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Trans/Forming Healthcare Law: Litigating Antidiscrimination Under the Affordable Care Act

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ABSTRACT: Although section 1557 of the Affordable Care Act outlaws sex discrimination in healthcare, its statutory language does not by itself articulate which actions may give rise to cognizable claims of discrimination. Further, the final rule implementing section 1557 confirms the recent trend in which courts recognize that anti-transgender discrimination is inherently discrimination “on the basis of sex.” This Article stands at the crossroads of these two doctrinal developments, and articulates what sorts of theories of discrimination are cognizable for transgender plaintiffs under the Affordable Care Act. It does so by looking to the text of the statute and final rule, as well as reasoning by analogy from existing antidiscrimination law.

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INTRODUCTION

Transgender\(^1\) people report severe, systemic discrimination in our nation’s healthcare system. A full 70% of transgender respondents in a recent study reported discrimination by a care provider in a healthcare setting,\(^2\) and 20% of transgender men and 24% transgender women even reported being refused care outright.\(^3\)

Against this background, and a widespread dissatisfaction by consumers with the nation’s health insurance markets, President Obama signed into law the Patient Protection and Affordable Care Act (ACA) on March 23, 2010. With its “core principles that everybody should have some basic security when it comes to their healthcare,”\(^4\) the ACA issued expansive consumer protections into the health insurance market. Little noticed in the fanfare, however, were sweeping civil rights provisions, which marked the “first Federal civil rights law to prohibit sex discrimination in healthcare.”\(^5\) Although the ACA’s antidiscrimination provisions mirror existing civil rights regimes, such as Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972, few initially noticed that the ACA—and its implementing regulations confirming that anti-transgender discrimination constitutes illegal sex discrimination—enacted a major expansion of antidiscrimination law for transgender people.

This Article does not advocate for changes to the Affordable Care Act, but rather outlines theories of discrimination that the law and its implementing rule adopt. In Part I of this Article, I briefly outline the nature and extent of the discrimination transgender people face in the healthcare system. In Part II, I discuss the specific legal mechanisms of the ACA’s antidiscrimination provisions. In Part III, I critique a pending lawsuit, \textit{Franciscan Alliance v. Burwell}, that has enjoined the ACA’s antidiscrimination rule. Lastly, in Part IV, I explore potential theories of discrimination cognizable under the ACA, using its interpretive rule and existing antidiscrimination law as guides.

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1. In this article, I use “transgender” as an umbrella term to signify a person whose gender identity or expression is different from that person’s sex assigned at birth. I use the term “cisgender” to signify a person whose gender identity syncs with that person’s sex assigned at birth.


I. THE STATUS QUO

Research suggests that discrimination and social stigma are detrimental to the health of transgender people. For example, transgender people are almost \textit{forty} times likelier to attempt suicide and four times likelier to contract HIV than cisgender people, and over a quarter of transgender respondents in a recent survey reported misusing alcohol or drugs to cope with discrimination. In the medical setting, 28% of transgender respondents reported postponing medical care due to discrimination, and 48% due to an inability to pay. Further, doctors’ offices, clinics, and other places of care are often unsafe spaces for transgender patients, leading many to delay or forego care altogether. Even within a healthcare system that ostensibly prioritizes patient confidentiality and the importance of disclosure to one’s care providers, a recent report revealed that a patient’s honesty about their transgender status to a provider actually \textit{increased} the likelihood of discrimination by medical providers.

Transgender individuals also experience a variety of negative social conditions—such as lack of social support, discrimination in employment opportunities (and thus increased barriers to health insurance), and homelessness—that correspond with worse health. For example, 97% of transgender individuals reported experiencing harassment or mistreatment at work, an estimated 19% of transgender people have been or are currently homeless, and 15% lived on $10,000 per year—twice the rate of the general population. Additional factors such as race, gender, and age compound these already harrowing statistics. For example, 43% of senior LGBT individuals responded that they had experienced or witnessed discrimination in nursing homes or long-term care facilities, and a recent report noted that “the combination of anti-transgender bias and persistent, structural racism \[is\] especially devastating” for transgender people of color.

\begin{itemize}
  \item \textit{Id.} at 73.
  \item LGBT Older Adults in Long-Term Care Facilities: Stories from the Field, JUST. IN AGING 8 (June 2015), http://www.justiceinaging.org.customers.tigertech.net/wp-content/uploads/2015/06/Stories- from-the-Field.pdf.
\end{itemize}
Health insurance companies have historically discriminated against transgender consumers by excluding transition-related care,\textsuperscript{14} barring recognition of same-sex partners,\textsuperscript{15} and requiring additional documentation for gender markers,\textsuperscript{16} intensifying an already serious problem. These discriminatory practices are particularly noticeable in the context of transition, which historically has been excluded from “reasonable and necessary” care clauses included in nearly every health insurance contract.\textsuperscript{17} However, discrimination against transgender individuals—through denial of care, inappropriate sex stereotyping, and providing a hostile care environment—is pervasive throughout routine healthcare provision. Nevertheless, the U.S. Department of Health and Human Services (HHS) has observed that “the Affordable Care Act may represent the strongest foundation we have ever created to begin closing LGBT health disparities.”\textsuperscript{18}

II. THE ACA AND ILLEGAL DISCRIMINATION

Congress has passed various antidiscrimination laws, including the Civil Rights Act of 1964,\textsuperscript{19} Title IX of the Education Amendments of 1972 (Title IX),\textsuperscript{20} the Age Discrimination in Employment Act,\textsuperscript{21} and the Americans with Disabilities Act.\textsuperscript{22} These antidiscrimination laws bar “discrimination” on the basis of certain traits (such as race or disability), and in certain contexts (such as employment, education, or housing). However, until the Affordable Care Act, the healthcare system was generally exempt from antidiscrimination suits by

\begin{enumerate}
\item[] 15. On March 14, 2014, HHS announced new guidance to insurance companies that stated “that it is illegal for insurance providers to deny family coverage to legally married same-sex couples if the company provides family coverage to married opposite-sex couples.” Sunnivie Brydum, HHS Orders Insurers to Cover All Married Same-Sex Couples, ADVOCATE (Mar. 14, 2014, 4:14 PM), http://www.advocate.com/health/2014/03/14/hhs-orders-insurers-cover-all-married-same-sex-couples.
\item[] 16. See Transgender Health Care, supra note 14 (warning transgender insurance customers that they may encounter logistical obstacles to obtaining health insurance, as when a mismatch between one’s legal name and the name on one’s Social Security card generates “inconsistencies” or “data matching issues” that require further documentation and create delays). For an explanation of how increased documentation requirements for gender marking burdens transgender individuals, see Dean Spade, Documenting Gender, 59 HASTINGS L.J. 731 (2008).
\end{enumerate}
private parties. Further, when a federal statute outlaws "discrimination," it is not immediately obvious what constitutes "discrimination," or what redress—private suit, government complaint, withdrawal of federal funds, or other action—is authorized by law. As a result, an entire field of law has developed to determine what constitutes permissible versus impermissible discrimination, and what sorts of burdens of proof are required for cognizable claims. Therefore, the mechanics of the ACA's antidiscrimination provisions are particularly important, as understanding discrimination in the healthcare context will require extending the jurisprudence of existing antidiscrimination law. Analogizing from these prior statutes and employing the theories identified in the ACA’s implementing rule will be plaintiffs’ strongest tools in attacking illegal healthcare discrimination.

A. The Mechanics of the ACA's Antidiscrimination Provision


Section 1557 sweeps broadly and applies to any health program receiving federal funds, including provider settings like clinics and hospitals; insurance companies that participate in Exchanges; all federal programs, such as Medicaid, Medicare, the Indian Health Service, and State Children’s Health Insurance Programs (SCHIPs); and any healthcare programs receiving federal funding, including community health educational programs and nurse programs. Section 1557 also authorizes not only the protected categories, but also the enforcement mechanisms of Title IV, Title IX, the Age Discrimination Act of 1975, and the Rehabilitation Act. Thus, the ACA creates a private federal cause of action for claimants of sex discrimination; and by virtue of Title IX’s extensive absorption of Title VII theories, the ACA incorporates an analysis mirroring the

23. See Sidney D. Watson, Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity, 55 Howard L.J. 855 (2012) (comparing private suits authorized by the ACA with the Johnson Administration’s desegregation of hospitals using the executive branch’s power).
26. Id. at § 1557(c).
27. See Watson, supra note 23.
well-developed Title VII claims in employment discrimination, even though Title VII is not itself mentioned in section 1557.28

Further, on May 18, 2016, HHS published a final rule ("the Rule") to implement the antidiscrimination provisions of the Affordable Care Act.29 The Rule, most of whose provisions became effective on July 18, 2016, explicitly adopts several theories of discrimination, including explicit and constructive denial of care. However, although the Rule lists particular forms of prohibited conduct, it does not limit the ACA’s antidiscrimination provisions to only those listed.30 Thus, subjects of discrimination need not limit theories of recovery to those articulated in the Rule itself. The Rule also clarifies that “sex” under section 1557 includes gender identity and gender stereotyping,31 and at least one court has agreed.32

When courts are receptive to transgender plaintiffs using sex discrimination theories, Title IX is a potent weapon.33 Title IX, the landmark sex equality law enacted in 1972, states that “no person . . . shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal Assistance.”34 Title IX provides powerful tools, including rights of action by private plaintiffs and the Department of Justice, and carries an extensive jurisprudence. Further, transgender plaintiffs may access sex discrimination claims under theories of (1) improper sex stereotyping, whereby the transgender individual is treated adversely because she does not conform to what a woman should look like in the

28. Wolfe v. Fayetteville, Ark. Sch. Dist., 648 F.3d 860, 865 n.4 (8th Cir. 2011) (quoting Gossett v. Okla. ex rel. Bd. of Regents for Langston Univ., 245 F.3d 1172, 1176 (10th Cir. 2001)) (“Courts have generally assessed Title IX discrimination claims under the same legal analysis as Title VII claims.”). The ACA also authorizes other enforcement mechanisms, such as an official complaint-and-investigation system via HHS’s Office of Civil Rights (OCR). See infra Part III. But see Order at 35 n.28, Franciscan All., Inc. v. Burwell, No. 7:16-00108-O (N.D. Tex. Dec. 31, 2016) (doubting that Title VII and Title IX sex discrimination jurisprudence are identical).


30. See Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,406 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92) (“Because it has been long-established that harassment is a form of prohibited discrimination under each of the laws cited in Section 1557 and this part, OCR does not believe a separate harassment provision is necessary and therefore declines to revise the proposed rule to include one.”).


eye of the discriminator; and (2) sex discrimination per se, because the plaintiff was discriminated against “on the basis . . . of sex” when she suffered adverse action due to changes to her anatomical sex. Title IX provides a further benefit to plaintiffs in the form of remedies: although an injunction is the ordinary remedy, the Supreme Court has held that plaintiffs may obtain monetary damages for intentional discrimination. Monetary remedies not only allow the victims of discrimination to redress their particular injuries, but also are helpful in bringing about systemic change in the healthcare system, much as tort suits have curtailed malpractice. Furthermore, because Title IX does not provide an administrative remedy whereby complainants themselves have standing to recover, plaintiffs in a private suit need not exhaust any administrative remedies before filing suit. In addition to a private right of action, Title IX, and thus Section 1557, also authorizes other enforcement remedies, including a complaint-and-investigation system under the HHS Office of Civil Rights; enforcement proceedings by the Department of Justice; loss of federal funding; a future bar on doing business with the government; and false claims liability.

B. Current Limitations of Section 1557

If the Affordable Care Act has ushered in a new antidiscrimination regime covering transgender patients, why does anti-transgender discrimination persist


36. See, e.g., Schroer v. Billington, 577 F. Supp. 2d 293, 308 (D.D.C. 2008) (“Even if the decisions that define the word ‘sex’ in Title VII as referring only to anatomical or chromosomal sex are still good law . . . the [defendant]’s refusal to hire Schroer after being advised that she planned to change her anatomical sex by undergoing sex reassignment surgery was literally discrimination ‘because of . . . sex.’”).

37. See, e.g., Franklin v. Gwinnett Cty. Pub. Sch., 503 U.S. 60, 75 (1992) (“[A]pplication of the traditional rule . . . will require state entities to pay monetary awards out of their treasuries for intentional violations of federal statutes.”). But see Brief of the United States as Amicus Curiae, Davis v. Monroe Cty. Bd. of Educ., 526 U.S. 629 (1999) (No. 97-843) (noting that monetary damages have not been awarded for lower standards of liability, but rather deliberate perpetuation of discrimination); 45 C.F.R. § 92.301(b) (“Compensatory damages for violations of Section 1557 are available in appropriate administrative and judicial actions brought under this rule”).

38. See Joanna C. Schwartz, A Dose of Reality for Medical Malpractice Reform, 88 N.Y.U. L. REV. 1224, 1224 (2013) (“Malpractice litigation is not significantly compromising the patient safety movement’s call for transparency. In fact, the opposite seems to be occurring: The openness and transparency promoted by patient safety advocates appear to be influencing hospitals’ responses to litigation risk.”).

39. See Watson, supra note 23, at 878-79.

40. 45 C.F.R. § 92.301 (2016).


42. Id. at 31,472; see also 45 C.F.R. § 92.301 (“The enforcement mechanisms available for and provided under Title VI of the Civil Rights Act of 1964 . . . shall apply for purposes of Section 1557.”).
in the healthcare system? First, many healthcare providers simply will not prioritize compliance with antidiscrimination policies without a risk of liability via private suit,\textsuperscript{43} similar to how school athletic programs remained largely closed to women until lawsuits famously led to a nationwide expansion of opportunities.\textsuperscript{44} Further, HHS has only recently finalized regulations to implement section 1557, and plaintiff-side attorneys believed that more complex suits enforcing the law stood little chance of success on the merits before final rules were announced.\textsuperscript{45} Critical legal theorists have also observed the limitations of civil rights regimes in eradicating discrimination, noting that courts have taken a limited approach to enforcing civil rights statutes and that only the most privileged plaintiffs have access to the legal services needed to challenge illegal discrimination in court.\textsuperscript{46}

Moreover, many providers are simply not culturally competent to deal with transgender patients and are unaware that their conduct may constitute illegal discrimination.\textsuperscript{47} Cultural incompetence is very common; in a recent report by the National Center for Transgender Equality, nearly 50\% of respondents reported having to teach medical providers about transgender care.\textsuperscript{48} These experiences reflect an intuitive challenge in combatting anti-transgender discrimination: although most can spot obvious examples of discrimination (such as an outright denial of care based on gender identity), a great deal of discrimination is wider and based on ignorance, as when a patient is subjected to “a hostile or insensitive environment."\textsuperscript{49} Because transgender individuals often face harassment in medical care settings, theories of discrimination via hostile care environment will be important in efforts to decrease barriers to care faced by transgender people.\textsuperscript{50} However, although there are limits to what antidiscrimination law can accomplish, developing the cognizable theories of discrimination articulated in this Article would undoubtedly curtail much discrimination in the healthcare sector by imposing costs for discrimination and incentivizing healthcare organizations to reform themselves.

\textsuperscript{43} Cf. Schwartz, supra note 38.
\textsuperscript{46} Dean Spade, What's Wrong with Trans Rights?, in TRANSFEMINIST PERSPECTIVES IN AND BEYOND TRANSGENDER AND GENDER STUDIES 184, 186 (Anne Enke ed., 2012) (“Most people who experience discrimination cannot afford to access legal help, so their experiences never make it to court.”).
\textsuperscript{47} See, e.g., Tari Hanneman, Healthcare Equality Index 2016, HUM. RTS. CAMPAIGN 9 (2016).
\textsuperscript{48} See Grant et al., supra note 3, at 72.
\textsuperscript{50} See infra Section IV(d).
III. FRANCISCAN ALLIANCE V. BURWELL

Legal attacks on section 1557—and antidiscrimination law as a whole—also present a significant challenge to healthcare equality for transgender people. As an illustration, on December 31, 2016, Judge Reed O’Connor of the Northern District of Texas issued a nationwide injunction against enforcement of the Rule, finding that the Rule violated the Administrative Procedure Act and the Religious Freedom Restoration Act. However, the injunction merely bars implementation of the Rule, so victims of anti-transgender discrimination still may pursue their claims in court according to the statute, although those claims will likely be more difficult to win.

On its face, the lawsuit challenging the Rule merely appears to be a few Catholic organizations seeking expanded religious conscience protections and conservative states taking a swipe at the federal government. However, the suit, brought by the Becket Fund for religious liberty, a conservative organization opposed to equal rights for LGBT people, challenges the very premise that transgender people suffer discrimination “because . . . of sex,” and therefore attempts to build case law to create a “transgender exception” to existing sex discrimination law.

After finding that the plaintiffs had standing, the court began its analysis by denying that the Rule deserved deference under Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc. The court found that the Rule failed Chevron step one for a lack of ambiguity because “[s]ection 1557 clearly incorporates Title IX’s prohibition of sex discrimination.” The court then moved to the “precise question at issue in this case: What constitutes Title IX sex discrimination?” Citing his own recent opinion on transgender rights in education, Judge O’Connor found that “the meaning of sex in Title IX unambiguously refers to ‘the biological and anatomical differences between male and female students as determined at their birth.’” Thus, the court found that the Rule “revised the core of Title IX sex discrimination under the guise of

55. 467 U.S. 837 (1984); see Order, supra note 28, at 28.
56. Id. at 30.
57. Id. at 31.
58. Id. (citing Texas v. United States, No. 7:16-cv-00054, 2016 WL 4426495, at *14 (N.D. Tex. Aug. 21, 2016)).
simply incorporating it," and exceeded the grounds incorporated by section 1557.59

After determining that the Rule did not deserve Chevron deference and that the Rule exceeded Title IX’s definition of “sex,” the court found that the Rule’s failure to abide by statutory religious protections rendered it “contrary to law” under the Administrative Procedure Act.60 First, the court found that the Rule failed to incorporate Title IX’s religious protections and thus “nullifies Congress’s specific direction to prohibit only the ground proscribed by Title IX.”61 Next, the court found that the Rule did not pass muster under the Religious Freedom Restoration Act, finding that the Rule “imposes a substantial burden on Private Plaintiffs’ religious exercise.”62 Judge O’Connor found no compelling government interest to justify such a burden. Further, even if the government did have a compelling interest, it “failed to prove the Rule employs the least restrictive means” to achieve it.63

Judge O’Connor recently set aside the Obama Administration’s antidiscrimination guidance for protecting transgender students, and so his injunction against the Rule was expected.64 Conservative commentators have also already adopted the court’s reasoning in the court of public opinion. Noting that “Obama Can’t Redefine Sex,” no less than the editorial column of the Wall Street Journal has heralded the opinion as striking against “the Obama Administration,” which is “guilty of imposing its policy choices by fiat rather than doing the hard work of democracy.”65

However, the court’s opinion and plaintiffs’ arguments do not pass legal muster. First, the court’s assertion that “Congress intended to prohibit sex discrimination on the basis of biological differences between males and females”66 fails to appreciate that prohibitions on improper sex stereotyping have been at the center of sex equality jurisprudence for as long as it has existed. Although individuals may have private opinions on what a man or woman should look like or how they should behave, sex discrimination law takes a careful look at classifications that tell men and women how to be men and women.67 The law

59. Id.
60. The Court worked on an expedited schedule, and thus did not reach the constitutional questions.
61. Order, supra note 28, at 37.
62. Id. at 40.
63. Id. at 41.
64. See Preliminary Injunction Order, Texas v. United States, No. 7:16-cv-00054-O (N.D. Tex. Aug. 21, 2016) (enjoining Department of Education guidance interpreting Title IX as barring anti-transgender discrimination).
67. Price Waterhouse v. Hopkins, 490 U.S. 228, 251 (1989) (holding that a woman who was denied a promotion for failure to appear feminine enough raised an actionable claim of sex discrimination); cf. United States v. Virginia, 518 U.S. 515, 531 (1996) (“Parties who seek to defend gender based government action must demonstrate an exceedingly persuasive justification for that action.” (internal quotation omitted)).
views even purportedly benign stereotypes with a cautious eye, because those stereotypes tend to place the subject "not on a pedestal, but in a cage."\(^68\) As a result, even the very earliest sex equality precedents recognize that laws barring discrimination on the basis of sex prohibit not only disparate treatment between men and women, but also disparate treatment among men and among women against those who do not conform to the ways the discriminator thinks a man or woman should appear or act.\(^69\) Thus, for a discriminator to discriminate against a hypothetical transgender woman on the basis of her transgender status is essentially to claim that the victim does not conform to what the discriminator thinks a "real woman" or a "real man" should look like. Such behavior is classic discrimination under a sex stereotyping theory, regardless of the sex of the transgender woman in the discriminator’s mind.\(^70\)

In its opinion, the court fails to appreciate this anti-stereotyping aspect of sex discrimination law. Judge O’Connor states that “even in Price Waterhouse, the Supreme Court seems to acknowledge the binary nature of sex,” citing the oft-quoted language that “Congress intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes.”\(^71\) However, by essentializing sex stereotypes to merely the “biological differences” between men and women, Judge O’Connor has misread Price Waterhouse and much of sex discrimination law. Yes, antidiscrimination law generally holds that sex classifications may in certain circumstances “take\([\]\) into account a biological difference.”\(^72\) However, a problem arises when discriminators assign roles and responsibilities, envisioning the way a man or woman “should act,” and then justify those stereotypes on irrelevant anatomical facts. Judge O’Connor commits this very error when he implies that the Rule would likely lead to the closure of specialty services targeted “exclusively for women (e.g., obstetrics and gynecology; hysterectomies; hormone treatments; reconstructive surgery).”\(^73\) Judge O’Connor errs because he fundamentally misreads the phrase “exclusively for women.” The Rule does not mandate gynecological care for

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69. Diaz v. Pan Am. World Airways, Inc., 442 F.2d 385 (5th Cir. 1971) (holding that firing flight attendants for marrying discriminated impermissibly among women by reinforcing the notion that one must be sexually available to heterosexual businessmen to become a stewardess, thus effectively notifying men they need not apply); cf. Ann C. McGinley, Erasing Boundaries: Masculinities, Sexual Minorities, and Employment Discrimination, 43 U. MICH. J.L. REFORM 713, 744 (2010) (“[P]ermitting discrimination against effeminate men is a means of enforcing the masculinity of the job which, in turn, creates barriers not only to effeminate men, but also to women who would be interested in the job.”).
70. See Glenn v. Brumby, 663 F.3d 1312 (11th Cir. 2011) (recognizing that discrimination against a transgender plaintiff constituted unconstitutional sex stereotyping under the Equal Protection Clause); Smith v. City of Salem, 378 F.3d 566 (6th Cir. 2004) (recognizing Title VII discrimination claim for transgender plaintiff on sex stereotyping theory); Schwenk v. Hartford, 204 F.3d 1187 (9th Cir. 2000) (recognizing gender-motivated violence claim of transgender plaintiff on a sex stereotyping theory). But see Ulane v. E. Airlines, Inc., 742 F.2d 1081 (7th Cir. 1984) (denying a transgender plaintiff relief); Holloway v. Arthur Andersen & Co., 566 F.2d 659 (9th Cir. 1977) (denying a transgender plaintiff relief).
73. Order, supra note 28, at 10.
individuals with a prostate and without a uterus, but rather bars care exclusion for transmen with a uterus. If a care provider refuses to provide gynecological care to a hypothetical transman with a uterus because of his gender identity, of course that care provider has discriminated. Judge O'Connor's central extralegal mistake is thinking of our hypothetical transman as a "biological woman" and thus failing to see how specialty services "for women" could exclude anyone with a uterus. Although this is inaccurate and cruel, it is irrelevant. Rather, Judge O'Connor commits a mistake in legal reasoning when he reads Price Waterhouse as barring disparate treatment merely between "biological men" and "biological women" resulting from sex stereotypes instead of seeing how antidiscrimination law bars disparate treatment among men and among women. It does not matter if the discriminator views our hypothetical transman as a man or woman; the moment of illegal discrimination is when the discriminator discriminates on the basis of his nonconformity with stereotypes of how a man or woman is supposed to act. Thus, even if a clinic views our hypothetical transman as "a woman," that clinic has discriminated if it denies gynecological care to him on the basis of his nonconformity with what a woman should be like, namely his gender identity and presentation. As a result, the Rule does not bar medical services typically associated with one sex (e.g., gynecology), but rather bars the denial of care provision because the patient does not look or act like the discriminator expects.

Moreover, the court conceives of gender identity as a category separate from sex, much in the same way that the defendants in General Electric Co. v. Gilbert argued that discrimination on the basis of "pregnancy" was not actionable sex discrimination. However, the Franciscan Alliance plaintiffs and the Gilbert defendants are incorrect in the same way—namely, failing to appreciate the obvious relationship between sex and gender identity, and sex and pregnancy. Illustrating this clear relationship, well-respected medical groups confirm that transition-related care is medically necessary, precisely because the conflict among a person's internal sense of gender, physical body, and the expected social roles of their sex assigned at birth can cause significant distress.

74. 45 C.F.R. § 92.206 ("[A] covered entity shall treat individuals consistent with their gender identity, except that a covered entity may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.").

75. Unless of course the discriminator fails to treat the individual consistently with their gender identity, see 42 CFR § 92.206, or creates a hostile care environment by misgendering the patient, see infra Section IV(d).


77. See Coleman v. Maryland Court of Appeals, 132 S. Ct. 1327, 1344 (2012) (Ginsburg, J., dissenting) ("First, as an abstract statement, it is simply false that a classification based on pregnancy is gender-neutral."") (internal quotations and citations omitted).

In other words, sex discrimination against transgender people impedes medical wellness, which is why the American Medical Association “supports public and private health insurance coverage for treatment of gender identity disorder,”\textsuperscript{79} and the American Psychiatric Association “[a]dvocates for removal of barriers to care and supports both public and private health insurance coverage for gender transition treatment.”\textsuperscript{80}

Second, the order is deficient in its vision of what constitutes religious liberty and medical standards of care. The private plaintiffs do “not believe that transition-related procedures are ever in the best interests of [] patients and providing or covering any transition-related service would violate their deeply held religious beliefs.”\textsuperscript{81} Thus, the private plaintiffs argue that the Rule violates not only their sincerely held religious beliefs but also their medical duties. In addition, the state plaintiffs seek to set aside the Rule because the regulation “undermines the longstanding sovereign power of the States to . . . ensure appropriate standards of medical judgment” and forces a doctor to provide care “even if a doctor believes such procedures are harmful to the patient.”\textsuperscript{82}

Of course, what constitutes the standard of care is a commonly litigated question in healthcare law. Although a physician must “meet the standard of skill possessed generally by others practicing in his field under similar circumstances,”\textsuperscript{83} common practice “strictly . . . is never its measure” because “a whole calling may have unduly lagged in the adoption of new and available” practices.\textsuperscript{84} Thus the appropriate standard of care for a patient is generally a question to be determined in each case, with the reasonable ordinary physician serving as the guidepost. As a result, a physician may give her medical opinion

\textsuperscript{(comparing European and American approaches to “medical necessity” of transition-related care). Should the courts find that sex discrimination prohibitions only apply to cisgender people, Congress could overturn the interpretation by legislating that sex discrimination includes discrimination on the basis of gender identity.}


\textsuperscript{80.} Press Release, Transgender L. Ctr., APA Releases Official Positions Supporting Access to Care and the Rights of Transgender and Gender Variant Persons (Aug. 17, 2012), http://transgenderlawcenter.org/archives/1717. Some federal courts have also recognized that gender-appropriate transition care is medically necessary. See Kosilek v. Spencer, 774 F.3d 63, 96 (1st Cir. 2014) (en bane) (indicating that a total denial of gender-appropriate transition care could fall below “society’s minimum standards of decency”); Fields v. Smith, 653 F.3d 550 (7th Cir. 2011) (striking down a ban on transition-related care for prisoners on Equal Protection grounds).

\textsuperscript{81.} Order, supra note 28, at 9 (quoting Complaint, supra note 53, at 37-38).

\textsuperscript{82.} Complaint, supra note 53, at 3.

\textsuperscript{83.} McCourt v. Abernathy, 457 S.E.2d 603, 607 (S.C. 1995); see also Johnston v. St. Francis Med. Ctr., 35-236 (La. App. 2 Cir. 10/31/01) (“A physician is not held to a standard of absolute precision; rather his conduct and judgment are evaluated in terms of reasonableness under the circumstances existing when his professional judgment was exercised.”); Hall v. Hilburn, 466 So. 2d 856 (Miss. 1985) (“[W]hen a physician undertakes to treat a patient, he takes on an obligation enforceable at law to use minimally sound medical judgment and render minimally competent care in the course of services he provides.”).

\textsuperscript{84.} The T.J. Hooper v. N. Barge Corp., 60 F.2d 737, 740 (2d Cir.) (Hand, J.), cert. denied, 287 U.S. 662 (1932).
to a patient, and still violate tort law, if her medical opinion is not in line with the established standard of care. In a similar fashion, the categorical denial of all transition-related care for every patient in every circumstance likely constitutes discrimination as a matter of law if the physician makes that harmfulness determination based on non-medical factors, such as an opinion regarding transition, even if sincerely held.

Moreover, this categorical exclusion based on non-medical factors raises a significant and dangerous *Palmore* problem of secondary discrimination. In *Palmore v. Sidoti*, a Florida family court judge awarded child custody in a divorce action to the child’s white father, instead of the child’s white mother, who had begun cohabitating with a black man.\(^85\) The family court judge made this custody determination not based on his own prejudice, but rather by noting that under the purportedly neutral best interests of the child standard, the child would suffer social stigma from living in an interracial household. The Supreme Court unanimously reversed the family court judge, noting that the Equal Protection Clause prohibits a court from “giv[ing] ... effect” to private biases.\(^86\)

In a similar fashion, antidiscrimination law bars secondary discrimination, wherein the discriminator points not to his own bias, but rather to a purportedly neutral alternative standard, such as the preference of a third party. For example, an airline cannot fire stewardesses when they marry and avoid liability by stating that it has no prejudice, but rather that customers prefer stewardesses to appear sexually available.\(^87\)

Just as the Florida family court judge could not incorporate private biases into the neutral best interests of the child standard and an airline could not avoid liability by pointing to customer preference, a medical institution cannot *ipso facto* incorporate private biases into science-based medical determinations. If the provider refuses to perform a legal duty to provide medical care according to established professional standards because of private biases, that provider has acted illegally. By arguing that a discriminator may justify its discrimination based on neutral principles of medical judgment, which in actuality are a cover for its own private biases, the plaintiff’s argument opens a loophole in antidiscrimination law big enough to swallow most liability.

A provider cannot state the magic words “in our professional judgment” and hope to avoid liability if it has not in actuality based that opinion on sound medical principles, which overwhelmingly support care in accordance with a transgender patient’s true gender and sense of self.\(^88\) Of course, this principle

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\(^86\) *Id.* at 433.

\(^87\) *Diaz v. Pan Am. World Airways, Inc.*, 442 F.2d 385 (5th Cir. 1971) (applying Title VII and rejecting the airline’s contention that it rejected male applicants because of customers’ ostensible gender preferences).

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does not mean that every transition-related medical procedure must be provided to every patient seeking it, but rather that an institution must provide care in accordance with sound medical judgment in line with professional standards of care—just as with all medicine. If a white storeowner can refuse to hire an African-American clerk and evade employment discrimination law by citing not his own biases, but rather customer preference or the tenets of his religion, then every discriminator will use that loophole. Although the plaintiffs attempt to mimic the argument raised in *Hobby Lobby* by arguing that that federal law bars mandatory care provision violating their sincerely held religious beliefs, such an argument presents a severe and fundamental challenge to antidiscrimination law as a whole by opening an avenue for secondary discrimination, and courts should pause before giving it effect.

Finally, the complaint makes a passionate argument on federalism grounds, asserting that the rule "exposes the States to litigation by its employees and patients, despite the fact that neither Congress nor the States expressed any interest to waive the States' sovereign immunity in this area." However, the ACA explicitly incorporates Title IX's enforcement remedies, and so the ACA likely abrogates state immunity, ordinarily protected by the Eleventh Amendment in suits by the federal government and private plaintiffs. The abrogation incorporated into the Affordable Care Act is unambiguous: Congress imposed conditions on states receiving federal funds under Title IX and the Affordable Care Act, and, by abrogating states' Eleventh Amendment sovereign immunity, Congress put states on notice that accepting federal funds waived their constitutional immunity to discrimination suits.

Further, this waiver of Eleventh Amendment immunity to discrimination suits is valid under the Spending Clause of Article I and Section 5 of the Fourteenth Amendment's

89. *Burwell v. Hobby Lobby Stores, Inc. (Hobby Lobby)*, 134 S. Ct. 2751, 2764-67 (2014) (holding that HHS regulation imposing mandatory contraception coverage is illegal under RFRA as applied to closely held corporations).


93. *See Seminole Tribe of Fla. v. Florida*, 517 U.S. 44, 65, 72-73 (1996) (holding that, without a waiver of immunity, Congress cannot abrogate states' Eleventh Amendment sovereign immunity when it legislates pursuant to Article I); Fitzpatrick v. Bitzer, 427 U.S. 445, 456 (1976) (holding that Congress can abrogate states' Eleventh Amendment sovereign immunity when it legislates pursuant to Section 5 of the Fourteenth Amendment, regardless of waiver of immunity); *see also* *Title IX Legal Manual*, U.S. DEP’T JUST., at VIII(D), https://www.justice.gov/crt/title-ix#D (stating the Department of Justice’s position that states have waived Eleventh Amendment immunity under Title IX).
authorization of Congress to enact “appropriate legislation” to enforce the Equal Protection Clause. 94

The state plaintiffs also argue that the Rule “undermines the longstanding sovereign power of the States to . . . ensure appropriate standards of medical judgment,” and thus violates federalism principles. 95 The federal system does generally delegate the regulation of medical professions to the states. 96 However, the Rule does not regulate standards of care; rather, it simply states that care providers cannot deviate from established standards of care because a patient has a characteristic protected by section 1557. Thus the Rule differs categorically from a situation like that giving rise to the case Gonzales v. Oregon, in which the federal government impermissibly changed a medical standard of care by fiat. 97

IV. LEGAL THEORIES OF HEALTHCARE DISCRIMINATION

Although the ACA states that “an individual shall not, on the basis of any ground prohibited under [Title VI, Title IX, the Age Discrimination Act, or Section 504], be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance,” the Act does not define what constitutes discrimination. 98 As a result, regulators and advocates will need to construct cognizable theories of discrimination. The question of what exactly could constitute discrimination or participation exclusion in healthcare, an inherently technically complex and individualized field, poses a further problem for antidiscrimination law. Without such legal theorizing by regulators, attorneys, and commentators, courts often struggle to identify the boundaries of existing antidiscrimination law; for example, in Minnesota in 2001, two courts interpreting the state’s transgender-inclusive Human Rights Act came to different conclusions on such a basic issue as the ability of employees to use an on-site bathroom. 99

94. U.S. CONST. art. I, § 8; U.S. CONST. amend. XIV, § 5; see also Melanie Hochberg, Protecting Students Against Peer Sexual Harassment: Congress’s Constitutional Powers to Pass Title IX, 74 N.Y.U. L. REV. 235 (1999) (arguing that Title IX was passed pursuant to both the Spending Clause and the Fourteenth Amendment).

95. Complaint, supra note 53, at 3.

96. See, e.g., Gonzales v. Oregon, 546 U.S. 243, 270 (2006) (“The structure and limitations of federalism . . . allow the states great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons.” (internal citations omitted)); Watson v. Maryland, 218 U.S. 173, 176 (1910) (“The police power of the States extends to the regulation of certain trades and callings, particularly those which closely concern the public health.”).

97. Gonzales, 546 U.S. 243 (striking down on statutory grounds the Attorney General’s interpretation of the Controlled Substances Act as barring physician-assisted suicide, thus effectively barring the Oregon Death with Dignity Act).


This Section theorizes how antidiscrimination advocates can take the ACA into court. First, I show that section 1557 authorizes lawsuits to remedy discrimination against private parties. Next, I articulate three theories of discrimination cognizable under the ACA, using existing antidiscrimination jurisprudence as a guide.

A. Section 1557’s Implied Cause of Action

Title IX precedents strongly suggest that a private cause of action exists under the ACA, and at least one district court has agreed. The implementing final rule also authorizes a private right of action in line with existing federal civil rights laws.

In determining whether a private right of action exists, courts look first to a plain reading of the statute, searching for evidence of congressional intent that “the statute manifests an intent ‘to create not just a private right but also a private remedy.’” The plain language of section 1557 states that the “enforcement mechanisms provided for and available under . . . title IX . . . shall apply for purposes of violations of” section 1557. The Supreme Court has held that Title IX is phrased “with an unmistakable focus on the benefited class,” thus implying a cause of action. Therefore, because the language of section 1557 includes the same kind of “rights-creating language” that is present in the enforcement mechanisms of Title IX, those private rights of action are carried over into the ACA.

Critics may argue that Alexander v. Sandoval, which held that Title VI did not authorize a private right of action to enforce disparate-impact regulations because it authorized other alternative mechanisms, cuts against a private right of action under section 1557, because the ACA also authorizes alternative mechanisms of civil rights enforcement. However, congressional intent in section 1557 appears to be very clear—to adopt the rights and remedies of the antecedent antidiscrimination statutes, including Title IX. Further, when

721 (Minn. 2001) (holding that a company policy preventing transgender people from using gender-appropriate bathrooms was not illegal discrimination based on sexual orientation).

100. Rumble v. Fairview Health Servs., No. 14-CV-2037, 2015 WL 1197415, at *11 (D. Minn. Mar. 16, 2015) (“Congress intended [in the ACA] to create a new, health-specific, antidiscrimination cause of action that is subject to a singular standard, regardless of a plaintiff’s protected class status.”)

101. 45 C.F.R. § 92.302(d) (2016) (“An individual or entity may bring a civil action to challenge a violation of Section 1557 or this part in a United States District Court in which the recipient or State-based Marketplace is found or transacts business.”).


106. See id. at 290 (“The express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others.”).
Congress enacted the antecedent civil rights statutes referenced in the statute, it envisioned both public and private enforcement.\textsuperscript{107} Congress re-enacted language interpreted by the Court to be rights-creating, a fact the Court has noted confers private causes of action.\textsuperscript{108} In oft-quoted language, the Court found that a plaintiff in a civil rights action was seen to act "not for himself alone but also as a 'private attorney general,' vindicating a policy that Congress considered of the highest priority."\textsuperscript{109}

Hence, the congressional re-enactment of Title IX's language in the ACA indicates legislative intent to adopt an implied cause of action into the ACA for sex discrimination claims.\textsuperscript{110} Congress\textsuperscript{111} and the courts\textsuperscript{112} broadly construe re-enactment of "enforcement mechanisms" to include both administrative remedies, such as the Office of Civil Rights' complaint-and-investigation system, as well as private litigation.\textsuperscript{113} Although the Office of Civil Rights (OCR) at HHS has already responded to complaints of sex discrimination under a gender identity theory,\textsuperscript{114} OCR's small budget and staff cannot possibly take on the mighty task of effectuating congressional policy to eradicate sex discrimination in the healthcare system.

Having established that section 1557 authorizes a private cause of action to remedy illegal discrimination in the courts, the next three sections focus on cognizable theories of discrimination in the healthcare context.

\textsuperscript{107} See, e.g., Drew S. Days III, "Feedback Loop": The Civil Rights Act of 1964 and Its Progeny, 49 ST. LOUIS U. L.J. 981, 1000 (2005) ("Congress envisioned... a 'public-private nexus' in which some combination of federal administrative action, suits by the Department of Justice or the Equal Employment Opportunity Commission, and litigation initiated by private parties would make for a most effective combination of enforcement mechanisms.").

\textsuperscript{108} Alexander, 532 U.S. at 288 (interpreting congressional re-enactment of rights-creating language in an initial statute to be relevant to the question of rights-creating language in a subsequent statute).


\textsuperscript{110} See WILLIAM M. ESKRIDGE, JR. ET AL., CASES AND MATERIALS ON LEGISLATION: STATUTES AND THE CREATION OF PUBLIC POLICY 1042 (4th ed. 2007) ("The Court should generally be reluctant to imply causes of action to enforce federal statutes, but not when Congress has relied on that understanding in subsequent legislation." (citing Franklin v. Gwinnett Cty. Pub. Sch., 503 U.S. 60, 77-78 (1992) (Scalia, J., concurring in the judgment)); see also Three Rivers Ctr. for Indep. Living, Inc. v. Hous. Auth. of Pittsburgh, 382 F.3d 412, 425 (3d Cir. 2004) ("Where, as here, Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the interpretation given to the incorporated law, at least insofar as it affects the new statute." (quoting Lorillard v. Pons, 434 U.S. 575, 580-81 (1978))).

\textsuperscript{111} See, e.g., 19 U.S.C. § 3802(b)(4)(A)(v) (2012) (expressing congressional intent to establish "accessible, expeditious, and effective civil, administrative, and criminal enforcement mechanisms").

\textsuperscript{112} See, e.g., Suter v. Artist M., 503 U.S. 347, 360 (1992) (analyzing "enforcement mechanisms" under the Adoption Act, which includes a private right of action and gives the Secretary of Health and Human Services authority to punish non-compliant recipients).

\textsuperscript{113} See, e.g., Sindram v. Fox, 374 Fed. App'x 302, 305 (3d Cir. 2010) ("The ADA's enforcement mechanism includes federal agency oversight and [implies] a private cause of action for injunctive relief... ").

B. Denial of Care

Explicit denial of care to a patient on the basis of gender identity is the most obvious theory of illegal discrimination under the ACA, as the Rule explicitly states. The Rule foresees this sort of discrimination and bars it, mandating that covered entities "treat individuals consistent with their gender identity," and requiring that covered entities not "[h]ave or implement a categorical coverage exclusion or limitation for all health services related to gender transition," or "[o]therwise 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 if such denial, limitation, or restriction results in discrimination against a transgender individual." Federal courts have only recently had the opportunity to interpret the Rule, as few cases have been filed alleging discrimination on this theory. However, outright refusal of care would most likely qualify as discrimination via exclusion from a health program or activity in the same way that refusing to admit a woman to medical school solely because she is a woman constitutes exclusion from participation on the basis of sex. This theory would apply to famous cases like that of Tyra Hunter, a transgender woman who died after being injured in a car accident because she was refused emergency medical care while lying in a pool of her own blood.

However, denial of care may also occur in disparate treatment cases in which transgender individuals are provided inferior or delayed care because of their transgender status. One such case, Rumble v. Fairview Health Services, is currently in litigation. In Rumble, the plaintiff alleges that his care provider provided delayed care and a hostile and embarrassing medical exam, and outed him as a transgender man. In denying the defendant’s motion for dismissal, the district court adopted such a disparate treatment theory of discrimination, finding that "these facts demonstrate that the alleged mistreatment rises to the level of the denial of benefits of appropriate medical care."

115. 45 C.F.R. § 92.206 (2016) (providing that a covered entity "shall provide individuals equal access to its health programs or activities without discrimination on the basis of sex").
116. Id.
117. 45 C.F.R. § 92.207(b)-4 and (b)-5 (2016).
Of course, denial of care can be systemic as well as individualized. For example, insurance policies that exclude medically appropriate care related to transition constitute discrimination.\(^1\) As a result, many health insurance companies have lifted prohibitions on paying for transition-related care, including government-run insurance regimes like Medicare.\(^2\) However, some health plans continue to exclude transition-related care, and the ACLU recently filed a case, Robinson v. Dignity Health, seeking redress for a health system’s categorical exclusion of transition-related care.\(^3\)

C. Anti-Stereotyping and Constructive Denial of Care

In contrast to an explicit denial-of-care claim, a care provider may constructively deny care to a patient by applying inappropriate standards of care. This sort of claim finds its home in sex discrimination law’s anti-stereotyping theory.\(^4\)

For example, when a transgender woman begins hormone replacement therapy, any sudden disruption of that regimen can have dire medical consequences. Imagine a clinic that refuses to give our fictional patient feminine hormones, and instead provides her with “appropriate” levels of male hormones that match her male-assigned body. Our fictional clinic may cite medical standards of care of endocrinology indicating that female hormones in high levels are inappropriate for a male-assigned body.

Our fictional plaintiff has a claim for discrimination against the clinic under a sex stereotyping theory. The Supreme Court has long recognized that impermissible sex stereotyping constitutes sex discrimination, that generalizations about “‘the way women are,’ estimates of what is appropriate for most women, no longer justify denying opportunity to women whose talent and capacity place them outside the average description.” Congress was motivated by similar concerns in enacting antidiscrimination laws on the basis of sex: “in forbidding employers to discriminate against individuals because of sex, Congress intended to strike at the entire spectrum of disparate treatment between women and men resulting from sex stereotypes.” Under the anti-sex stereotyping theory, civil rights law disapproves policies that seek to tell

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123. See 45 C.F.R. § 92.207(b)(5) (2016) (“[A] covered entity shall not . . . 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 if such denial, limitation, or restriction results in discrimination against a transgender individual.”).


126. In addition to individual discrimination claims, anti-transgender discrimination as a whole can be categorically conceptualized as sex discrimination under a sex-stereotyping theory. See supra Part III.


individuals how their gender "should act" or "should look," even if based on purportedly "benign" stereotypes. The anti-stereotyping component of illegal sex discrimination not only protects against disparate treatment between men and women, but also among men and among women. Congress aims to eradicate illegal sex discrimination by preventing powerful institutions (including employers, educational facilities, and medical clinics) from pushing those in their charge (workers, students, patients) into stereotypical notions of what it means to be a man or a woman. So, a male individual who is "harassed because he [does] not conform to [his employer's] vision of how a man should look, speak, and act" is the victim of illegal sex discrimination, not because he is male, but because of the sort of male he is or appears to be.

So, although there is nothing per se illegal about the publication of sex-appropriate hormonal standards of care, our fictional clinic has applied these standards inappropriately in order to force our fictional patient into stereotypical notions of what a "real" female body does or does not look like. Our hypothetical is largely drawn from a test case, Taylor v. Lystila, that was dismissed when the plaintiff passed away. In the complaint, the plaintiff, Naya Grace Taylor, a transgender woman, alleged that her primary care physician, Dr. Aja Lystila, "consistently refused to provide Naya any transition-related care." Dr. Lystila refused to supervise hormonal treatment for Taylor, claiming a lack of experience in transition-related care, even though the clinic regularly supervises hormonal care for cisgender patients. Eventually, the clinic claimed that it did "not have to treat 'people like you,'" because of religious beliefs held by employees of the clinic. The clinic further refused to provide a "bridging" prescription to allow Taylor to find another suitable clinic, creating additional medical problems.

The complaint opens by referencing the standards of care the plaintiff considers to be appropriate. This is not a minor point. Rather, noting what the patient considers appropriate is very important because it allows us to see the sort of illegal sex stereotyping that lies at the heart of the alleged discrimination. So, although Taylor does not use the words "sex stereotyping," her complaint looks to standards for transgender patients promulgated by the World Professional Association for Transgender Health (WPATH), and not, for example, cisgender-specific standards published by the American College of

129. See Frontiero v. Richardson, 411 U.S. 677, 684 (1973) ("Traditionally, such discrimination was rationalized by an attitude of 'romantic paternalism' which, in practical effect, put women, not on a pedestal, but in a cage.").


132. Id. at ¶ 31.

133. Id. at ¶¶ 24, 27, 33.

134. Id. at ¶ 25.

135. Id. at ¶ 19.
This indicates an emphasis on care in accordance with her gender identity, a medical aim that a reasonable physician would likely seek, after consultation with Taylor about her health. So, although the ACE might promulgate standards of care indicating that intense hormone therapy is inappropriate for a cisgender patient, WPATH’s standards for transition-related care are likely more medically appropriate for a transgender patient undergoing transition. Thus, Taylor essentially alleges that her care providers committed illegal sex discrimination by forcing her into accepting a hormone regimen to make her body more stereotypically male, and refusing her care that would align better with her actual gender. As a result, the clinic has violated a legal duty by relying on personal opinions regarding gender instead of making a professional judgment based on sound medical principles.

The Final Rule prohibits this kind of discrimination, noting that

a covered entity shall not . . . deny or limit . . . health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual’s sex assigned at birth, gender identity, or gender otherwise recorded in a medical record or a health insurance plan is different from the one to which such health services are ordinarily or exclusively available. 137

This provision of the Rule bars the sort of discrimination that Taylor experienced by preventing the use of gender-inappropriate standards.

D. Hostile Care Environment

Just as racial or sexual harassment in educational and employment environments constitutes illegal discrimination, a hostile care environment for transgender patients constitutes cognizable discrimination under the ACA. 138 Although the final rule does not include an explicit harassment provision, HHS notes that “OCR interprets the final rule to prohibit all forms of unlawful harassment based on a protected characteristic.” 139 Much in the same way that “it is precisely because the supervisor is understood to be clothed with the employer’s authority that he is able to impose unwelcome sexual conduct on subordinates,” 140 a care provider is not only charged with administering care, but

136. However, endocrinology organizations are increasingly publishing standards on transgender care. See Wylie C. Hembree et al., Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline, 94 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3132, 3134 (2009) (defining and discussing “gender dysphoria”).

137. 45 C.F.R. § 92.206 (2016).


also with a larger duty to provide a safe environment where appropriate care can be administered. Under Title VII,\textsuperscript{141} "discriminatory intimidation, ridicule, and insult that is ‘sufficiently severe or pervasive to alter the conditions of the victim’s employment and create an abusive working environment’" constitutes illegal discrimination.\textsuperscript{142} Similarly, Title IX bars hostile environments that are "sufficiently serious that [they] interfere[] with or limit[] a student’s ability to participate in or benefit from [a] school’s program[s]."\textsuperscript{143} The similarity between the standards under Titles IX and VII reflects antidiscrimination law’s concern that educational institutions and employers have a large degree of power over students and employees respectively, and that the market does not do a particularly good job of punishing bad behavior in those contexts.

Analogizing from these standards, the ACA bars sufficiently severe or pervasive harassment that disrupts or undermines a person’s ability to participate in care provision,\textsuperscript{144} or to receive any benefits, services, or care by a medical institution. Such a standard "requires neither asexuality nor androgyny" in the care environment, nor does it “expand” section 1557 “into a general civility code"\textsuperscript{145} requiring the highest standards of politeness or oft-maligned “safe spaces.” Rather, illegal harassing conduct creates a hostile environment only if “the conduct is sufficiently serious to interfere with or limit an individual’s ability to participate in or benefit from a program.”\textsuperscript{146} Such a standard “cannot be . . . a mathematically precise test.”\textsuperscript{147} Rather, a court determines “whether an environment is ‘hostile’ or ‘abusive’ . . . only by looking at all the circumstances,” including “the frequency of the discriminatory conduct; its severity; whether it is physically threatening or humiliating, or a mere offensive utterance; and whether it unreasonably interferes with” care provision.\textsuperscript{148} Care providers can subject transgender patients to a hostile environment through slurs and offensive remarks, or through "inappropriate name or pronoun use, invasive inquiries about . . . genitalia, or transgender status, denial of access to the restroom or housing facility . . . use of epithets, and/or hostile or intimidating.

\textsuperscript{141} Title IX very often follows Title VII litigation, and thus so does section 1557. See supra note 28.
\textsuperscript{142} Harris v. Forklift Systems, Inc., 510 U.S. 17, 21 (1993) (quoting Meritor Savings Bank, FSB v. Vinson 477, U.S. 57, 65 (1986)); see also 29 C.F.R. § 1604.11(a) (2016) (explaining that a hostile environment occurs if “submission to such conduct is made . . . a term or condition of an individual’s employment”).
\textsuperscript{144} See 81 Fed. Reg. 31376, 31406 (May 18, 2016) (“[H]arassing conduct creates a hostile environment if the conduct is sufficiently serious to interfere with or limit an individual’s ability to participate in or benefit from a program.”).
\textsuperscript{147} Harris, 510 U.S. at 22.
\textsuperscript{148} Id. at 23.
behavior."  

Discrimination can also occur in the processes that precede actual care provision, as when transgender patients are "forced to revert to the gender [they] were assigned at birth in order to access healthcare, or hav[e] a dentist . . . ask questions about [their] genitals." Systematic harassment of transgender patients through inappropriate gender pronoun use or social isolation in the care environment on the basis of gender identity can also constitute a hostile care environment.

The district court in Rumble v. Fairview adopted a similar line of reasoning. Mr. Rumble alleged that he encountered a medical environment that made him "not feel safe" to the point that he "preferred to leave." Rumble alleges the hostility began when his treating physician asked Rumble "hostile . . . questions . . . [in] an attempt to embarrass" him, and also performed a painful physical examination of his genitals, even after Rumble twice cried out for him to stop. The plaintiff also alleges that Dr. Steinman made comments that "were . . . indirect, offensive references to the Plaintiff's gender identity." Upon receiving his healthcare bill, the plaintiff noticed that it stated "DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER." Rumble alleges that this environment "denied [him] the full and equal enjoyment of an individual seeking professional and humane medical care from an emergency room physician." Such a standard is not a bare minimum, but rather depends on the context in which the harassment occurred: "[w]hether gender-oriented conduct rises to the level of actionable 'harassment' . . . depends on a constellation of surrounding circumstances, expectations, and relationships."

Further, Title IX—and thus the Affordable Care Act—adopts different standards of liability depending on whether the harasser is an agent of the institution. Thus, in Gebser v. Lago Vista, the Supreme Court held that a plaintiff may not receive monetary damages from a school board that employed a teacher unless the district "has actual notice of, and is deliberately indifferent to, the

150. Id.
154. Id. at 8-9.
156. Id. at *18.
157. Id. at *19.
158. Id. at *16 (quoting Davis ex rel. LaShonda D. v. Monroe Cty. Bd. of Educ., 526 U.S. 629, 651 (1999) (internal quotation omitted)).
teacher's misconduct. The district may be notified if an "appropriate person" or "an official who at a minimum has authority to address the alleged discrimination and to institute corrective measures on the recipient's behalf... fails adequately to respond." In contrast, Title IX imposes a higher hurdle to liability for student-on-student harassment. In Davis v. Monroe County Board of Education, the Supreme Court held that liability could attach to a district based on student-on-student harassment only if the district "acts with deliberate indifference to known acts of harassment in its programs or activities," the "harassment... is so severe, pervasive, and objectively offensive that it effectively bars the victim's access to an educational opportunity or benefit," and the district has "substantial control over both the harassment and the context in which the harassment occurs."

In the healthcare context, a distinction similar to that between teacher and fellow student is appropriate. For example, the same underlying policy considerations apply to harassment of a student by a teacher as to harassment of a patient by any agent of a clinic. Thus, although a clinical secretary may not be providing what we normally think of as healthcare, any agent of the clinic is able to deny the benefits of, or participation in, care provision through discrimination. On the other hand, a hostile care environment promulgated by non-agents of the clinic, such as fellow patients, aligns more closely with the Title IX standard for student-on-student harassment because, although fellow patients are not able to make substantive care decisions, they are able to create a hostile environment that may effectively interfere with the benefits of care provision. In contrast, because agents of the clinic serve as leaders of the care environment, they have greater responsibility for ensuring that the clinical setting is discrimination-free.

In Rumble, the court determined that the plaintiff had plausibly alleged Davis liability against the clinic for discrimination by an independent contractor employed by the clinic, because

(1) [the doctor's] actions effectively barred Rumble's access to reasonable, non-harassing medical care; (2) an appropriate person at [the hospital] knew of [the doctor's] discriminatory acts; (3) [the hospital] official acted with deliberate indifference to the discrimination; and (4) [the hospital] had substantial control over [the doctor] and the emergency room.

160. Id. at 290.
161. Davis, 526 U.S. at 630, 633.
162. Id. (holding that school boards may be liable under Title IX for failing to stop student-on-student harassment under certain circumstances).
Because many American clinics have independently contracted care providers, hostile care environment suits will likely center on this standard of liability for plaintiffs seeking monetary damages.

Education litigation surrounding transgender students offers additional theories of section 1557 discrimination by analogy. These suits largely center around students’ ability to access gendered spaces, such as locker rooms, or to access certain gender-based activities, such as sports teams. For example, in a landmark ruling, the Maine Supreme Court announced that the denial of access to gender-appropriate spaces for a transgender student violated the Maine Human Rights Act. In a similar fashion, Title IX has increasingly begun to require equal access to gender-exclusive programs, like sports teams, and NCAA guidelines—although not binding—have begun to allow transgender student-athletes to participate if certain qualifications are met. Courts have also granted relief on First Amendment grounds to transgender students asserting the right to wear gender-appropriate clothing. Hospitals, like schools, may violate antidiscrimination provisions by denying transgender patients access to gender-appropriate spaces, including bathrooms, by refusing to provide transgender people gender-specific care like gynecology or urology, or by restricting the clothing transgender individuals may wear.

Educational institutions, especially colleges and universities, have a special duty to protect students from sexual assault under Title IX as well. In fact, the Department of Education has issued guidance to educational institutions on the


169. See supra Part III.

170. Although the First Amendment theory of liability does not apply to private clinics, restricting gender-appropriate clothing still may constitute harassment.

subject of protecting transgender individuals from sexual violence. Clinics, as sites of vulnerable patients, could theoretically incur similar liability for sex discrimination through a failure-to-protect theory of sexual violence.

CONCLUSION

Although section 1557 is a welcome addition to antidiscrimination law, much work has yet to be done to articulate what constitutes “discrimination” in the healthcare context more broadly, as well as against transgender individuals more narrowly. However, as courts, lawmakers, and regulators come to envision anti-transgender discrimination as a form of sex discrimination, the ACA offers fertile ground for advocates to curb discrimination in our nation’s healthcare system.