NATIONAL CENTER FOR LESBIAN RIGHTS

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August 13, 2019

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

Attention: Section 1557 NPRM, "Nondiscrimination in Health and Health Education Programs or Activities," RIN 0945-AA11

The National Center for Lesbian Rights (NCLR) writes to urge that the Department of Health and Human Services (HHS) withdraw the above-referenced Proposed Rule in its entirety, as it would endanger patient health and encourage discrimination in health care delivery.

NCLR is a non-profit, public interest law firm that litigates precedent-setting cases at the trial and appellate court levels, advocates for equitable public policies affecting the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community, provides free legal assistance to LGBTQ people and their advocates, and conducts community education on LGBT issues. NCLR has been advancing the civil and human rights of LGBTQ people and their families across the United States through litigation, legislation, policy, and public education since its founding in 1977. We also seek to equip individuals and communities to assert their own legal rights and to increase public support for LGBTQ equality through public education. NCLR recognizes the critical importance of access to affordable health care for all people, and we are concerned about the harm that would result from the rescission of critical nondiscrimination protections that have served to increase access to health care for our community.

Our comments address the following points:

1. With the Proposed Rule HHS is ignoring the LGBTQ community's reliance interest in the protections of the current Final Rule;
2. By rescinding the 2016 Final Rule, HHS will be encouraging discrimination in health care against LGBTQ people; and
3. HHS has improperly added a religious exemption to this critical nondiscrimination rule.

Each is discussed more fully below.

I. HHS is Ignoring the LGBTQ Community's Reliance Interest in the Current Rule

Section 1557 is the key nondiscrimination provision of the Affordable Care Act (ACA).[1] It prohibits discrimination in health programs and activities receiving federal financial assistance, health programs and activities administered by the executive branch, as well as entities created under the ACA, including the Marketplaces and health plans sold through the Marketplaces. Section 1557 protects against discrimination on the basis of race, color, national origin (including language access), sex, age, and disability, and does so by building on existing civil rights laws.[2] It is the first federal law to ban sex discrimination in health care.

HHS underwent an extensive, 6-year process to develop regulations for Section 1557, including a Request for Information, a Notice of Proposed Rulemaking, and a Final Rule issued in 2016 (the "2016 Final Rule").[3] The 2016 Final Rule provides that discrimination on the basis of sex includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping and gender identity.

The existence of the 2016 Final Rule, along with prior HHS guidance from 2012 clarifying the scope of the statutory protections,[4] has created a reliance interest on the part of many people who might otherwise be subject to sex discrimination based on gender identity, sex stereotyping, or termination of pregnancy. When the Final Rule was issued in 2016, HHS engaged in public education efforts to inform people of their rights under the then-new rule. Organizations like ours assisted in these efforts. Health insurers changed their coverage policies to eliminate discriminatory exclusions. In response, LGBTQ people reasonably relied on the assurances in that rule, understanding that they now had federal protection against hostile and exclusionary treatment in the health care system. They have made decisions about where to live and work—and which health care providers to use—based on that reliance.

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[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010); 42 U.S.C. § 18116.

[2] Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.), Title VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000e et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Section 794 of Title 29, or the Age Discrimination Act of 1975 [42 U.S.C. § 6101 et seq.].

[3] U.S. Dep't of Health & Human Servs., *Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities*, 78 Fed. Reg. 46558 (Aug. 1, 2013); U.S. Dep't of Health & Human Servs., *Nondiscrimination in Health Programs and Activities* (Notice of Proposed Rulemaking), 80 Fed. Reg. 54172 (Sept. 8, 2015); U.S. Dep't of Health & Human Servs.,*Nondiscrimination on the Basis of Race, Color, National Origin, Sex, Age, or Disability in Health Programs or Activities Receiving Federal Financial Assistance and Health Programs or Activities Administered by the Department of Health and Human Services or Entities Established under Title I of the Patient Protection and Affordable Care Act*, 45 C.F.R. Part 92, 81 Fed. Reg. 31376 (May 18, 2016) (hereinafter "2016 Final Rule").

[4] 81 Fed. Reg. 31387, citing Letter from Leon Rodriguez, Director, U.S. Dep't of Health & Human Servs., Office for Civil Rights, to Maya Rupert, Federal Policy Director, National Center for Lesbian Rights (Jul. 12, 2012), https://www.nachc.com/client/OCRLetterJuly2012.pdf.

Under the Administrative Procedure Act, agency action is unlawful if it is “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.” 5 U.S.C. § 706(2)(A). One of the grounds for a finding that a regulation is arbitrary and capricious is if it ignores reliance interests that have developed around the prior policy.

> One of the basic procedural requirements of administrative rulemaking is that an agency must give adequate reasons for its decisions. … That requirement is satisfied when the agency's explanation is clear enough that its “path may reasonably be discerned.” But where the agency has failed to provide even that minimal level of analysis, its action is arbitrary and capricious and so cannot carry the force of law.
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> Agencies are free to change their existing policies as long as they provide a reasoned explanation for the change. … In explaining its changed position, an agency must also be cognizant that longstanding policies may have “engendered serious reliance interests that must be taken into account.” “In such cases it is not that further justification is demanded by the mere fact of policy change; but that a reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy.” It follows that an “[u]nexplained inconsistency” in agency policy is “a reason for holding an interpretation to be an arbitrary and capricious change from agency practice.” An arbitrary and capricious regulation of this sort is itself unlawful and receives no Chevron deference.
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> Applying those principles here, the unavoidable conclusion is that the 2011 regulation was issued without the reasoned explanation that was required in light of the Department's change in position and the significant reliance interests involved. … A summary discussion may suffice in other circumstances, but here—in particular because of decades of industry reliance on the Department's prior policy—the explanation fell short of the agency's duty to explain why it deemed it necessary to overrule its previous position.

Encino Motorcars, LLC v. Navarro, 136 S. Ct. 2117, 2125–26 (2016) (emphasis added) (internal citations omitted).

Other than a conclusory statement that there can be no reliance interest here due to the injunction against its own enforcement,[5] HHS does not seriously address the harm that would ensue if it were to reverse course and eliminate protections against discrimination that members of our community have come to count on.

[5] *Franciscan Alliance v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016).

II. By Rescinding the Current Rule HHS Will Be Promoting Discrimination Against LGBT People, Which Is Serious and Widespread

The rescission by HHS of express nondiscrimination protections for gender identity, sex stereotyping, and termination of pregnancy is also unlawful because it would have the effect of involving the federal government in promoting private discrimination.

In *Reitman v. Mulkey*, 387 U.S. 369 (1967), the United States Supreme Court took up the question of whether the state of California could amend its constitution to overturn state antidiscrimination statutes. After California enacted laws prohibiting race discrimination in housing, the voters approved a ballot initiative adopting a constitutional amendment that repealed those laws. In striking down that constitutional amendment, the Court held that while the state could have remained neutral with respect to private discrimination – it was not required by the federal constitution to proactively forbid it – by amending its constitution to allow such discrimination, the state was in effect encouraging private race discrimination.

The situation created by this Proposed Rule is strikingly similar. Congress enacted a prohibition on sex discrimination in health care in the ACA, and HHS promulgated regulations, as permitted by the statute, to give meaning to that nondiscrimination protection. Consistent with the plain text of the statute and clear trend in federal case law, and with its mandate to facilitate (rather than impede) access to health care, HHS in 2016 specified that sex discrimination included discrimination based on gender identity, sex stereotyping, and termination of pregnancy. Now the agency seeks to remove protections that it had lawfully extended just three years ago. If this rule is finalized as proposed, it would put HHS in the position of fostering private health care discrimination, contrary to the proscription against such discrimination in section 1557 of the ACA.

This discrimination is not hypothetical. LGBT people, women, and other vulnerable groups face significant barriers to getting the care they need.[6] If it goes forward, the Proposed Rule will compound the barriers to care that LGBT individuals face, particularly the effects of ongoing and pervasive discrimination, by inviting providers to refuse to provide services and

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[6] *See, e.g.,* Lourdes Ashley Hunter et al., *Intersecting Injustice: Addressing LGBTQ Poverty and Economic Justice for All* 4-5 (2018), https://perma.cc/DC6H-228W (LGBTQ people more likely than non-LGBTQ people to live in poverty); *id.* at 63-76 (discussing barriers to accessing health care for low-income LGBTQ people); Human Rights Watch, *"You Don't Want Second Best": Anti-LGBT Discrimination in US Health Care* 17 (2018), https://perma.cc/79KG-W3QU; Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care; Sandy E. James et al., *The Report of the U.S. Transgender Survey* 93–126 (2016), www.ustranssurvey.org/report; Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx; Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010), http://www.lambdalegal.org/publications/when-health-care-isnt-caring.

information vital to LGBT health. HHS in fact acknowledges in the proposed rule that entities that changed their discriminatory practices due to the existing rule might revert to their prior behavior.[7]

As a civil rights organization that has been advocating for the LGBT community for over four decades, we at NCLR see firsthand the negative effects of stigma and discrimination on LGBT people seeking care. Despite significant gains in societal acceptance and legal protections, we still face hostility and ill treatment simply for being who we are, and sometimes the consequences are fatal. For example, NLCR represents the mother of a transgender youth who died by suicide after being denied appropriate care and discharged prematurely by a hospital in southern California.[8]

LGBT people of all ages continue to face discrimination in health care on the basis of their sexual orientation and gender identity. The Department's Healthy People 2020 initiative recognizes that "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[9] This surfaces in a wide variety of contexts, including physical and mental health care services.[10] In a recent study published in *Health Affairs*, researchers examined the intersection of gender identity, sexual orientation, race, and economic factors in health care access.[11] They concluded that discrimination, as well as insensitivity or disrespect on the part of health care providers, were key barriers to health care access.[12]

There is a growing body of research documenting how LGBT people encounter barriers in the health care system and suffer disproportionately from a variety of conditions due to health care access issues compounded by stigma and discrimination. In 2010, Lambda Legal found that fifty-six percent of lesbian, gay, and bisexual survey respondents (out of 4,916 total respondents) experienced health-care discrimination in forms such as refusal of health care, excessive precautions used by health-care professionals, and physically rough or abusive behavior by health-care professionals. Seventy percent of transgender and gender nonconforming respondents experienced the same, and sixty-three percent of respondents living with HIV/AIDS had experienced health-care discrimination. In addition, low-income

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[7] 84 Fed Reg 27876.
[8] *See* http://www.nclrights.org/cases-and-policy/cases-and-advocacy/case-prescott-v-rchsd/.
[9] *Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health*, U.S. DEPT. HEALTH & HUMAN SERV., https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health, (last accessed on Mar. 8, 2018); Inst. of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* 1 (Nat'l Acads. Press 2011), https://perma.cc/G9RY-SBXN.
[10] HUMAN RIGHTS WATCH, *All We want is Equality: Religious Exemptions and Discrimination against LGBT People in the United States*, (Feb. 2018), https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people.
[11] Ning Hsieh and Matt Ruther, HEALTH AFFAIRS, *Despite Increased Insurance Coverage, Nonwhite Sexual Minorities Still Experience Disparities In Access To Care* (Oct. 2017) 1786–1794.
[12] *Id*.

LGBT people and LGBT people of color experienced increased barriers to health care.[13] The 2015 U.S. Transgender Survey found that 23 percent respondents did not see a provider for needed health care because of fears of mistreatment or discrimination.[14]

A recent survey conducted by the Center for American Progress found that among lesbian, gay, bisexual, and queer (LGBQ) respondents who had visited a doctor or health care provider in the year before the survey:

- 8 percent said that a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation;
- 6 percent said that a doctor or other health care provider refused to give them health care related to their actual or perceived sexual orientation;
- 7 percent said that a doctor or other health care provider refused to recognize their family, including a child or a same-sex spouse or partner;
- 9 percent said that a doctor or other health care provider used harsh or abusive language when treating them;
- 7 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).[15]

Among transgender people who had visited a doctor or health care providers' office in the past year:

- 29 percent said a doctor or other health care provider refused to see them because of their actual or perceived gender identity;
- 12 percent said a doctor or other health care provider refused to give them health care related to gender transition;
- 23 percent said a doctor or other health care provider intentionally used the wrong name;
- 21 percent said a doctor or other health care provider used harsh or abusive language when treating them;
- 29 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).[16]

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[13] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination against LGBT People and People with HIV*, 2010, https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isntcaring.pdf.

[14] NAT'L CTR. FOR TRANSGENDER EQUALITY, *The Report of the 2015 U.S. Transgender Survey* 5 (2016), *available at* https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[15] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care.

When LGBT patients are turned away or refused treatment, it is much harder—and sometimes simply not possible—for them to find a viable alternative. In the CAP study, nearly one in five LGBT people, including 31% of transgender people, said that it would be very difficult or impossible to get the health care they need at another hospital if they were turned away. That rate was substantially higher for LGBT people living in non-metropolitan areas, with 41% reporting that it would be very difficult or impossible to find an alternative provider.[17] For these patients, being turned away by a medical provider is not just an inconvenience: it often means being denied care entirely with nowhere else to go.

Health-care disparities in general are often more pronounced in rural areas in the United States, and this is further compounded for LGBT individuals, often due to a lack of cultural competency. This hinders physical and mental health providers from meeting the health needs of rural communities.[18] The lack of connection to positive, affirming resources also isolates LGBT youth, making them more susceptible to self-destructive behavior patterns.[19] Isolation continues into adulthood, when LGBT populations are more likely to experience depression and engage in high-risk behaviors.[20]

NCLR has been holding convenings of LGBT people in rural communities for the past several years, and we hear consistently about difficulties in accessing adequate health care. The challenges our community faces in these rural settings include having few providers with LGBT competency, difficulty maintaining health insurance coverage due to employment challenges, transportation difficulties to get to what medical providers there are, food deserts, and specific health conditions that are often more prevalent among LGBT people because of having to live with discrimination and social isolation, including poor eating habits, smoking, and substance abuse.

In rural areas, if care is denied, there may be no other sources of health and life-preserving medical care.[21] The ability to refuse care to patients would therefore leave many individuals in rural communities with no health care options. Medically underserved areas already exist in

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[16] *Id*.

[17] *Id*.

[18] Cathleen E. Willging, Melina Salvador, and Miria Kano, "Pragmatic Help Seeking: How Sexual and Gender Minority Groups Access Mental Health Care in a Rural State," *Psychiatric Services* 57, no. 6 (June 2006): 871–4, http://doi.org/10.1176/ps.2006.57.6.871.

[19] Colleen S. Poon and Elizabeth M. Saewyc, "Out Yonder: Sexual-Minority Adolescents in Rural Communities in British Columbia," *American Journal of Public Health* 99, no. 1 (January 2009): 118–24, http://doi.org/10.2105/AJPH.2007.122945.

[20] Trish Williams et al., "Peer Victimization, Social Support, and Psychosocial Adjustment of Sexual Minority Adolescents," *Journal of Youth and Adolescence* 34, no. 5 (October 2005): 471–82, https://doi.org/10.1007/s10964-005-7264-x.

[21] Since 2010, eighty-three rural hospitals have closed. *See Rural Hospital Closures: January 2010 – Present*, THE CECIL G. SHEPS CTR FOR HEALTH SERVS. RES. (2018), http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

every state,[22] with over 75 percent of chief executive officers of rural hospitals reporting physician shortages.[23] Many rural communities experience a wide array of mental health, dental health, and primary care health professional shortages, leaving individuals in rural communities with less access to care that is close, affordable, and high quality, than their urban counterparts.[24]

III. HHS Has Improperly Inserted a Religious Exemption Into the ACA's Nondiscrimination Protections

Nothing in the legislative history or statutory text permits HHS to create exceptions to Section 1557's prohibition on discrimination. The approach taken in the 2016 Final Rule of not adding a new religious exemption was sound, as religious exemptions in health care cause real harm to real people. The problems for patients presented by the expansion of religious exemption provisions in both federal and state law have been exacerbated by the growth in health care systems owned and operated by religious orders. Mergers between Catholic and nonsectarian hospitals have continued as hospital consolidation has intensified. Catholic hospitals and health systems must follow the church's Ethical and Religious Directives for Catholic Health Care Services ("Directives"), which prohibit a wide range of reproductive health services, such as contraception, sterilization, abortion care, and other needed health care.[25] Nonsectarian hospitals must often agree to comply with these Directives in order to merge with Catholic hospitals.[26]

Providers in one 2008 study disclosed that they could not provide the standard of care for managing miscarriages at Catholic hospitals, and as a result, women's care was delayed or they were transferred to other facilities at great risk to their health.[27] The reach of this type of religious refusal of care is growing with the proliferation of religiously affiliated entities that provide health care and related services.[28] New research shows that women of color in many

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[22] Health Res. & Serv. Admin, *Quick Maps – Medically Underserved Areas/Populations*, U.S. DEP'T OF HEALTH & HUM. SERV., https://datawarehouse.hrsa.gov/Tools/MapToolQuick.aspx?mapName=MUA, (last visited Mar. 21, 2018).

[23] M. MacDowell et al., *A National View of Rural Health Workforce Issues in the USA,* 10 RURAL REMOTE HEALTH (2010), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760483/.

[24] Carol Jones et al., *Health Status and Health Care Access of Farm and Rural Populations,* ECON. RESEARCH SERV. (2009), *available at* https://www.ers.usda.gov/publications/pub-details/?pubid=44427.

[25] U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (6th ed. 2018), http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf.

[26] Elizabeth B. Deutsch, *Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act's Nondiscrimination Mandate*, 124 Yale L. J. 2470, 2488 (2015).

[27] Lori R. Freedman, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, AM. J. PUB. HEALTH (2008), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/.

[28] *See, e.g.*, *Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, AM. CIVIL LIBERTIES UNION & MERGER WATCH (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.

states disproportionately receive their care at Catholic hospitals. In nineteen states, women of color are more likely than are white women to give birth in Catholic hospitals.[29]

Refusals in the context of reproductive health care sometimes run in both directions – they prevent access to contraception and abortion, but also to assisted reproductive technologies (ART) to enable pregnancy. Not only does this infringe on individuals' right to information and care, for those with certain medical conditions it directly contravenes the standard of care. For individuals with cancer, for example, the standard of care includes education and informed consent around fertility preservation, according to the American Society for Clinical Oncology and the Oncology Nursing Society.[30] Refusals to educate patients about or to provide ART, or to facilitate ART when requested, are contrary to the standard of care.

While religiously-based objections to contraception and abortion are well known and have posed access barriers for years, less evident is how these types of refusals can also affect the LGBT community. Not only are LGBT people affected by denials of reproductive health care, other types of medically necessary care, such a transition-related care, are also frequently refused.

Many religious health care providers are opposed to infertility treatments altogether or are opposed to providing it to certain groups of people such as members of the LGBT community.[31] Health care providers have even sought exemptions from state antidiscrimination laws to avoid providing reproductive services to lesbian parents.[32] For example, in one case, an infertility practice group subjected a woman to a year of invasive and costly treatments only to ultimately deny her the infertility treatment that she needed because she is a lesbian.[33] When doctors at the practice group recognized that the woman

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[29] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 12 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

[30] Alison W. Loren et al., *Fertility Preservation for Patients With Cancer: American Society of Clinical Oncology Clinical Practice Guideline Update*, 31 J. CLINICAL ONCOLOGY 2500-10 (July 1, 2013); Ethics Committee of the American Society for Reproductive Medicine, *Fertility preservation and reproduction in patients facing gonadotoxic therapies: a committee opinion*, 100 AM. SOC'Y REPROD. MED. 1224-31 (Nov. 2013), http://www.allianceforfertilitypreservation.org/_assets/pdf/ASRMGuidelines2014.pdf; Joanne Frankel Kelvin, *Fertility Preservation Before Cancer Treatment: Options, Strategies, and Resources*, 20 CLINICAL J. ONCOLOGY NURSING 44-51 (Feb. 2016).

[31] U.S. CONF. OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH SERVICES 25 (5th ed. 2009), *available at* http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf. (Directive 41 of the Ethical and Religious Directives for Catholic Health Care states: "Homologous artificial fertilization is prohibited when it separates procreation from the marital act in its unitive significance.")

[32] Douglas Nejaime et al., *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 Yale L.J. 2516, 2518 (2015). *See*, e.g., *N. Coast Women's Care Med. Grp., Inc. v. San Diego Cnty. Superior Court*, 189 P.3d 959 (Cal. 2008) (on the potential impact of healthcare refusal laws on same-sex couples).

[33] *Benitez v. N. Coast Women's Care Med. Grp., Inc.*, 106 Cal. App. 4th 978 (2003); *see also* LAMBDA LEGAL, BENITEZ V. NORTH COAST MEDICAL GROUP (Jul. 1, 2001), http://www.lambdalegal.org/in-court/cases/benitez-v-north-coast-womens-care-medical-group.

needed in vitro fertilization to become pregnant, every doctor in the practice refused, claiming that their religious beliefs prevented them from performing the procedure for a lesbian.[34] Because this was the only clinic covered by her health insurance plan, the woman had to pay out-of-pocket for the treatment at another clinic, which subjected her to serious financial harm.

LGBT people are all too familiar with discrimination and hostile treatment, including in health care settings, and inviting health care institutions and providers to turn away people and deny them care would exacerbate the widespread mistreatment experienced by many LGBT people in the health care system today. HHS should withdraw this Proposed Rule.

The National Center for Lesbian Rights appreciates the opportunity to comment on this proposed rule. If you require additional information, please contact Julie Gonen, NCLR's federal policy director, at jgonen@nclrights.org or 202-734-3547.

Sincerely,

National Center for Lesbian Rights

[34] *Id.*