20discriminate,medications%20and%20how%20to%20take>.

²² In addition to violating section 1557, a state program in this instance may also be violating the ACA contraceptive coverage requirement. The Department has already made clear that the ACA contraceptive coverage requirement is a floor for coverage. Should a state restriction on contraceptives make compliance with the ACA's contraceptive coverage requirement impossible, the federal government will step in to enforce the ACA. Dep'ts of Lab., Health & Hum. Serv., & Treasury, *FAQs About Affordable Care Act Implementation Part 54* (July 28, 2022) at 7, <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-54.pdf>.

²³ In the context of insurance coverage requirements, the Department already recognizes that any item or service necessary to access contraception is part of contraception. Dep'ts of Lab., Health & Hum. Serv., & Treasury, *supra* note 22, at 10.

- iii. The Final Rule must make clear that Section 1557 prohibits discrimination where a patient is denied medications or treatments for care unrelated to abortion because the medicine is also used for abortion care.

When the Supreme Court overturned the constitutional right to abortion in *Dobbs*, it emboldened covered entities to start denying medications and treatments for chronic health conditions and other disabilities that could prevent, complicate, or end pregnancies or fertility. As the Department has already recognized in its July 13, 2022 guidance, Section 1557 prohibits discrimination in the form of refusing to fill prescriptions for medications that are considered “abortifacients” but may be prescribed to treat other health conditions, such as cancer, arthritis, and ulcers.²⁴ We have seen this form of discrimination following the *Dobbs* decision in states where abortion is now banned. After the *Dobbs* decision, for example, a patient in Tennessee was denied methotrexate, a drug that has relieved her disabling pain from rheumatoid arthritis for the last eight years but is also used in abortion care. Desperate for her medication, she decided to be permanently sterilized.²⁵

Similarly, the drug mifepristone is currently being tested for treating breast cancer, brain cancer, prostate cancer, alcoholism, post-traumatic stress disorder, and depression, among other conditions.²⁶ It also is approved for termination of pregnancies. Following the *Dobbs* decision, patients who could be pregnant are at risk when seeking mifepristone for purposes besides abortion. Patients being refused any form of health care—because of stereotyping that the patient could be pregnant and having an abortion—falls under Section 1557’s protections. To this end, the Final Rule must include language in § 92.206 and § 92.207 addressing the denial of medications or treatments that could prevent, complicate, or end pregnancies yet are prescribed for purposes beyond sexual and reproductive health care, including treatment for severe chronic conditions.²⁷ Recommended additions to proposed regulatory text will be discussed further under III(b)(iv).

b. The Final Rule must identify other examples of discrimination related to reproductive health care

In the post-*Dobbs* reality, any person capable of pregnancy or who appears to be capable of pregnancy may be subject to discrimination while seeking health care. Patients seeking life-threatening emergency care for pregnancy or related conditions may be turned away by providers refusing to provide care. And patients who have had an abortion in the past may be refused care for unrelated medical conditions because their doctor is anti-abortion. The Final Rule must make explicitly clear that Section 1557 prohibits these forms of discrimination.

- i. The Final Rule should make clear that Section 1557 prohibits discrimination relating to treating pregnancy emergencies and complications, including termination of pregnancy, miscarriage management, and other pregnancy outcomes.

Patients needing emergency abortion care or miscarriage management face discrimination from health professionals who object to such care;²⁸ examples abound of individuals who present with emergency

²⁴ U.S. DEPT. OF HEALTH & HUM. SERVS., *supra* note 21.

²⁵ Katie Shepherd & Frances Stead Sellers, *Abortion Bans Complicate Access to Drugs for Cancer, Arthritis, Even Ulcers*, WASH POST (Aug. 8, 2022), <https://www.washingtonpost.com/health/2022/08/08/abortion-bans-methotrexate-mifepristone-rheumatoid-arthritis/>.

²⁶ Caroline Hopkins, *The ‘Abortion Pill’ May Treat Dozens of Diseases, but Roe Reversal Might Upend Research*, ABC NEWS (June 25, 2022), <https://www.nbcnews.com/health/health-news/abortion-pill-may-treat-dozens-diseases-ro-reversal-might-upend-resea-rcna34812>.

²⁷ See U.S. DEPT. OF HEALTH & HUM. SERVS., *supra* note 21; see also Shepherd & Sellers, *supra* note 25.

²⁸ *Tamesha Means v. United States Conference of Catholic Bishops*, ACLU, <https://www.aclu.org/cases/tamesha-means-v-united-states-conference-catholic-bishops> (last visited September 8, 2022).

pregnancy complications only to be denied critical, time-sensitive, and often life-saving medical care because a provider considers this care to be abortion.²⁹ These tragic circumstances have occurred both before and after passage of the ACA, and have been increasingly documented since the *Dobbs* decision. The Department should make clear that such behavior constitutes discrimination on the basis of pregnancy or related conditions, including termination of pregnancy, under Section 1557. And as described in more detail below, the Department should elucidate how EMTALA works together with Section 1557 to protect patient access to reproductive health care in emergency situations.

- ii. The Final Rule should make clear that Section 1557 protects against discriminatory refusals to provide information or referrals about abortion and other reproductive health care.

Section 1557 prohibits refusing to provide information, resources, or referrals about abortion care and other reproductive health care. Such discriminatory refusal of care constitutes discrimination based on pregnancy or related conditions. For example, many Indigenous individuals rely on the Indian Health Service for health care, but IHS facilities often fail to provide information to patients about abortion care or counseling about pregnancy options.³⁰ One patient reported that at one IHS hospital, health care providers were explicitly told not to talk about abortions, while at another IHS facility, patients seeking information about abortion were instructed to “Google it.”³¹ These are forms of sex-based discrimination that Section 1557 protects against.

Providers who operate in states that ban abortion may also be emboldened to deny information about abortion that a patient can receive outside of their state, even if such information is not unlawful to provide. It is critical for the Final Rule to make clear to providers, hospitals, and other entities subject to Section 1557 requirements their responsibility to continue providing information and referrals relating to a pregnancy, including termination of pregnancy.

- iii. The Final Rule should make clear that Section 1557 protects against discrimination based on a person’s actual or perceived decision relating to abortion care.

In the final rule’s preamble discussion of § 92.206, the Administration should include examples making clear that it is discriminatory to refuse to provide health care because of a patient’s actual or perceived abortion care history. Such discriminatory treatment may occur when a provider discovers and objects to a patient’s history of having had an abortion, and therefore refuses to provide any care whatsoever to the patient—even when the health care the patient now seeks is not abortion care. Further, sometimes a provider may suspect that a patient has previously had or will have an abortion and will refuse to provide the patient any health care on this basis as well. In both instances, the health care provider is discriminating based on sex.

Patient health suffers when a provider’s own biases against abortion are substituted for necessary medical care. Not only is the patient denied the immediate care they need, but also the patient’s trust in the health care system erodes when they do not feel safe with their providers and even fear consequences for disclosing their medical history. This is precisely the discrimination that Section 1557 was meant to address.

²⁹ Brief of Amici Curiae Rachael Lorenzo, Mindy Swank and Meghan Eagen In Support of Appellees and for Affirmance, *New York et al. v. Dept’ Health & Human Servs.*, No. 19-4254, Doc. 323, 7–20 (3d Cir. Aug. 3, 2020) (collecting stories of individuals denied life-saving care to treat emergency pregnancy complications).

³⁰ Ex. F Decl. of Rachael Lorenzo 15, Nov. 18, 2020, 1:20-cv-11297-PBS.

³¹ Ex. F Decl. of Rachael Lorenzo 15, Nov. 18, 2020, 1:20-cv-11297-PBS.

iv. The Final Rule should make clear that Section 1557 prohibits discrimination related to discrimination in maternity care.

Pregnant Black, Indigenous, Latina/x, Asian American and Pacific Islander, and all people of color, and others who live at the intersections of Section 1557's protected identities, are often subjected to discrimination throughout pregnancy and the postpartum period, including mistreatment during labor and delivery.³² For example, in a 2018 California survey, Black, Asian, and Pacific Islander women who gave birth in hospitals reported higher rates of unfair treatment, harsh language, and rough handling than white women.³³ Among subspecialty provider offices, 44 percent of gynecology offices were inaccessible due to factors such as inaccessible equipment and lack of transfer assistance, leaving wheelchair users unable to access abortion or maternal care.³⁴ Section 1557 implementing regulations must address this discrimination.

c. **The Final Rule must enumerate these specific forms of discrimination in sections § 92.206 and § 92.207.**

The critical necessity of clear nondiscrimination protections related to pregnancy or related conditions, including termination of pregnancy cannot be understated, especially at this tumultuous moment in the reproductive and sexual health landscape. We appreciate HHS' enumeration of specific forms of sex discrimination prohibited in § 92.206(b) and § 92.207(b). We urge HHS to strengthen these provisions by enumerating specific forms of sex discrimination based on pregnancy or related conditions, including termination of pregnancy and other reproductive health care and decisions, and provide examples of such discrimination in the Preamble. We urge the Department to provide additional language in § 92.206 and § 92.207 that expands upon the ways Section 1557 protects against discrimination based on pregnancy or related conditions, including termination of pregnancy.

In § 92.206, the Department addresses requirements for covered entities to provide individuals equal access to health programs and activities without discriminating on the basis of sex. To that end, the Department outlines specific ways covered entities are prohibited from discriminating based on gender identity. We strongly support the Department's efforts to clarify Section 1557's application to the forms of discrimination identified in proposed § 92.206(b). We also appreciate the examples of such discrimination that the Department provides in the preamble section explaining § 92.206 protections. We ask the Department to go further and include additional sections to § 92.206 that focus on specific forms of discrimination based on pregnancy or related conditions prohibited by Section 1557, including intersectional discrimination. Accordingly, we propose the following additions and amendments to § 92.206(b):

(3) Adopt or apply any policy or practice of treating individuals differently or separating them on the basis of sex in a manner that subjects any individual to more than *de minimis* harm, including by adopting a policy or engaging in a practice that prevents an individual from participating in a health program or activity consistent with the individual's gender identity, **or subjects pregnant people to discriminatory treatment during childbirth, including rough handling, harsh language, or undertreatment of pain;**

³² Saraswathi Vedam et al., *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16 REPROD HEALTH, no. 77, 2019 at 1, <https://doi.org/10.1186/s12978-019-0729-2>.

³³ CAROL SAKALA ET AL., NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, LISTENING TO MOTHERS IN CALIFORNIA: A POPULATION-BASED SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES, 64-65 (Sept. 2018) <https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothersCAFullSurveyReport2018.pdf>.

³⁴ Tara Lagu et al., *Access to Subspecialty Care for Patients With Mobility Impairment: A Survey*, 158 ANNALS OF INTERNAL MED. 441 (2013), <https://www.acpjournals.org/doi/10.7326/0003-4819-158-6-201303190-00003>.

...

(5) **Deny or limit services, or a health care professional's ability to provide services, on the basis of pregnancy or related conditions, including termination of pregnancy, contraception, miscarriage management, fertility care, maternity care, or any health services;**

(6) **Deny or limit services based on an individual's reproductive or sexual health care decisions or history, including termination of pregnancy, miscarriage, or adverse pregnancy outcome; or**

7) **Deny or limit services, or a health care professional's ability to provide services, that may prevent, cause complications to, or end fertility or pregnancies, including medications or treatments for disabilities or emergency medical conditions under 42 U.S.C. § 1395dd.**

We agree with the Department's judgment that the statutory text of Section 1557 is clear: Congress intended that the law apply to U.S. health insurance and other health-related coverages. Thus, we strongly support the Department's restoration of and improvements to § 92.207, including its inclusion of specific forms of prohibited discrimination. However, as with proposed § 92.206, the Department must strengthen the text of proposed § 92.207 to address sex discrimination related to pregnancy or related conditions, including discrimination related to abortion, fertility care, and contraception. Accordingly, we urge the Department to amend proposed § 92.207(b) as follows:

(4) Have or implement a categorical coverage exclusion or limitation for all services related to gender transition or other gender-affirming care, **termination of pregnancy, contraception, fertility care, miscarriage management, pregnancy loss, maternity care, other reproductive and sexual health services, or any health services**, if such denial, limitation, or restriction results in discrimination on the basis of sex;

(5) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost-sharing or other limitations or restrictions on coverage, for specific health services related to gender transition or other gender-affirming care, **termination of pregnancy, contraception, fertility care, miscarriage management, pregnancy loss, maternity care, other reproductive and sexual health services, or any health services**, if such denial, limitation, or restriction results in discrimination on the basis of sex; or

...

(7) **Deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations on coverage for health services that may prevent, cause complications to, or end fertility or pregnancies, if such denial, limitation, or restriction results in discrimination on the basis of sex.**

In addition, we urge The Department to specify in the preamble that the health services addressed in our proposed § 92.207(b)(7) include both the full spectrum of reproductive and sexual health services and treatments and medications for people with disabilities that may prevent, cause complications to, or end fertility or pregnancies.

- d. It is critical that the Final Rule adopt these recommendations, especially because the *Dobbs* decision has created significant legal and medical uncertainty for patients and providers across the country.**

The *Dobbs* decision has created chaos in our health care system, increasing the risk that patients will experience discriminatory care and suffer because of legal and medical uncertainty. Pregnant people are being subjected to increased surveillance, monitoring, and potential criminalization. Even before the Supreme Court overturned *Roe*, restrictions and limitations on abortion care had resulted in surveillance and criminalization of pregnancy outcomes, falling hardest on individuals with intersecting marginalized identities.³⁵ Such criminalization was not limited to abortion, but extended to other pregnancy outcomes, including miscarriage.³⁶ People have been surveilled and prosecuted for pregnancy outcomes such as suffering a miscarriage from accidentally falling down stairs, experiencing a stillbirth as a result of a breech home birth, and using drugs while pregnant, even with a healthy birth.³⁷ After the *Dobbs* decision, some patients are facing discrimination for care that is mistaken for abortion, both in cases where the health care is unrelated to pregnancy or related care. The discriminatory targeting of people for their behavior while pregnant, for pregnancy outcomes, based on a perception of the person's pregnancy status, or because of a personal objection to pregnancy or related care is a violation of Section 1557. It reduces access to health care by deterring patients from seeking out care.³⁸ Patients may delay or forgo altogether care relating to a pregnancy outcome due to fear they could be both discriminated against and criminalized for that outcome. The breakdown of trust and safety caused by discrimination in health care is precisely what Section 1557 was designed to protect against.

Dobbs has caused legal and medical uncertainty. It has placed health care providers in untenable positions, fearing legal liability for providing necessary health care to patients in states where abortion is illegal or being forced by their institutions to refuse care to abortion patients because of the institution's own determinations of potential legal liability.³⁹ It has impacted patients who need care, related or unrelated to a pregnancy outcome. It has opened the door to attacks on contraception, emboldening health care providers and entities to refuse contraceptive care. In a time of such great fear, legal uncertainty, and potential harm to patients, the Department needs to be absolutely clear about the kinds of actions that constitute sex-based discrimination that Section 1557 protects against.

In sum, the Final Rule must strongly and explicitly state that Section 1557 continues to prohibit discrimination on the basis of pregnancy or related conditions—including on the basis of termination of pregnancy. Additionally, the Department should be explicit that the protections for discrimination against pregnancy or related conditions reaches a range of reproductive health care, decisions, services, and situations.

IV. Section 1557 and Other Federal Laws

³⁵ See Brief for If/When/How: Lawyering for Reproductive Justice et al. as Amici Curiae Supporting Petitioners, *June Medical Services L.L.C v. Russo*, 140 S. Ct. 2103 (2020) (No. 18-1323), at 25–26, <https://www.ifwhenhow.org/resources/amicus-brief-june-v-gee/>.

³⁶ JEANNE FLAVIN, *OUR BODIES, OUR CRIMES: THE POLICING OF WOMEN'S REPRODUCTION IN AMERICA* 84 (N.Y. Univ. Press 2009).

³⁷ See Brief for If/When/How: Lawyering for Reproductive Justice et al. *supra* note 36, at 25-26, <https://www.ifwhenhow.org/resources/amicus-brief-june-v-gee/>.

³⁸ See Brief for If/When/How: Lawyering for Reproductive Justice, et al. *supra* note 36, at 29, (citing Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, 3 HEALTH & JUST. 2, 6, 15 (2015)).

³⁹ Reese Oxner & María Méndez, *Texas Hospitals are Putting Pregnant Patients at Risk by Denying Care Out of Fear of Abortion Laws*, *Medical Group Says*, TEXAS TRIBUNE (July 15, 2022), <https://www.texastribune.org/2022/07/15/texas-hospitals-abortion-laws/>.

a. **The Final Rule must include the proposed rule’s clarification that EMTALA protects emergency care for pregnancy or related conditions, including termination of pregnancy.**

In the preamble to the proposed rule, the Department explained that EMTALA protects the care a person needs when presenting with an “emergency medical condition.” Both the proposed rule’s preamble and guidance the Department provided on July 11, 2022 (“July guidance”) makes clear that the EMTALA statute preempts any state laws or mandates that employ a more restrictive definition of an emergency medical condition.⁴⁰ In the July guidance, the Department clarifies that “emergency medical conditions involving pregnant patients may include, but are not limited to, ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features.”⁴¹ This clarification should also be incorporated into the final rule’s discussion of EMTALA. Additionally, the Department should be clear that EMTALA and Section 1557 provide reinforcing protections to patients needing emergency care, especially when it comes to termination of pregnancy.

The Final Rule should make clear that Section 1557 incorporates a provision in Section 1303 barring refusals of abortion care in emergency situations. As discussed in the following part, Section 1303 of the ACA incorporates specific provisions related to religious refusals, requiring covered entities provide care “except as otherwise provided for [under Title I of the ACA].”⁴² Among other provisions, Section 1303 incorporates harmful federal laws that allow certain health care entities to refuse to provide abortion care, including the Weldon, Church, and Coats-Snowe Amendments.⁴³ Notably, the refusal provisions do *not* permit refusals of abortion care in emergency situations, as these statutes yield to EMTALA.⁴⁴ Section 1303 itself clarifies that its application of refusal laws excludes emergency care.⁴⁵ The Final Rule must make clear that Section 1557 protects against discrimination in emergency situations for abortion or miscarriage management and requires covered entities—that otherwise offer comprehensive or comparable care—to provide such emergency care to the patient. This requirement remains unless a statutory exception applies. Because no such exception permits refusal of such care in emergency situations, Section 1557 requires such care.

b. **The Department Properly Rejected Applying Harmful Title IX Exceptions to Section 1557’s Protections Against Sex Discrimination**

We strongly support the Proposed Rule’s recognition that Section 1557 does not require the Department to incorporate the language of Title IX’s “abortion neutrality provision,” commonly referred to as the Danforth Amendment.⁴⁶ This proposed approach is consistent with both the underlying statute and the 2016 Rule. We

⁴⁰ U.S. DEPT. OF HEALTH & HUM. SERVS., HHS SECRETARY LETTER TO HEALTH CARE PROVIDERS ABOUT EMERGENCY MEDICAL CARE (Jul. 11, 2022), <https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-care-providers.pdf>.

⁴¹ U.S. DEPT. OF HEALTH & HUM. SERVS., HHS SECRETARY LETTER TO HEALTH CARE PROVIDERS ABOUT EMERGENCY MEDICAL CARE (Jul. 11, 2022), <https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-care-providers.pdf>.

⁴² 42 U.S.C. 18116(a)

⁴³ See 42 U.S.C. § 18023(c)(2).

⁴⁴ *New York v. United States Dep’t of Health & Hum. Servs.*, 414 F. Supp. 3d 475, 538 (S.D.N.Y. 2019).

⁴⁵ 42 U.S.C. § 18023(d) (“Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law.”).

⁴⁶ The Danforth Amendment is a statutory exception incorporated in Title IX that provides: “[n]othing in this chapter shall be construed to require or prohibit any person, or public or private entity, to provide or pay for any benefit or service, including the use of facilities, related to an abortion. Nothing in this section shall be construed to permit a penalty to be imposed on any person or individual because such person or individual is seeking or has received any benefit or service related to a legal abortion.” 20 U.S.C. § 1688.

also strongly support the Proposed Rule’s recognition that Section 1557 does not require the Department to incorporate the language of Title IX’s religious exemption.

The 2020 Rule erred in incorporating both the Danforth Amendment and Title IX’s religious exemption, as the incorporation exceeded the statutory authorization delegated to the Department and is contrary to the underlying law.

i. Incorporation of the Danforth Amendment and the Title IX religious exemption exceeds the Department’s statutory authority

The delegation language of the APA only permits department regulations “to implement” the underlying statute of Section 1557, not to limit the statute contrary to Congress’s intent. Any silence on incorporation of the Danforth Amendment is not an oversight on the part of Congress, rather an intentional decision, as “Congress legislates with knowledge of our basic rules of statutory construction.”⁴⁷ Section 1557 incorporates the bases of discrimination prohibited by Title IX; it does not incorporate the Title IX exemptions.

When the Department included both exceptions in the 2020 Rule, it exceeded its statutory authority, an approach that relied heavily upon the district court’s flawed 2016 decision in *Franciscan Alliance v. Burwell*.⁴⁸ We agree with the Department’s position in the Proposed Rule that the *Franciscan Alliance* decision does not bind this new rulemaking.⁴⁹ We maintain that *Franciscan Alliance*⁵⁰ was wrongly decided because the district court failed to construe the statutory language of Section 1557 in conformity with the law’s “dominating general purpose”⁵¹ and incorporated Title IX exemptions that Congress had not included in the legislation. It is well settled that courts “begin with the text...[and] presume that a legislature says in a statute what it means and means in a statute what it says there,” as Congress legislates with the background of the law.⁵² In *Franciscan Alliance*, following promulgation of the 2016 Rule, anti-abortion plaintiffs challenged the rule in district court and requested Danforth be incorporated.⁵³ The district court wrongly sided with plaintiffs, reasoning that the Department was required to incorporate the full language of Title IX’s Danforth Amendment and religious exemption because the statutory text of Section 1557 referenced the grounds prohibited under Title IX. The district court found that the text of Section 1557 bars discrimination “on the ground prohibited under Title IX...[and] Congress specifically included in the text of Section 1557... the signal ‘et seq.,’ which means ‘and the following,’ after the citation to Title IX...[this] can only mean Congress intended to incorporate the entire statutory structure, including the abortion and religious exemptions.”⁵⁴ Judge O’Connor’s reasoning was flawed because Congress had the opportunity to expressly incorporate the Title IX exceptions into Section 1557 and chose not to.

Additionally, the *Franciscan Alliance* decision was only a single district court case that was decided incorrectly. In fact, the court in *Whitman-Walker Clinic, Inc. v. U.S. Dep’t of Health & Hum. Servs.* held the opposite with regard to the incorporation of the religious exemption from Title IX, declaring its inclusion in the

⁴⁷ *McNary v. Haitian Refugee Ctr.*, 498 U.S. 479, 496 (1991) (referring to presumption favoring judicial review of administrative action). *See also* *United States v. Fausto*, 484 U.S. 439, 463 n.9 (1988) (Stevens, J., dissenting) (Court presumes that “Congress is aware of this longstanding presumption [disfavoring repeals by implication] and that Congress relies on it in drafting legislation.”).

⁴⁸ *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016).

⁴⁹ Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, 47879 (proposed Aug. 4, 2022).

⁵⁰ *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016).

⁵¹ *SEC v. Joiner*, 320 U.S. 344, 350-51 (1943).

⁵² *Conn. Nat’l Bank v. Germain*, 503 U.S. 249, 253-54 (1992) (citations omitted). *See also* *Rice v. Rehner*, 463 U.S. 713, 732 (1983) (referencing the Court’s consistent approach that a canon of construction should not be followed “when application would be tantamount to a formalistic disregard of congressional intent.”).

⁵³ *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660, 671 (N.D. Tex. 2016).

⁵⁴ *Id.* at 690.

2020 rule arbitrary and capricious under the APA.⁵⁵ Specifically, the court in *Whitman-Walker* found that the inclusion of the Title IX religious exemptions in the 2020 rule violated the APA because the Department had failed to consider how this inclusion would impact access to care – the central purpose of Section 1557 and the ACA itself.⁵⁶

The court in *Franciscan Alliance* also decided the APA claim with regard to the 2016 rule,⁵⁷ which it later vacated.⁵⁸ The court ultimately issued a permanent injunction as to enforcement of Section 1557 under the Plaintiffs’ Religious Freedom Restoration Act (RFRA) claim only, which was an individualized assessment that applied only to the plaintiffs.⁵⁹ On August 26, 2022, the Fifth Circuit confirmed that Franciscan Alliance’s APA claim is moot because “Franciscan Alliance cannot use the APA to vacate [the *Whitman-Walker*] injunction[] or Section 1557.”⁶⁰ Again, the 2016 *Franciscan Alliance* decision therefore does not constrain this new rulemaking.

We strongly support the Department’s position that “as a textual matter, the more natural understanding of ‘grounds prohibited’ is that it refers simply to the basis on which discrimination is prohibited.” The Department was correct to point out that this understanding reflects the language used in subsection (b) of Section 1557, which refers to “discrimination on any basis described in subsection (a),” which suggests that “ground” in subsection (a) means the “basis” for discrimination, i.e., race, color, national origin, sex, age, and disability.” This position is further supported by the fact that Congress took efforts to explicitly incorporate exceptions into Section 1557, and provided that the anti-discrimination provisions applied “except as otherwise provided” for in that title. If Congress had wanted to provide explicit exceptions for religious objections or for abortion it could have done so, either by explicitly referencing the exceptions in Title IX or by articulating specific exceptions in the text of the statute.

As the Department pointed out in the 2016 rule and the preamble to the 2022 proposed rule, Congress clearly chose which parts of the four statutes to incorporate, by referencing the enforcement mechanisms and the grounds for discrimination, best understood as the bases of discrimination prohibited, from the referenced statutes.⁶¹ We appreciate the Department’s recognition that the religious exemption exceeds statutory authority and should not be incorporated into Section 1557 and would urge it to articulate the same arguments in its discussion of the Danforth Amendment. The drafters of 1557 did not pick and choose among the multiple Title IX exceptions, including those specific to military training, admissions decisions, and membership practices of certain tax-exempt organizations, and there is no justification for HHS to do so either.

There is no ambiguity in what Congress decided to include and to exclude in the statute and there is no reasonable reading that would indicate that some, but not other exceptions from Title IX, were to be included.

1. Incorporation of the Danforth Amendment is contrary to the underlying law.

⁵⁵ See *Whitman-Walker Clinic, Inc. v. U.S. Dep’t of Health & Hum. Servs.*, 485 F. Supp. 3d 1, 43–46 (D.D.C. 2020).

⁵⁶ *Id.* at 44–45.

⁵⁷ *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660, 688 (N.D. Tex. 2016).

⁵⁸ *Franciscan All., Inc. v. Becerra*, 414 F. Supp. 3d 928, 944–46 (N.D. Tex. 2019) (determining that the proper remedy for the plaintiffs’ APA claim was vacatur, not a permanent nationwide injunction).

⁵⁹ *Franciscan All., Inc. v. Becerra*, 553 F.Supp.3d 361, 378 (N.D. Tex. 2021) (imposing an injunction only as to “[p]laintiffs, their current and future members, and those acting in concert or participation with them, including their respective health plans and any insurers or third-party administrators in connection with such health plans.”).

⁶⁰ *Franciscan All., Inc. v. Becerra*, No. 21-11174, 2022 WL 3700044, at *4 (5th Cir. Aug. 26, 2022).

⁶¹ Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, 47839 (proposed Aug. 4, 2022); Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31379–80 (May 18, 2016).

Incorporation of the Danforth Amendment in the Section 1557 regulation is contrary to congressional intent of the underlying law and ultimately harms patients. The legislative intent behind Section 1557 was “to expand access to care and coverage and eliminate barriers to access”⁶² as the government has a “compelling interest in ensuring that individuals have nondiscriminatory access to health care.”⁶³ Abortion is a critical form of health care, and patients seek or need abortion care for a wide variety of reasons, including personal reproductive health decisions, miscarriage management, or emergency procedures related to adverse pregnancy outcomes. Patients not only deserve but require nondiscriminatory access to abortion care, in accordance with the congressional intent of Section 1557. The Danforth Amendment should not be included because it is the Department’s responsibility to ensure regulations accurately implement the protections provided in Section 1557, not limit the protections, contrary to Congress’s intent.

Incorporation of Danforth would prioritize the beliefs of health care entities—including hospitals and insurance companies—over patient care. Abortion patients already face additional barriers to care that often lead to an inability to access abortion care altogether, especially following the *Dobbs v. Jackson Women’s Health Org.* decision declaring that there is no federal constitutional right to abortion.⁶⁴ Within 30 days of the *Dobbs* decision, eleven states had banned abortion, with some imposing criminal penalties.⁶⁵ This number continues to grow: 26 states are likely to ban or have already banned abortion, leaving people without access to care in their state. Many people are not able to travel to another state to access abortion, or are significantly delayed by the cost and logistical arrangements required to do so. Delays in accessing abortion, or being unable to access abortion at all, pose risks to people’s health. While abortion is very safe at any point in pregnancy, risks increase with gestational age. And because pregnancy and childbirth are far more medically risky than abortion,⁶⁶ forcing people to carry a pregnancy to term exposes them to an increased risk of physical harm. Further, a person’s ability to access abortion has consequences not only for that person, but also for their family and community. Abortion bans most harm people who are poor or have low incomes, people living in rural counties or urban areas without access to adequate prenatal care or obstetrical providers, and Black people. Pregnancy and childbirth are more dangerous for Black women than for white women: as of 2020, the national maternal mortality rate for Black women is approximately three times the rate for white women.⁶⁷ These abortion bans force Black women to bear this disproportionate risk to their health and their lives. Adding the Danforth Amendment to Section 1557 would compound the harms of barriers that patients already face when seeking care.

2. A Blanket Religious Exemption is Contrary to the Purpose of 1557 and Unnecessary

It is vital to acknowledge that the inclusion of the religious exemption from Title IX or a new blanket religious exemption would be detrimental to the operation of a law precluding discrimination in the context of health care. We appreciate the recognition by HHS when considering exemptions from Title IX that education and health care are quite different contexts, particularly in the choice of, and access to, services. The decision to

⁶² Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31377 (May 18, 2016).

⁶³ *Id.* at 31380.

⁶⁴ *Dobbs v. Jackson Women’s Health Org.*, 142 S.Ct. 2228 (2022).

⁶⁵ Marielle Kirstein, Rachel K. Jones & Jesse Philbin, *One Month Post-Roe: At Least 43 Abortion Clinics Across 11 States Have Stopped Offering Abortion Care*, GUTTMACHER (July 28, 2022), <https://www.guttmacher.org/article/2022/07/one-month-post-roe-least-43-abortion-clinics-across-11-states-have-stopped-offering>.

⁶⁶ Elizabeth Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 J. OBSTET. GYNECOL. 215 (Feb. 2012).

⁶⁷ Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2020*, CDC (Feb. 2022), <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/E-stat-Maternal-Mortality-Rates-2022.pdf>.

seek health care at a particular institution is often driven by geographic location, cost, insurance coverage, and the type of care being sought and the urgency of that care. Allowing denials of care based on religious objections can have a direct impact on patients, including putting someone's life and health at risk.

There is clear evidence from across the country of health care institutions and providers refusing to provide a range of services based on personal or religious objection, including abortion, miscarriage management, contraception, fertility services, gender-affirming care, and end-of-life care.⁶⁸ Women and LGBTQ+ individuals are most impacted by denials of care and those who typically have fewer options face an even greater risk of harm, such as those with lower incomes; those in live in rural areas; people with disabilities; and those who face systematic discrimination, such as women of color. Due to the increase in religiously affiliated hospital systems,⁶⁹ particularly in certain areas of the country, it can also be impossible for some of the more marginalized populations to seek care elsewhere if they face a denial.

A lack of information and transparency when individuals are denied health care also contributes to the increase in risk. Patients have been sent home from a health care facility without being informed of their own health status and treatment options despite the clear violation of informed consent, creating a barrier for that patient to obtain appropriate care. When a lack of information is combined with the need for urgent care, such as with some pregnancy complications, a patient's health, and even their life, is put at risk.⁷⁰

The denial of information and services, whether due to religious objection or for other reasons, can violate the standards of care, as established by the medical community. Allowing such denials is in direct conflict with the purpose of 1557, to ensure all people can receive medically appropriate health care without discrimination, and the ACA itself, to expand access to health care.

ii. Religious Exemptions Based on other Federal Statutes Must be Weighed Against the Harm to Patients

HHS has proposed that health care entities that seek an exception to the anti-discrimination provisions of 1557 can claim that a requirement violates RFRA or a federal refusal law and receive an individualized assessment for an exemption based on their religious objection. We agree that requested exemptions must be assessed on a case-by-case basis, with the Department conducting a fact-specific inquiry and assessing the burden on religious exercise in conjunction with the potential impact on a patient or potential patient seeking health care. However, it is important to emphasize that patients can and have been harmed by the imposition of these federal refusal laws. The Weldon Amendment, Church Amendments, and Coats-Snowe Amendment allow certain institutions and individuals to deny medical care to patients without requiring protections for those

⁶⁸ See Catholics for Choice, *Is Your Health Care Compromised? How the Catholic Directives Make for Unhealthy Choices*, CATHOLICS FOR CHOICE (2017), https://www.catholicsforchoice.org/wp-content/uploads/2017/01/2017_Catholic-Healthcare-Report.pdf; Amy Chen & Hayley Panan, *Health Care Refusals & How They Undermine Standards of Care Part II: The Impact of Health Care Refusals, Discrimination, and Mistreatment on LGBTQ Patients and Families*, NAT'L HEALTH L. PROG. (June 13, 2022), <https://healthlaw.org/health-care-refusals-how-they-undermine-standards-of-care-part-ii-the-impact-of-health-care-refusals-discrimination-and-mistreatment-on-lgbtq-patients-and-families/>.

⁶⁹ See Tess Solomon et al., *Bigger and Bigger: the Growth of Catholic Health Systems*, CMTY. CATALYST (2020), <https://www.communitycatalyst.org/resources/publications/document/2020-Cath-Hosp-Report-2020-31.pdf>; Lois Uttley & Christine Khaikin, *Growth of Catholic Hospitals and Health Systems*, MERGER WATCH (2016).

⁷⁰ See, e.g., Julia Kaye et al., *Health Care Denied*, ACLU (May 2016), <https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied> (includes the story of Tamesha Means, who was turned away from a Catholic hospital - the only hospital in her community - in the midst of a painful, nonviable miscarriage); Nat'l Women's L. Ctr., *Below the Radar: Health Care Providers' Religious Refusals Can Endanger Pregnant Women's Lives and health*, NAT'L WOMEN'S L. CTR. (Jan. 2011), <https://nwlc.org/wp-content/uploads/2015/08/nwlcbelowtheradar2011.pdf> (includes the stories of two women who were refused the full spectrum of appropriate care for an ectopic pregnancy at their local emergency rooms).

seeking care. While we understand that Section 1303 of the ACA incorporates federal refusal laws despite a potential conflict with the purpose of 1557 and other ACA provisions, it is worth noting that these provisions are harmful and these denials undermine the protections of Section 1557.

Due to the potential for genuine harm, we appreciate the Department’s acknowledgment that weighing the potential harm to third parties when considering whether to grant exemptions in the health care context should be part of a RFRA analysis and urge the Department to make this element of the assessment for the application of federal refusal laws, including RFRA, clear in the final rule. We also agree with the Department’s statement that a rule that substantially burdens religious practice could still be imposed if it was based on a compelling interest and achieved by the least restrictive means.⁷¹ RFRA was intended to protect religious minorities, not to be used as a means to discriminate or to harm third parties.⁷² We would also request that any exemptions, whether based on RFRA or another federal refusal law, be determined in a transparent manner with the analysis and conclusion made publicly available.

V. Discrimination on the Basis of Sexual Orientation, Gender Identity, and Sex Characteristics

We welcome the explicit recognition that section 1557’s prohibition on sex discrimination includes discrimination on the basis of sex stereotypes, sexual orientation, gender identity and sex characteristics, including intersex traits. As noted in the preamble to the NPRM, LGBTQI+ people experience health disparities and encounter barriers when seeking health care. The National Academies of Sciences, Engineering, and Medicine report that discrimination against sexual- and gender-diverse persons in obtaining health insurance, and in the terms of insurance coverage, is longstanding, and has long been a barrier to accessing health care, which in turn has long contributed to deep and broad health inequalities in LGBTQI populations.⁷³ The effects are exacerbated for youth and people of color. These problems persist in 2022. Data in a new report from the Center for American Progress “reveal that LGBTQI+ communities encounter discrimination and other challenges when interacting with health care providers and health insurers, underscoring the importance of strengthening nondiscrimination protections through Section 1557 of the Affordable Care Act.”⁷⁴

The inclusion of sex stereotypes, sexual orientation, gender identity and sex characteristics is consistent with settled federal law governing sex discrimination. Supreme Court case law, including *Price Waterhouse v. Hopkins*⁷⁵ and *Bostock v. Clayton County*,⁷⁶ makes clear that federal sex discrimination law includes sex stereotypes, sexual orientation and gender identity. It is essential that this rule track those decisions to provide assurance to participants, beneficiaries and enrollees and notice to covered entities that these bases are unequivocally included. We are also pleased to see the explicit inclusion of discrimination based on sex

⁷¹ Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, 47839 (proposed Aug. 4, 2022).

⁷² See Emily London & Maggie Siddiqi, *Religious Liberty Should Do No Harm*, ACLU (Apr. 2019), <https://www.americanprogress.org/wp-content/uploads/2019/03/ReligiousLiberty-report-6.pdf> (“The purpose of [RFRA] is to ‘protect the free exercise of religion’ while clearly defining and more robustly protecting the right of religious liberty for all Americans. It passed with widespread, bipartisan support and was triumphed among faith communities, civil rights advocates, and politicians alike. . . . In 2014, however, the U.S. Supreme Court decision in *Burwell v. Hobby Lobby* marked a major shift in the interpretation of religious exemptions from religiously neutral laws. Rather than simply protecting the rights of religious people, RFRA was expanded and misused to discriminate.”).

⁷³ National Academies of Sciences, Engineering, and Medicine, et al., *Understanding the Well-Being of LGBTQI+ Populations* 350, (2020), <https://nap.nationalacademies.org/catalog/25877/understanding-the-well-being-of-lgbtqi-populations>.

⁷⁴ Medina C and Mahowald L, “Advancing Health Care Nondiscrimination Protections for LGBTQI+ Communities,” CENTER FOR AMERICAN PROGRESS (September 8, 2022), <https://www.americanprogress.org/article/advancing-health-care-nondiscrimination-protections-for-lgbtqi-communities/>.

⁷⁵ 490 U.S. 228 (1989).

⁷⁶ 590 U.S. ___; 140 S. Ct. 1731 (2020).

characteristics, including intersex traits, as such discrimination is inherently sex-based. We would like to see the language in § 92.101(a)(2) be amended to explicitly include transgender status as follows:

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

While the terms “gender identity” and “transgender status” are often used interchangeably, there have been instances in which those seeking to permit discrimination against transgender people have justified it by pressing distinctions between the two concepts.⁷⁷ It is therefore preferable to enumerate both in the regulatory text. We propose that this change also be made in §§ 92.206(b)(1), (b)(2) and (b)(4), and in § 92.207(b)(3).

We support the requirement that covered entities develop and implement written policies and procedures to ensure compliance with this rule, and that the procedural requirements apply across all covered nondiscrimination bases. We also support the notice requirements in § 92.10. We note, however, that the description of prohibited sex discrimination in § 92.8 (Policies and Procedures) and § 92.10 (Notice of nondiscrimination) differs from the language of § 92.101 (Discrimination prohibited). While the differences are not extensive, for the sake of clarity it would be preferable to use consistent language throughout the rule; the more expansive definition in § 92.101 should be utilized.

The restoration of protections for gender-affirming care is an essential component of the proposed rule, as denials of access to and insurance coverage for such care are among the most common manifestations of discrimination against the LGBTQI+ community. The enumeration in §§ 92.206 and 92.207 of the types of discrimination that is prohibited will provide necessary guidance to covered entities regarding their obligations. § 92.206 importantly clarifies that while providers may exercise clinical judgment when determining if a particular service is appropriate for an individual patient, they may not refuse gender-affirming care to a patient based on a personal belief that such care is never clinically appropriate. We suggest strengthening the language pertaining to providers complying with a state or local law as a justification for denying gender-affirming care to state unequivocally that Section 1557, as federal law, preempts any such state or local law restricting access to this care.

We are pleased that this NPRM restores explicit protections against discrimination on the basis of association in § 92.209. This is consistent with longstanding interpretations of other antidiscrimination laws, which cover discrimination based on an individual’s own characteristics or those of someone with whom they are associated or with whom they have relationship. As noted in the NPRM preamble, certain protected populations, including LGBTQ people, are particularly susceptible to discrimination based on association. An individual in a same-sex relationship or marriage could be subjected to discrimination based on their own and their spouse or partner’s sex, whereas that same individual might not be similarly mistreated were they not in a same-sex relationship. It is important that the final rule make clear that this kind of associational discrimination is within the ambit of the rule’s protections.

The 2020 version of the regulations implementing section 1557 inexplicably removed protections against sexual orientation and gender identity discrimination from a number of regulations governing programs run by the Centers for Medicare and Medicaid Services (CMS). We are pleased to see that those are being restored here and also expanded into additional CMS programs. We note, however, that the language around sex discrimination in these CMS “conforming amendments” does not match the proposed sex discrimination

⁷⁷ See, e.g., Making Admission or Placement Determinations Based on Sex in Facilities Under Community Planning and Development Housing Programs, 85 Fed. Reg. 44811 (Jul. 24, 2020) (codified at 24 C.F.R. pts. 5, 576).

language in 1557 itself. We encourage HHS and CMS to adopt identical language to avoid confusion and ensure consistency of implementation.

VI. Intersectional enforcement (§ 92.101; 92.301)

We support strong enforcement of § 1557 and welcome The Department’s recognition in the preamble that the law protects people who experience intersectional discrimination. This can include individuals who experience health care discrimination stemming from some combination of sexism (e.g., people who are pregnant or capable of pregnancy or LGBTQ+), racism, xenophobia (e.g., people with limited English proficiency (LEP)), ableism, or ageism. However, greater clarity regarding intersectional protections and enforcement is needed in the regulatory text.

Thus, the Department should amend the proposed regulatory text at § 92.101(a)(1) to clarify that intersectional discrimination is prohibited. Specifically, this regulation should read: “Except as prohibited in Title I of the ACA, an individual must not, on the basis of race, color, national origin, sex, age, disability, **or any combination thereof**, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any health program or activity operated by a covered entity.”

In addition, §92.301 should ensure that HHS will have clear and accessible procedures for individuals to file, and the agency to investigate and remediate, discrimination complaints, including intersectional discrimination complaints. The Department must therefore make explicit throughout implementing regulations that Section 1557 creates a health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff’s protected class or classes.

VII. Notice and meaningful access

The ability for all individuals to receive health care information and services in their primary language or through language assistance and auxiliary aids and services is vital to living and sustaining healthy lives. Approximately 66.1 million people in the U.S. speak a language other than English at home⁷⁸, including more than 25.5 million people—nearly one in ten people in the U.S.—who are Limited English Proficient (LEP) and speak English less than “very well.”⁷⁹ And approximately 18%, or 28 million, U.S. women are living with a disability and are two to three times more likely than non-disabled women to experience violence when seeking health care in both the private and public sphere.⁸⁰ A person’s language proficiency or physical disability should not determine their access to or the quality of care they receive. We urge the Department to provide clearer guidance on Section 1557 protections for language access and availability of language assistance services and auxiliary aids and services.

a. The Final Rule must ensure language access protections for individuals with communication barriers.

For individuals with LEP, communication barriers make it more difficult to navigate an already complicated health care system and exacerbate existing inequities in access to culturally and linguistically appropriate care. Moreover, these barriers are often compounded by discrimination based on national origin, immigration status, race, ethnicity, sexual orientation, and gender identity. Discriminatory care contributes to the pervasive culture of fear and distrust in the health care system, with undocumented pregnant people postponing prenatal care or giving birth at home to avoid interaction with dangerous clinical environments. This

⁷⁸ U.S. Census Bureau, American Community Survey: Table S1601, (2021), <https://data.census.gov/cedsci/table?q=language>.

⁷⁹ *Id.*

⁸⁰ Center for Reproductive Rights, Rights of Women and Girls with Disabilities to be Free from Violence and Abuse and to Exercise their Sexual and Reproductive Rights, https://reproductiverights.org/sites/default/files/documents/Women%20w%20Disabilities%20UPR%20Fact%20Sheet_FINAL.pdf.

fear and distrust is understandable, considering that in recent years we have witnessed the Trump administration block detained undocumented minors' access to abortion care and have heard reports that immigrants detained by ICE were subjected to forced sterilizations in a Georgia detention center.⁸¹ Discussions about sexual and reproductive care can be sensitive and raise concerns regarding privacy, confidentiality, and state-based violence. It is critical that individuals have access to adequate language services, in a private and confidential setting, allowing for information about and access to sexual and reproductive health care to be available in a culturally and linguistically competent manner.

b. Communication and accessibility plans must be included in § 92.8.

The Department must clarify in § 92.8 that covered entities must affirmatively develop a communication and accessibility plan before developing relevant policies and procedures. Protections around language access have long included recommendations around development of language access plans to help covered entities meet the needs of people with LEP.⁸² The 2016 final rule did not require covered entities to develop language access plans but said if an entity has a language access plan, OCR must consider it when evaluating compliance. The proposed rule eliminates recommendations that entities develop language access plans, and instead requires that entities implement written policies and procedures in its health programs and activities that demonstrate compliance with § 1557 language access requirements.

Requiring development of policies and procedures, and then requiring relevant staff to receive training, will hopefully ensure that covered entities are better able to meet the requirements of § 1557. We are unclear, however, whether the requirements to develop policies and procedures incorporate advance planning to identify what services might be required. We suggest that OCR either clarify this or specifically require covered entities to develop a communication and accessibility plan. For example, the 2022 Proposed Rule discusses the need for “language access procedures” which discusses how to schedule an interpreter, how to identify whether an individual is LEP, etc. But no requirement exists for a covered entity to think *in advance* of what types of language services it may need. That is, without gathering data about the populations in its service area and their communication needs, the entity may not be able to develop effective policies and procedures. Further, covered entities should plan to ensure accessibility for individuals with physical and/or behavioral health disabilities. This should include compliance with the Medical Diagnostic Equipment Accessibility Standards that were finalized by the Access Board in 2016.⁸³ Yet it goes beyond physical accessibility.

We recommend OCR modify § 92.8 to clarify that covered entities must affirmatively develop a communication and accessibility plan before developing relevant policies and procedures. In the alternative, OCR could add a new provision requiring the development of a communication and accessibility plan prior to the development of policies and procedures. OCR should also develop and include a “model access plan”, and explain how covered entities should develop one, in its Sec. 1557 rule, similar to the language access plan included in its 2013 LEP Guidance. It is imperative that covered entities have proactive insights into the particular needs of the community they're serving and develop procedures to meet those needs.

c. Notices of nondiscrimination and availability of language assistance services are vital to ensuring individuals have access to the protections and services they need.

We strongly support the Department's proposed requirements in § 92.10 and § 92.11 to strengthen notices of nondiscrimination and availability of language assistance services and auxiliary aids and service. The Final Rule must provide clearer guidance on these protected services.

⁸¹ Laura Jiménez, Prism, *Latinas/xs face systemic barriers to reproductive care at every level*, (2020), <https://prismreports.org/2020/10/05/latinaxs-face-systemic-barriers-to-reproductive-care-at-every-level/>

⁸² DEPARTMENT OF HEALTH AND HUMAN SERVICES, GUIDANCE TO FEDERAL FINANCIAL ASSISTANCE RECIPIENTS REGARDING TITLE VI PROHIBITION AGAINST NATIONAL ORIGIN DISCRIMINATION AFFECTING LIMITED ENGLISH PROFICIENT PERSONS, August 4, 2003, <https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-vi/index.html>.

⁸³ U.S. Access Board, *Medical Diagnostic Equipment Accessibility Standards*, <https://www.access-board.gov/mde/>.

i. § 92.10 Notice of nondiscrimination

We strongly support the requirements related to a notice of nondiscrimination. When this provision was removed in prior rulemaking, many individuals never received information about their rights; did not know how to access interpreters, auxiliary aids and services; and did not know how to file a complaint or a grievance. In addition to the current requirements, we also recommend including a requirement that any entity receiving a religious exemption under proposed section 92.302 include the existence and scope of such exemption in its required notices. If a covered entity will not provide certain services due to a religious belief or other conscience-based health care refusal, that it must include that information on the notice so the public knows what care it can or cannot receive.

ii. § 92.11 Notice of availability of language assistance services and auxiliary aids and service

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

The Department must include guidance mandating the notice be positioned toward the front, or on the first page, of these vital and significant publications. If notices are placed at the middle or end of multi-page publications containing important information relevant to the patient, they can be easily missed or buried among other information, and individuals with LEP will be less likely to see the notice and know that they can get language assistance services. We also recommend that OCR require covered entities to require the notice include a large print statement, at least 18 point font. Additionally, we suggest that OCR develop and provide covered entities with model notices and translated information in the relevant languages that will be needed across the country. These notices should be related to the different types of publications they are included on; that is, a notice would likely be different for a consent form versus information about a public health emergency versus a notice about one's rights or benefits.

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

d. § 92.201 Meaningful access for limited English proficient individuals

We strongly support the rule's specific requirements to ensure meaningful access to care for individuals with limited English proficiency, including the requirements related to machine translation. Regarding the section on "evaluation of compliance," we raise similar concerns to the ones above related to the lack of a requirement to develop a language access plan. We appreciate that OCR will evaluate the entity's written language access procedures but those procedures will only be as good as the information on which they are based. And the proposed rule does not seem to require a covered entity to gather information about the needs of LEP individuals in its service area prior to developing policies and procedures.

We also strongly support the provision that prevents minor children from interpreting or facilitating communications except in emergency situations involving imminent danger. Research has shown that the ability of a provider to accurately diagnose a patient's condition can be jeopardized by untrained interpreters, such as family and friends, especially minor children, who are prone to omissions, additions, substitutions, volunteered opinions, semantic errors, and other problematic practices.

It is critical that HHS finalize the language prohibiting minors from interpreting in emergencies and

prohibiting other adults accompanying an individual can only interpret if the individual specifically requests it. In these situations, we would suggest that HHS should describe the steps that should occur.

Signed,

Advancing New Standards in Reproductive Health
Advocates for Youth
Alabama Arise
American Humanist Association
American Society for Reproductive Medicine
APLA Health
Association of Maternal & Child Health Programs
Association of Nurses in AIDS Care
Autistic Self Advocacy Network
Bans Off Miami
Big Cities Health Coalition
California Pan-Ethnic Health Network
Catholics for Choice
Cedar River Clinics
Center for American Progress
Center for Reproductive Rights
Coalition for Asian American Children and Families
Cobalt
Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
Community Catalyst
Ethnic Minorities of Burma Advocacy & Resource
Family Equality
FL National Organization for Women
Florida Health Justice Project
Fund Texas Choice
Girls for Gender Equity
Global Justice Center
Grandmothers for Reproductive Rights (GRR!)
Greater Orlando National Organization for Women
Guttmacher Institute
Health People, Inc.
Housing Works
Indigenous Women Rising
Ipas
Kentucky Health Justice Network
Lawyers for Good Government
LCLAA
Louisiana Coalition for Reproductive Freedom
Love Me Unlimited 4 Life

Maine Equal Justice
Miami Coalition to Advance Racial Equity
National Abortion Federation
National Advocates for Pregnant Women
National Center for Lesbian Rights
National Council of Jewish Women
National Family Planning & Reproductive Health Association
National Health Law Program
National Latina Institute for Reproductive Justice
National Organization for Women
National Partnership for Women & Families
National Women's Health Network
National Women's Law Center
OutCenter Southwest Michigan
Planned Parenthood Federation of America
Population Institute
Positive Women's Network-USA
Power to Decide
Prevention Institute
Pro-Choice Connecticut
Pro-Choice Oregon
Pro-Choice Washington
ProgressNow New Mexico
Religious Coalition for Reproductive Choice
Reproaction
Reproductive Equity Now
Reproductive Health Access Project
Rhia Ventures
SHERo Mississippi
Shriver Center on Poverty Law
SIECUS: Sex Ed for Social Change
State Innovation Exchange
Tennessee Disability Coalition
Tennessee Justice Center
The Advocates for Human Rights
The Afiya Center
The Leadership Conference on Civil and Human Rights
The Praxis Project
The Womxn Project
UCSF Bixby Center for Global Reproductive Health
United State of Women
URGE: Unite for Reproductive & Gender Equity
#VOTEPROCHOICE
Women's Foundation of Florida