

National
Family Planning
& Reproductive Health Association

November 9, 2015

Jocelyn Samuels
Director
US Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, SW
Room 509F
Washington, DC 20201

Re: **1557 NPRM (RIN 0945-AA02)**

Dear Ms. Samuels:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to submit comments in response to the Notice of Proposed Rule Making for Section 1557 of the Affordable Care Act (ACA).

NFPRHA is a national membership organization representing providers and administrators committed to helping people get the family planning education and care they need to make the best choices for themselves and their loved ones. NFPRHA's members operate or fund a network of nearly 5,000 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals in 50 states and the District of Columbia. Services are provided through state, county, and local health departments as well as hospitals, family planning councils, Planned Parenthoods, federally qualified health centers, and other private non-profit organizations.

NFPRHA commends the US Department of Health and Human Services (HHS) and the Office of Civil Rights (OCR) for issuing proposed regulations that take critical steps toward realizing the promise of Section 1557 in ending sex discrimination in health care.

Sex discrimination in health care results in women paying more for health care,¹ receiving improper diagnoses and less effective treatments,^{2 3} and sometimes being denied care altogether.⁴ Further, numerous surveys, studies, and reports have documented the widespread discrimination experienced by LGBT individuals and their families in the health system.⁵ In response, the ACA included broad protections against sex discrimination in health programs and activities, with Section 1557, which prohibits discrimination in federally funded and operated health programs and activities, as the cornerstone of this protection. Strong regulations implementing Section 1557, paired with robust enforcement, are necessary to ensure that all women can access quality, affordable health care.

We commend HHS for proposing a strong rule that establishes many of the principles necessary to end sex discrimination in health care. Specifically, we commend HHS for:

- Making clear that all tax credits created by Title I of the ACA, as well as any funds extended by HHS to pay for health insurance coverage, are considered Federal financial assistance;
- Relying on the approach of the Civil Rights Restoration Act in defining “health program or activity.” This approach makes clear that Section 1557 reaches *all* the operations of an entity principally engaged in providing or administering health services or health insurance coverage, including employee health benefits;⁶ importantly, as a result, if a health insurance issuer participates in the marketplaces or receives Medicare Part D payments for any of its plans, then all the plans sold by that issuer will be covered by Section 1557;
- Making clear that sex discrimination includes discrimination on the basis of “pregnancy, false pregnancy, termination of pregnancy or recovery therefrom, childbirth or related medical conditions, sex stereotyping, or gender identity”—and setting out explicit, detailed protections against discrimination on the basis of gender identity, in particular;
- Recognizing that family members and minor children are not qualified interpreters under requirements related to access for patients with limited English proficiency, thus protecting confidentiality; and,
- Recognizing a private right of action to challenge discrimination by federally funded health programs and activities or by the marketplaces.

Although the proposed rule will go a long way toward ending sex discrimination in health care, NFPRHA urges HHS to further strengthen the rule as set out below and move

expeditiously in finalizing and implementing the regulations, delivering on Section 1557's new protections. As lead agency for enforcement of Section 1557, HHS must also work aggressively to ensure that Section 1557 is broadly implemented across all federally funded and operated health programs and activities. The final regulations should address how HHS will ensure this broad enforcement.

NFPRHA requests clear guidance as to the reach of the sex discrimination prohibition.

The proposed Section 1557 regulations set out core sex discrimination prohibitions by incorporating certain implementing regulations for Title IX. However, the cross-referenced Title IX regulations reflect the different educational context for which they were created and accordingly do not reach the full breadth of discriminatory actions that are prohibited by Section 1557. For example, the referenced Title IX regulation prohibits “[a]pply[ing] any rule concerning the domicile or residence of a student or applicant, including eligibility for in-state fees and tuition” on the basis of sex⁷—a rule that has clear applicability to education programs and activities and limited relevance for health programs and activities. Therefore, in addition to the referenced Title IX provisions, the final rule should draw from the prohibitions incorporated from Title VI, Section 504, and Age Act in order to set forth standards at § 92.101(b)(3)) that more fully address discrimination in health programs and activities, as described below.

In addition, each covered entity must comply with the following provisions:

- (i) A covered entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination on the basis of their sex, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals on the basis of sex.⁸*
- (ii) In determining the site or location of a facility, a covered entity may not make selections with the effect of excluding individuals from, denying them the benefits of, or subjecting them to discrimination under any programs to which this regulation applies, on the basis of sex; or with the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the program or activity on the basis of sex.⁹*
- (iii) In the absence of a finding of discrimination, a covered entity in administering a program may take affirmative action to overcome the effects of conditions which resulted in limiting participation by persons on the basis of sex.¹⁰*

In addition, we recommend that HHS construe these proposed standards to prohibit actions by covered entities that have the effect of denying or restricting women's timely access

to providers specializing in family planning and sexual health services. We recommend inserting the following language in the preamble of the final rule discussing § 92.101(b)(3)(i)–(iii) to reinforce the rule’s application in the context of protecting women’s access to health care.

The standards we propose in 92.101(b)(3)(i)–(iii) are intended to reach a variety of circumstances in which the actions of covered entities undermine the ability of individuals to participate in and benefit from health programs and activities on the basis of sex. For example, a covered entity engages in unlawful sex discrimination when it employs criteria that have the effect of disfavoring or disqualifying otherwise eligible providers of family planning and sexual health services for participation in federal health programs, resulting in reduced access to federally supported health care for women in a region. In these and like circumstances, a covered entity must assure that its selection criteria and processes do not produce a result that has a discriminatory effect on individuals protected under Section 1557 and this rule.

PROVIDER NON-DISCRIMINATION

Since 2011, at least 15 states have attempted to restrict certain family planning and sexual health providers – such as Planned Parenthood health centers – from participating in federal public health programs administered by HHS, including Medicaid, the Title X family planning program, Centers for Disease Control and Prevention (CDC) Section 318 sexually transmitted disease (STD) prevention programs, the CDC National Breast and Cervical Cancer Early Detection program, and other critical health programs.¹¹ Although targeted at health care providers, these efforts ultimately restrict health care access for women across the nation and undermine the goals of federal health programs. This section makes a series of recommendations urging the HHS to use its authority under Section 1557 to prohibit these and similar actions by covered entities as impermissible forms of sex discrimination under the statute and final rule.

State efforts to prevent family planning and sexual health providers from furnishing federally supported health care services severely limit women’s access to health care. These efforts have a disproportionate negative impact on the health care access for low-income women and communities of color, further exacerbating health disparities and undermining the intent of public health care programs to improve the health and well-being of all communities. For example, in 2011, Texas made drastic cuts to their state family planning budget and tiered the remaining funds to effectively exclude family planning safety net health centers from participating. Additionally, the state prevented entities affiliated with abortion providers from

furnishing services through its Texas Women's Health Program – a program formerly supported by Medicaid family planning dollars prior to losing federal funding because it excluded qualified providers. The confluence of these restrictions has seriously compromised low-income women's access to health care across the state.

Overall, family planning organizations in Texas have served 54% fewer clients and the actions have forced 25% of family planning clinics in the state to close their doors since 2011.¹² The state of Texas reported similar declines in the utilization of family planning services as a result of its decision to exclude qualified family planning and sexual health providers from the Texas Women's Health Program.¹³ More than half of Texas women surveyed in a recent study reported the existence of at least one barrier in their access to reproductive health care services, citing the prohibitive cost of services and a lack of local providers, among other barriers. The study showed a particularly alarming impact on young, low-income, Spanish-speaking, and immigrant women.¹⁴

Similar state actions in Kansas have also limited patient access. After Kansas excluded Planned Parenthood from serving Title X family planning program patients, Planned Parenthood was forced to close one of its two facilities in the state, leaving its many low-income patients to find a new source of affordable, quality reproductive health care.

HHS has an important interest in maintaining equal access to health programs and activities for the populations protected by Section 1557. Consequently, we believe the final rule must offer protections that are capable of remedying the discrimination that results from the exclusion of family planning and sexual health providers from federal programs. This means protecting the rights of otherwise eligible providers to offer federally supported health care that is tailored to fit the health needs of groups protected under the rule, in addition to protecting individuals from attacks on their ability to access trusted providers of quality, affordable health care without discrimination.

NFPRHA urges HHS to include individuals and entities that provide health care or other related professional services in the prohibition on associational discrimination.

We support the proposed rule's express prohibition on associational discrimination. Discrimination by virtue of an individual or entity's association with members of a protected class has wide-ranging, harmful effects on access to health care for underserved and vulnerable populations and hinders the effectiveness of federally-supported health programs. We recommend that HHS clarify in the final rule that these protections extend to individuals or entities that provide health care or other related professional services that are subjected to

adverse treatment because of their professional relationship with the patients or clients they serve. The final rule should indicate that discrimination on the basis of association occurs when providers are discriminated against because they provide, refer for, or support services associated with individuals belonging to a class protected under Section 1557. Health care providers should not be penalized for offering to competently care for a class of individuals with particular medical needs.

The proposed rule provides that a covered entity may not “discriminate against an individual or entity in its health programs or activities on the basis of the race, color, national origin, age, disability, or sex of an individual with whom the individual or entity is known or believed to have a relationship or association.” This mirrors the language found in Title I and Title III of the Americans with Disabilities Act (ADA).¹⁵ In Section 302, the ADA prohibits associational discrimination against an “individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.”¹⁶ In the appendix to the Department of Justice’s 2010 regulations, the Attorney General observed that Congress’s use of the term “entity” in Section 302 demonstrated its intent to protect “health care providers, employees of social service agencies, and others who provide professional services to persons with disabilities . . . [from] discrimination because of their professional association with persons with disabilities.”¹⁷ Courts considering this question have agreed.¹⁸ Unfortunately, while the proposed preamble illustrates two situations where patients are able to avail themselves of Section 1557’s associational discrimination protections, the rule and preamble are devoid of any discussion of its application to individuals and entities that provide health care or other related professional services. NFPRHA urges HHS to clarify that associational discrimination applies to providers of health care or other related professional services.

The final rule should further state that unlawful discrimination based on association occurs when a provider is subject to adverse treatment because it is known or believed to furnish, refer for, or support services that are medically appropriate for, ordinarily available to, or otherwise associated with a patient population protected by Section 1557. Adverse treatment based on the provision of such services constitutes discrimination on the basis of a professional relationship between the provider and the class of patients or clients for whom those services are appropriate or specifically intended to benefit. In order to meaningfully protect providers from associational discrimination, HHS should presume that discrimination based on the provision of certain services functionally implies discrimination based on an association or relationship with those seeking or in need of such services.

NFPRHA recommends amending § 92.209 to include the following additional language consistent with the ADA's prohibition on associational discrimination and the broad, remedial purposes of Section 1557.

(a) General. A covered entity shall not exclude *or deter* from participation in, deny the benefits of, or otherwise discriminate against an individual or entity in its health programs or activities on the basis of the race, color, national origin, age, disability, or sex of an individual with whom the individual or entity is known or believed to have a relationship or association.

(b) Providers of health care or other related professional services. *For the purposes of this section, the term "individual or entity" shall include individuals or entities that provide health care and other related professional services to individuals.*

Discrimination on the basis of association shall include any action by a covered entity to exclude or deter from participation in, deny the benefits of, or otherwise discriminate against a provider in its health programs or activities based on the services the provider is known or believed to provide, refer for, or support that are medically appropriate for, ordinarily available to, or otherwise associated with individuals of a certain race, color, national origin, age, disability, or sex.

The rule's associational discrimination guarantee is particularly important in protecting the ability of providers of family planning and sexual health services to participate in federally supported or administered health programs when such providers are otherwise eligible and qualified. Because the provision of sex-specific women's health services establishes a provider's association with a potential or existing female patient population, the adverse treatment of family planning and sexual health providers based on the provision of sex-specific services should amount to impermissible associational discrimination based on sex. It follows that Section 1557 protects otherwise eligible health providers from actions by covered entities to deny or restrict their participation in federal health programs by virtue of the sex-specific services they are known to offer. For example, this formulation would prohibit states from using the provision of abortion as a disqualifying factor in recruiting or retaining health care providers for state-operated programs supported by the HHS. The provision of abortion functionally implies a relationship with a sex-based group of patients that are protected under Section 1557. NFPRHA recommends that HHS include language in the preamble of the final rule illustrating that discrimination against health care providers based on the sex-specific services they offer is a prime example of impermissible associational discrimination based on sex. Thus, we urge the Department to insert the following language into the preamble's discussion of §92.209.

Section 92.209(b) makes clear that, consistent with the ADA, individuals or entities that provide health care or other related professional services may not be subject to discrimination based on the race, color, national origin, age, disability, or sex of an individual with whom the provider is known or believed to have a professional relationship or association. Neither is associational discrimination permitted under Section 1557 and this rule when it is achieved by discrimination on the basis of services that an individual or entity is known or believed to provide, refer for, or support that are medically appropriate for, ordinarily available to, or otherwise associated with individuals of a certain race, color, national origin, age, disability, or sex. For example, a covered entity may not deny or restrict a provider from participating in a federally supported health program based on the provider's professional relationship with a predominantly female patient population. Similarly, an otherwise eligible provider may not be disqualified from participating in a federally supported health program because it provides a sex-specific health service, such as abortion.

NFPRHA urges HHS to include the protection of women's timely access to federally supported health care.

We urge the HHS to adopt sex discrimination standards that effectuate the full extent of Section 1557's protections and are capable of addressing actions by covered entities that have the effect of denying or restricting women's timely access to federally supported health care from providers specializing in family planning and sexual health services. Under Section 1557, states and other covered entities are responsible for operating federally supported health programs in a nondiscriminatory manner. This includes meaningfully ensuring women have an equal opportunity to seek health care through federal health programs. We believe covered entities engage in unlawful discrimination when they employ criteria for selecting health care providers for federal health programs that have the effect of disfavoring or disqualifying otherwise eligible family planning and sexual health providers, consequently reducing access to federally supported health care for women as a class. As states increasingly take official action to target these providers for exclusion from federal health programs, it is critical that adversely affected patients are able to avail themselves of Section 1557's protections.

Restrictions on the participation of otherwise eligible family planning and sexual health providers in federal health programs place serious obstacles on women seeking timely access to care. Women make up the vast majority of the patients that rely on the family planning safety net for critical preventive and primary care. For example, in 2014, the patients of the network of Title X-funded health centers was 91% female.¹⁹ In addition, more than 6 in 10 women who obtain care from a safety-net family planning health center consider it their usual source of

care, and as many as 4 in 10 women say it is their sole source of care.²⁰ Certain groups of women are particularly likely to consider a provider specializing in family planning and sexual health services their main source of health care, including women of color, young women, low-income women, and uninsured women.²¹ Local safety-net family planning health centers play an especially critical role for women in rural and medically underserved communities, where there are often no comparable alternative providers specializing in family planning and sexual health services.

When trusted, well-qualified family planning and sexual health providers are arbitrarily eliminated from participating in federal health programs, the many women who depend on such providers for their usual care may be forced to seek federally-supported services from geographically remote providers, settle for inferior care, or forgo care altogether. Women in need of services that reside in areas that lack adequate health care resources are likely to face significantly increased wait times and disproportionate increases in travel along with other associated costs, rendering access to a comparable alternative provider inconvenient, if not prohibitively expensive. In sum, the costs and delays imposed by such restrictions harm the health and well-being of women as a class. Notably, the adverse effects of such discriminatory actions extend beyond access to care via federal health programs. In many cases, state efforts to exclude family planning and sexual health providers have resulted in health center layoffs, reduced hours or services, or health center closures, dramatically disrupting the infrastructure of the family planning safety net in communities and reducing access to family planning and sexual health services as a whole in the affected regions.

SEX DISCRIMINATION AND RELIGIOUS EXCEPTIONS

NFPRHA urges HHS not to create exceptions from the prohibition on sex discrimination.

The proposed rule appropriately does not incorporate any of the exceptions from Title IX. The preamble to the proposed rule seeks comment as to whether exceptions such as those set out in Title IX's protection from sex discrimination in education programs and activities should be added to Section 1557's broad protection against sex discrimination.²² HHS further asks if the rule "appropriately protects religious beliefs" and if any additional exception from the protection against sex discrimination should be created to address religion.²³ NFPRHA believes that no such exceptions are appropriate.

Section 1557's statutory language does not incorporate any of the Title IX exceptions. It references Title IX solely for the grounds on which it prohibits discrimination (sex) and for its enforcement mechanisms.²⁴ Section 1557's ban against discrimination in health programs or

activities includes a single exception: it applies “[e]xcept as otherwise provided” in Title I of the ACA. The plain language of the statute bars incorporating the Title IX exceptions or any other exceptions to the prohibition of sex discrimination.²⁵ As the preamble to the proposed rule acknowledges, Title IX’s exceptions make little sense in the context of health programs and activities.²⁶

The Section 1557 statutory language also does not authorize the creation of a religious exemption—and certainly no law or policy rationale justifies singling out sex as the sole basis of discrimination for such an exemption. Any such exception, from Section 1557’s anti-discrimination requirement in general and from the sex discrimination prohibition in particular, would be contrary to the express purpose of Section 1557 and has the potential to cause great harm. Prior to the passage of the ACA, no broad federal protections against sex discrimination in health care existed. The ACA was intended to remedy this, as evidenced not only by the robust protection provided by Section 1557 itself, but also by the ACA’s particular focus on addressing the obstacles women faced in obtaining health insurance and accessing health care.²⁷ Any religious exemption would undermine the important, necessary, and intended protections against discrimination provided by the ACA and threaten harm to individuals, including the outright denial of services critical to women’s health and to the health of LGBT individuals.

The potential harm posed to individuals by religious exemptions from anti-discrimination laws is a key reason courts have long rejected arguments that religiously affiliated organizations can opt out of anti-discrimination requirements. Instead, courts have held the government has a compelling interest in ending discrimination and that anti-discrimination statutes are the least restrictive means of forwarding that interest.²⁸ Indeed, the majority opinion in *Burwell v. Hobby Lobby Stores, Inc.* makes it clear that the decision should not be used as a “shield” to escape legal sanction for discrimination in hiring on the basis of race because such prohibitions further a “compelling interest in providing an equal opportunity to participate in the workforce without regard to race” and are narrowly tailored to meet that “critical goal.”²⁹ The same principles apply here. Section 1557 was narrowly tailored to end longstanding discrimination in health care and must not include any religious exemptions. For all these reasons, the only exceptions permitted to Section 1557’s sex discrimination prohibition are those exceptions expressly stated in Title I of the ACA.

DISCRIMINATION ON THE BASIS OF SEXUAL ORIENTATION

NFPRHA urges HHS to make clear that discrimination on the basis of sex includes discrimination on the basis of sexual orientation

The proposed rule rightly recognizes that Section 1557's prohibition of discrimination on the basis of sex includes discrimination based on pregnancy, gender identity, and sex stereotypes. NFPRHA commends HHS for these clear statements and specifically applauds its clear affirmation of the key principle recognized across the federal government and by many federal courts: discrimination based on gender identity, gender expression, gender transition, or transgender status is by its very nature a form of sex discrimination. The proposed rule will be a powerful weapon in the ongoing fight to overcome discriminatory barriers to health care for transgender individuals. However, the proposed rule does not explicitly state that discrimination on the basis of sexual orientation is also a form of sex discrimination. HHS has invited comment on this issue.

We urge in the strongest terms that the final rule should recognize that, as the Equal Employment Opportunity Commission and several federal courts have held, sexual orientation discrimination is inherently based on sex.³⁰ Sexual orientation discrimination is based on a sex stereotype that a woman's intimate partner should be a man and a man's intimate partner should be a woman. Sexual orientation bias cannot occur without consideration of a person's sex—and unfortunately such bias still all too often compromises the health care offered to LGBT individuals.

NFPRHA appreciates the opportunity to provide comment on the proposed rule implementing Section 1557 of the Affordable Care Act. If you require additional information about the issues raised in this letter, please contact Mindy McGrath, NFPRHA Policy Director, at 202-293-3114 ext. 206 or at mmcgrath@nfprha.org.

Sincerely,



Clare Coleman
President & CEO

¹ Danielle Garrett et al., Nat'l Women's Law Ctr., Turning to Fairness: Insurance Discrimination Today and the Affordable Care Act 3 (March 2012), http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf. See also Brigitte Courtot & Julia Kaye, Nat'l Women's Law Ctr., Still Nowhere to Turn: Insurance Companies Treat Women Like a Pre-Existing Condition (Oct. 2009), <http://www.nwlc.org/sites/default/files/pdfs/stillnowheretoturn.pdf>.

² Nancy Maserjian et al., *Disparities in Physician's Interpretations of Heart Disease Symptoms by Patient Gender: Results of a Video Vignette Factorial Experiment*, 18 J. of Women's Health 1661 (2009).

³ Richard J. McMurray et al., *Gender Disparities in Clinical Decision Making*, 266 JAMA 559 (1991).

⁴ See Nat'l Women's Law Ctr., Health Care Refusals Harm Patients: The Threat to Reproductive Health Care (Jan. 2013), <http://www.nwlc.org/resource/health-care-refusals-harm-patients-threat-reproductivehealth-care.a>

⁵ Liza Baskin, *LGBT patients find little patience in health care*, DAILY RX (July 11, 2012), <http://www.dailyrx.com/lgbt-friendly-health-care-remains-out-reach-most>.

⁷ See 45 C.F.R. § 86.31(6) (2015).

⁸ See 45 C.F.R. § 80.3(b)(2) (2015); 45 C.F.R. 84(b)(4) (2015); 45 C.F.R. 91.11(b) (2015).

⁹ See 45 C.F.R. 80.3(b)(3) (2015); 45 C.F.R. 84(b)(5) (2015).

¹⁰ See 45 C.F.R. § 80.3(b)(6)(ii) (2015); 45 C.F.R. § 86.3(b) (2015); 45 C.F.R. § 91.16 (2015).

¹¹ Since 2011, eight states have taken action to eliminate women's health providers as Medicaid providers. (Alabama, Arizona, Arkansas, Indiana, Iowa, Louisiana, Pennsylvania, and Texas). States have similarly excluded women's health providers in Title X-funded programs (e.g., Kansas, North Carolina, New Hampshire, Ohio, Tennessee, and Texas), CDC Section 318 STI prevention programs (e.g., Arkansas, Georgia, Indiana, Tennessee, and Utah), and the National Breast and Cervical Cancer Early Detection Program (e.g., Texas). Similar actions are currently being considered in other states.

¹² Kari White et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, American Journal of Public Health (May 2015), available at <http://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.2014.302515>.

¹³ Texas Health and Human Services Commission, *Texas Women's Health Program: Savings and Performance Reporting* (Jan. 2015), available at <http://www.hhsc.state.tx.us/reports/2015/tx-womens-health-program-rider-44-report.pdf>.

¹⁴ Texas Policy Evaluation Project, *Research Brief: Barriers to Family Planning Access in Texas* (May 2015), available at http://www.utexas.edu/cola/orgs/txpep/_files/pdf/TxPEP-ResearchBrief_Barriers-to-Family-Planning-Access-in-Texas_May2015.pdf.

¹⁵ 42 U.S.C. §§ 12112, 12182.

¹⁶ 42 U.S.C. § 12182.

¹⁷ 28 C.F.R. pt. 35, app. B.

¹⁸ See, e.g., *A Helping Hand, LLC v. Baltimore Cnty., MD*, 515 F.3d 356 (4th Cir. 2008) (methadone clinic had standing to sue in its own right under Title II of the ADA due to discrimination based on its association with clients); *Addiction Specialists, Inc. v. Twp. of Hampton*, 411 F.3d 399 (3d Cir. 2005) (same); *United States v. City of Charlotte, N.C.*, 904 F. Supp. 482 (W.D.N.C. 1995) (contractor had standing to sue in its own right under Rehabilitation Act through associational theory because city refused to issue permit to construct housing for people living with AIDS).

¹⁹ Christina Fowler, Julia Gable, Jiantong Wang, and Beth Lasater. Family Planning Annual Report: 2014 national summary. Research Triangle Park, NC: RTI International.

²⁰ Rachel Gold et. al, *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System*, Guttmacher Institute (2009), available at <https://www.guttmacher.org/pubs/NextSteps.pdf>.

²¹ Perry Udem Research & Communication, *Women & OB/GYN providers*, Planned Parenthood Federation of America (2013), available at http://www.plannedparenthood.org/files/4914/0656/5723/PPFA_OBGYN_Report.FINAL.pdf.

²² Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,173 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

²³ *Id.*

²⁴ The Supreme Court held in a similar context that the incorporation by reference of protections from one civil rights statute into another does not mean that the limitations of the first apply to the second. See *Consol. Rail Corp. v. Darrone*, 465 U.S. 624 (1984) (holding that Section 504's reference to Title VI's remedies, procedures, and rights did not import limitations from Title VI not expressly provided in Section 504).

²⁵ While the proposed regulations incorporate “exceptions” from Title VI, Section 504, and the Age Act set out at 45 C.F.R. §§ 80.3(d), 84.4(c), 85.21(c), 91.12–.15, 91.17–.18 (2015), these incorporated provisions by and large do not actually set out exceptions from the relevant antidiscrimination mandates. Rather, they clarify that certain federal programs targeted to meet the particular needs of specific protected groups within the protected class are not properly considered discrimination. *See, e.g.*, 45 C.F.R. § 84.4(c) (2015).

²⁶ Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,173. For example, Title IX exempts social fraternities and sororities, Boys State and Girls State conferences, and beauty pageants offering scholarship prizes from its nondiscrimination rule. 20 U.S.C. § 1681(a)(6), (7), (9) (2012). Incorporating such exceptions into Section 1557 would be nonsensical at best.

²⁷ *See* 42 U.S.C. § 300gg(a) (2015) (allowing rating based only on family size, tobacco use, geographic area, and age, but not sex); 45 C.F.R. § 147.104(e) (2015) (prohibiting discrimination in marketing and benefit design, including on the basis of sex); *see also, e.g.*, 156 CONG. REC. H1632–04 (daily ed. March 18, 2010) (statement of Rep. Lee) (“While health care reform is essential for everyone, women are in particularly dire need for major changes to our health care system. Too many women are locked out of the health care system because they face discriminatory insurance practices and cannot afford the necessary care for themselves and for their children.”); 156 CONG. REC. H1891–01 (daily ed. March 21, 2010) (statement of Rep. Pelosi) (“It’s personal for women. After we pass this bill, being a woman will no longer be a preexisting medical condition.”); 155 CONG. REC. S12026 (daily ed. Oct. 8, 2009) (statements of Sen. Mikulski) (“[H]ealth care is a women’s issue, health care reform is a must–do women’s issue, and health insurance reform is a must–change women’s issue because . . . when it comes to health insurance, we women pay more and get less.”); 155 CONG. REC. S10262–01 (daily ed. Oct. 8, 2009) (statement of Sen. Boxer) (“Women have even more at stake. Why? Because they are discriminated against by insurance companies, and that must stop, and it will stop when we pass insurance reform.”); 156 CONG. REC. H1854–02 (daily ed. March 21, 2010) (statement of Rep. Maloney) (“Finally, these reforms will do more for women’s health . . . than any other legislation in my career.”).

²⁸ *See e.g., Bob Jones Univ. v. United States*, 461 U.S. 574 (1983) (holding that the government’s interest in eliminating racial discrimination in education outweighed any burdens on religious beliefs imposed by Treasury Department regulations); *Newman v. Piggie Park Enters., Inc.*, 390 U.S. 400 (1968) (holding that plaintiff could not refuse to comply with the Civil Rights Act of 1964 based on his religious beliefs); *Dole v. Shenandoah Baptist Church*, 899 F.2d 1389, 1392 (4th Cir. 1990) (holding plaintiffs cannot compensate women less than men based on the belief that “the Bible clearly teaching that the husband is the head of the house, head of the wife, head of the family”); *Hamilton v. Southland Christian Sch., Inc.*, 680 F.3d 1316 (11th Cir. 2012) (reversing summary judgment for religious school that claimed a religious right to fire teacher for becoming pregnant outside of marriage).

²⁹ *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014).

³⁰ *Couch v. Chu*, EEOC Appeal No. 0120131136, 2013 WL 4499198, at * 7 (Aug. 13, 2013).