ASIAN AMERICANS ADVANCING JUSTICE LOS ANGELES

August 13, 2019

Mr. Roger Severino
Director, Office of Civil Rights
U.S. Department of Health and Human Services
Hubert A. Humphrey Building, Room 509F
200 Independence Avenue, SW
Washington, D.C. 20201

RE: 1557 NPRM, RIN Number 0945-AA11, Nondiscrimination in Health and Health Education Programs or Activities

Dear Director Severino:

On behalf of Asian Americans Advancing Justice (Advancing Justice), I am submitting these comments in response to the U.S. Department of Health and Human Services' (HHS) Notice of Proposed Rulemaking (NPRM) regarding Nondiscrimination in Health and Health Education Programs or Activities, RIN Number 0945-AA11, regarding Section 1557 of the Patient Protection and Affordable Care Act (ACA) ("Section 1557"). Advancing Justice is a national affiliation of five independent nonprofit organizations dedicated to serving our nation's most rapidly growing racial minority community, Asian Americans, Native Hawaiians and Pacific Islanders (AANHPIs), and to building a more powerful voice for our communities. The Advancing Justice affiliation is comprised of our nation's oldest Asian American legal advocacy center located in San Francisco (Advancing Justice – Asian Law Caucus); our nation's largest Asian American civil rights, legal services and advocacy service organization located in Los Angeles (Advancing Justice – Los Angeles); the largest national Asian American policy advocacy organization located in Washington, D.C. (Advancing Justice | AAJC); the leading Midwest Asian American advocacy organization (Advancing Justice | Chicago); and the Atlanta-based Asian American advocacy organization that serves one of the largest and most rapidly growing Asian American communities in the South (Advancing Justice – Atlanta). Together, Advancing Justice has been working to increase visibility for Asian American and Pacific Islander immigrants by expanding federal immigration policies that promote family unification, integration and naturalization, ensuring an accurate reflection of AANHPIs in the 2020 census, and addressing language access barriers on behalf of our communities.

Further, Advancing Justice-LA's Health Access Project (HAP) coordinates the Health Justice Network (HJN), a statewide collaborative comprised of close to 60 community-based organizations and health care providers, which implements health care reform in California. HAP seeks to address the health care needs of AANHPI communities, to

ensure culturally and linguistically competent health care services to patients, and to increase access to affordable, quality health care for AANHPIs through outreach, education, and advocacy. As strong supporters of the ACA since its inception, Advancing Justice-LA's HJN have: 1) reached and educated over 2 million community members about the ACA and available health care programs; 2) enrolled or renewed close to 9800 consumers into Covered California, California's state marketplace; 3) assisted enrollment and renewal for close to 33,000 community members in Medi-Cal, California's Medicaid program; 4) assisted enrollments for over 22,000 individuals into county health programs; 5) assisted over 1,400 individuals with accessing oral health services; 6) assisted over 1,900 individuals with accessing behavioral health services; 7) provided case management for over 38,000 community members; and 8) educated and assisted over 5,500 community members with voter registration. Advancing Justice also recognizes that a large portion of the community we serve are part of the LGBTQ+ community, persons with disabilities or chronic diseases, and persons needing reproductive health services. Our comments are based upon our on-the-ground experience implementing the ACA in California.

Advancing Justice strongly opposes the NPRM provisions which seek to eliminate vital civil rights protections and threaten access to care and coverage for limited-English Proficient (LEP) patients, LGBTQ+ individuals, and persons needing reproductive health services. Our comments focus on the NPRM's language access provisions to ensure that persons with LEP have meaningful access required by Title VI of the Civil Rights Act of 1964 (Title VI) and its regulation as guaranteed pursuant to Section 1557. As such, we oppose the proposed changes to the language access protections as proposed in the NPRM. Additionally, we oppose any other efforts to otherwise eliminate or roll back protections and provisions contained in the 2016 Nondiscrimination in Health Programs and Activities Final Rule (2016 Final Rule) as they apply to other protected classes, including LGBTQ+ persons, women, persons who need access to reproductive health services, and persons with disabilities or chronic conditions. Section 1557 addresses not only protections for each protected class covered, but also the intersection of those protections. As such, an attack on the civil rights of one group in the NPRM is an attack on the civil rights of all.

Our comments are focused on the following specific areas of the proposed rule:

1. Proposed Subpart A--General Provisions (45 C.F.R. §§ 92.1 - 92.3)
2. Proposed § 92.5 Enforcement mechanisms
3. Proposed § 92.101 Meaningful access for individuals with limited English proficiency
4. Proposed Repeal of In-Language Taglines (§§ 92.4 - 92.8)
5. Proposed Repeal of Notices of Nondiscrimination (§ 92.8; Appendix B to 45 C.F.R. Part 92)
6. Proposed Repeal of Language Access Plans (§ 92.201(b)(2))
7. Proposed Repeal of Video Interpretation Standards
8. Proposed Repeal of Section 1557's Definition of Sex Discrimination

9. Proposed Incorporation of Title IX Abortion and Religious Exemptions

Incorporation of Other Comments

National Health Law Program. We support the comments submitted by the National Health Law Program (NHeLP) addressing many of the proposed changes to the 2016 Final Rule, as well as additional opposition to proposed changes that have not been specifically included in our comments. NHeLP is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people.

Lambda Legal. We support the comments submitted by Lambda Legal addressing the lack of need for religious exemptions, legal basis for protections based on sexual orientation, and need for protections based on gender identity. Lambda Legal is a national organization committed to achieving full recognition of the civil rights of lesbians, gay men, bisexuals, transgender people and those with HIV through impact litigation, education and public policy work.

Asian & Pacific Islander American Health Forum. We support the comments submitted by the Asian & Pacific Islander American Health Forum limiting application of the law to certain covered entities, ingrotections for LGBTQ+ persons and persons needing reproductive health care, and rolling back and eliminating certain language access. APIAHF works to improve access to and the quality of care for communities who are predominantly immigrant and many of whom are limited English proficient (LEP).

I. The proposed rule weakens language assistance service protections for LEP individuals.

Language access in health care is just as critical now as when the Title VI of the Civil Rights Act was originally passed in 1964. Over 25 million Americans are LEP.[1] An estimated 19 million LEP adults are uninsured.[2] Even with the current 2016 Final Rule language access protections in place, 65.2 percent of LEP patients in California report having a hard time understanding their doctor.[3] We oppose the following proposals that unduly weaken current language access protections and harm LEP patients.

Language access in health care services and activities particularly impacts Asian Americans (AAs), Native Hawiians (NH) and Pacific Islanders (PI), given the population's demographics. AANHPIs represent the fastest growing communities in the United States[4] and similarly represent incredible diversity. AANHPIs trace their heritage to nearly 100 different ethnic groups and speak more than 250 different languages. Sixty-

[1] Asian & Pacific Islander American Health Forum Analysis of 2017 American Community Survey Data.
[2] Asian & Pacific Islander American Health Forum Analysis of 2017 American Community Survey
[3] UCLA Center for Health Policy Research, 2017 California Health Interview Survey
[4] Asian American Center for Advancing Justice, *A Community of Contrasts: Asian Americans in the United States: 2011*, Executive Summary (2011), https://www.advancingjustice-la.org/sites/default/files/ENTERED_Community_of_Contrasts_2011.pdf.

six percent of AAs speak a language other than English at home and twenty-nine percent are LEP, meaning that English is not their primary language and they have a limited ability to read, write, speak or understand English.[5] For example, 82% of NHPIs speak a language other than English at home, including 16% of Micronesians who are LEP. Many Asian populations also have high LEP rates: 63% of Burmese, 45% of Nepalese and 44% of Bangladeshis are LEP. AANHPIs make up twenty-two percent of LEP individuals in the country.

Language barriers to health care are further compounded by immigration and citizenship status, educational attainment and poverty. Sixty percent of Asian Americans are foreign-born, representing every immigration status. Medically underserved communities—including communities where AANHPIs lack access to health care, have high rates of poverty, and have high numbers of LEP populations—are growing across the country. As of the 2000 Census, communities were classified as medically underserved or severely underserved there in 266 counties (or 12.1%) of all of the counties in the U.S.[6]

HHS seeks comment on continuing unaddressed civil rights barriers, which are significant when it comes to language access. For example, over the past Open Enrollment periods for the Marketplace, language has presented a significant barrier for AANHPIs attempting to enroll in coverage. Once enrolled, many LEP consumers continued to have difficulties understanding their benefits and coverage. For example, AANHPI community-based organizations reported cases in which individuals did not know their rights and did not realize they were sent legal notices because notices were not provided in their language. Without enforcement of language assistance services, including legal notices and taglines to inform persons of their rights, discrete communities, such as those AANHPIs with large numbers of LEP individuals, will be systematically excluded from opportunities to achieve better health and have their civil rights violated. This rationale and strong data record guided the intent behind including the Section 1557 nondiscrimination provision in the ACA and corresponding incorporation of existing civil rights protections.

A. Proposed Subpart A--General Provisions (45 C.F.R. §§ 92.1 - 92.3)

We oppose the proposed changes in §§ 92.1 - 92.3. The proposed changes would improperly narrow the scope of application of Section 1557. Section 1557 applies to any health program or activity, any part of which receives federal financial assistance or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the ACA. Thus, Section 1557 must apply to all health programs or activities administered by the Department (as well as other federal Departments) *plus* those established under Title I. Section 1557 must also apply to all parts of the covered entity, not only the portion receiving federal financial assistance. The

[5] Asian & Pacific Islander American Health Forum Analysis of 2017 American Community Survey Data.

[6] Rosy Chang Weir, Linda Tran & Winston Tseng, *Medically Underserved AAPI Communities*, Association of Asian Pacific Community Health Organizations (2005), http://www.aapcho.org/wp/wp-content/uploads/2012/07/MUA-Fact-Sheet.pdf.

proposed changes run counter to the statutory text and intent of Section 1557 and would severely limit its application. Thus, we oppose the proposed changes in §§ 92.1 - 92.3 in favor of the 2016 Final Rule.

B. Proposed 45 C.F.R. § 92.5 Enforcement mechanisms

We oppose the proposed changes to § 92.301 as newly designated § 92.5. The Office for Civil Rights (OCR) incorrectly limits the remedies available under Section 1557, in part by referencing the regulations implementing the cited statutes. One of the goals of Section 1557 was to build and expand on prior civil rights laws such that individuals seeking to enforce their rights would have access to the full range of available civil rights remedies and not be limited to only the remedies provided to a particular protected group under prior civil rights laws. This is why Section 1557 expressly provides individuals access to any and all of the "enforcement mechanisms provided for and available under" the cited civil rights statutes, regardless of the type of discrimination.

C. Proposed 45 C.F.R. § 92.101 Meaningful access for LEP individuals

We oppose the proposed changes to § 92.201 as newly designated §92.101. In reference to the proposed subsection (a), we disagree with the proposed change in emphasis from the individual to entities. Congress declared, in Section 1557, that "an individual shall not" be subject to discrimination. Section 1557 cannot offer less protection than the statute that authorizes such regulations. Switching the emphasis on ensuring covered entities take reasonable steps to provide meaningful access "to each LEP individual" as provided in the 2016 Final Rule would weaken meaningful access, runs counter to Congress' intent, and the administrative record supporting the 2016 Final Rule. We would also like to emphasize that it is insufficient for an entity to only provide language services to those who actually walk in its door (or call its office). Instead, a covered entity must be prepared to provide language services to all those eligible to be served. By removing the specific identification of those eligible to be served, a covered entity may actually be discriminating since eligible clients or patients will not seek services from a covered entity if they perceive the entity is not prepared to assist in his or her language needs. Thus, we oppose the proposed §92.101 in favor of the language provided in the 2016 Final Rule.

In reference to the proposed subsection (b), we oppose codification of the four-factor test in Section 1557 regulations, which will likely result in less focus on an individual's needs when evaluating compliance. As language access advocates, we appreciate the Department's historical emphasis on ensuring meaningful access for LEP individuals as required by Title IV and consistent with decades of precedent and enforcement by the U.S. Supreme Court, HHS, and the Department of Justice, and have provided significant input on how to interpret the four-factor test to ensure its application results in meaningful access for LEP persons required by law. We oppose codification of the four-factor test for two main reasons.

First, it is already the interpretation of OCR that the two-factor test in the 2016 Final Rule is consistent with Title VI, the only statute in Section 1557 that prohibits national origin discrimination against LEP individuals.[7] The protections in Section 1557 and its regulations cannot be anything less than those already guaranteed by Title VI. This interpretation negates the claims made by OCR in the current NPRM that it seeks to align Section 1557 with Title VI, as they are already in alignment.

Second, in providing the two-factor test based upon, informed by, and consistent with Title VI, OCR was providing a method of articulating how it would engage in its enforcement review in the health activities and programs context, a specific application of Title VI and newly created by Section 1557. The two-factor test incorporates the principles in the HHS LEP Guidance and allows OCR to better explain how the factors will be considered in the specific 1557 health activities and programs context, giving substantial weight to the nature and importance of the particular communication at issue.

We also caution against the use of any factor related to resources and costs to be an an excuse for not providing any type of language assistance since federally funded entities are required to provide language assistance services pursuant to Title VI and Section 1557. As OCR has previously reiterated from the Department of Justice's LEP Guidance, Title VI policies advance the longstanding principle that "federally assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English." Section 1557 policies must do the same. That is, costs and potentially limited resources cannot outweigh the requirement to provide language access services to ensure meaningful access for LEP individuals to federally funded programs and activities.

D. Proposed repeal of current Section 1557 regulation provisions and standards

We strongly oppose the proposed repeal of current Section 1557 regulation provisions and standards, including the proposed repeal of standards for taglines, notices of non-discrimination, language access plans, and video interpretation. We disagree that these provisions were not justified by need, were overly burdensome, and created inconsistent requirements. By focusing primarily on the costs and burdens to covered entities, as opposed to appropriately focusing on the costs to LEP individuals, OCR is not acting consistently with the balancing principles identified by it in the 2003 HHS LEP Guidance.

[7] See 45 CFR part 92 "...the proposed rule adopted recipients' existing obligations under Title VI to take reasonable steps to provide meaningful access to individuals with limited English proficiency and codified the standards consistent with long-standing principles from the HHS LEP Guidance regarding the provision of oral interpretation and written translation services."

There are numerous studies that have documented the problems associated with a lack of language assistance, such as translated taglines and notices. For example, the Institute of Medicine (now the National Academy of Medicine), which stated that:

> Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision-making or ethical compromises (e.g., difficulty obtaining informed consent). Linguistic difficulties may also result in decreased adherence with medication regimes, poor appointment attendance, and decreased satisfaction with services.[8]

Lack of language services limits the amount and quality of care that LEP individuals receive.[9] One study showed that language problems were among the leading barriers to child health services cited by Latino parents and could increase medical errors because of misdiagnosis and misunderstanding of physicians' orders.[10]

Moreover, when ignoring the costs to LEP individuals, the proposed regulation does not take into account the human cost to LEP patients, including the pain and suffering, and possible death to the patient, and increases barriers to care, which often creates dangerous delays and unnecessary and risky procedures, ultimately increasing the chances of negative outcomes. In turn, bad outcomes and delayed access increase health care system costs. In a report released by the National Health Law Program, a survey of one malpractice carrier's closed claims found 2.5% of the cases involved language issues and cost the carrier over $5 million in damages, settlements and legal fees.[11] Thus, medical malpractice claims involving significant language barriers and resulting in patient injuries provide insight as to the impacts and costs of discrimination against individuals with LEP. As the study of 35 medical malpractice claims concluded,

> [t]hose costs include damages paid to patients, legal fees, the time lost when defending a lawsuit, the loss of reputation and patients, the fear of possible monetary loss, and the stress and distraction of litigation. . . .

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[8] Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* 17 (2002) (citations omitted); *see also* Jane Perkins, Mara Youdelman & Doreena Wong, National Health Law Program, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities* (2003). http://www.healthlaw.org/index.php?option=com_content&view=article&id=326:ensuring-linguistic-access-in-health-care-settings-legal-rights-and-responsibilties&catid=45; E. Jacobs, et al., *Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature*, The California Endowment (2003), http://www.calendow.org/uploadedFiles/language_barriers_health_care.pdf.

[9] *See, e.g.*, G. Flores et al.., *Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters*, 111 Pediatrics 6–14 (2003); T.K. Ghandi et al. *Drug Complications in Outpatients*, 15 J. of Gen. Internal Med. 149–54 (2000); D. K Pitkin et al., *Limited English Proficiency and Latinos' Use of Physician Services*, 57 Medical Care Research and Review 76–91 (2000).

[10] *See, e.g.*, G. Flores et al.., *Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters*, 111 Pediatrics 6–14 (2003); T.K. Ghandi et al. *Drug Complications in Outpatients*, 15 J. of Gen. Internal Med. 149–54 (2000); D. K Pitkin et al., *Limited English Proficiency and Latinos' Use of Physician Services*, 57 Medical Care Research and Review 76–91 (2000).

[11] K. Quan & J. Lynch, *The High Costs of Language Barriers in Medical Malpractice* 15, National Health Law Program (2010) [hereinafter Medical Malpractice. Reporthttp://www.healthlaw.org/images/stories/High_Costs_of_Language_Barriers_in_Malpractice.pdf.

> [T]he heightened risk of patient harm from poor medical care is the ultimate critical and unacceptable cost.[12]

1. Proposed repeal of in-language taglines

We oppose the proposed repeal of the taglines requirement (45 C.F.R. §§ 92.4 - 92.8; Appendix B to 45 C.F.R. Part 92). We were strong proponents of the 2016 Final Rule requiring covered entities to provide in-language taglines informing recipients of the availability of language assistance of significant documents as a solid step towards ensuring LEP patients are informed of their rights and able to access necessary language assistance services. The proposed repeal, combined with the elimination of the notice of nondiscrimination, threatens this progress and puts in jeopardy the civil rights of LEP persons. The inclusion of taglines is well-supported by long-standing federal and state regulations, guidance, and practice.[13] In the absence of fully translated documents, taglines are necessary "to ensure that individuals are aware of their protections under the law, and are grounded in OCR's experience that failures of communication based on the absence of auxiliary aids and services and language assistance services raise particularly significant compliance concerns under Section 1557, as well as Section 504 and Title VI."[14] The use of in-language taglines is also a cost-effective approach to ensuring covered entities are not overly burdened while maintaining access for LEP individuals. This is particularly true two years after its implementation, given that HHS has already provided translated taglines for at least 15 languages. As such, we oppose the proposal to eliminate the in-language tagline requirement on covered entities.

2. Proposed repeal of notices of nondiscrimination

Additionally, we oppose the repeal of the requirement on covered entities to provide a notice of nondiscrimination that informs the public of their legal rights to nondiscriminatory health care services (45 C.F.R. § 92.8; Appendix B to 45 C.F.R. Part 92) . The notice requirement is consistent with the long history of civil rights regulations requiring the posting of notice of rights, including Title VI, Section 504, Title IX and the Age Act, which all require that recipients of federal financial assistance notify recipients that they do not discriminate.

OCR has provided no explanation for how individuals will know of their rights and how elimination of notices will not deny LEP individuals, LGBTQ+ persons, women, and persons with disabilities meaningful access. Without the notice, members of the public will have limited means of knowing that language services and auxiliary aids and services are available, how to request them, what to do if they face discrimination, that

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[12] *Id.* at 15.
[13] See Title VI Coordination Regulations, 29 C.F.R. § 42.405(d) (1); Marketplace and QHP issuer requirements, 45 C.F.R. § 155.205(c) (2) (iii); Medicaid Managed care plans, 42 C.F.R. § 438.10(d) (3); DOL WIOA Nondiscrimination requirements, 29 C.F.R. § 38.9(g) (3); USDA SNAP Bilingual Requirements, 7 C.F.R. § 272.4(b); and the 2003 HHS LEP Guidance.
[14] Nondiscrimination in Health Programs and Activities, Notice of Proposed Rulemaking, 45 CFR Part 92, September 8, 2015.

they have the right to file a complaint, and how to file such a complaint. Because the notice has already been in implementation for two years, and since HHS has already provided sample notices of nondiscrimination, this is a cost-effective way to inform beneficiaries, enrollees, applicants, and members of the public at large of the availability of language services and that the entity does not discriminate on the basis of race, color, national origin, (which has been interpreted to include language), sex, age, or disability, along with other useful information. [15] The burdens of wall space or use of information technology, staff, or other resources are greatly outweighed by the benefit of having the notice available to inform the public of their rights.

OCR also incorrectly asserts that the nondiscrimination notice is redundant of existing civil rights notices under other statutes. Rather, the notice recognizes the fact that individuals may face multiple forms of discrimination and in fact eliminates duplication by consolidating the underlying statutes' notice requirements into one.

OCR states it has received little evidence that more beneficiaries are seeking language assistance and uses this claim as a justification to remove the notice and taglines. This claim, which relies on reports from health plans, is insufficient to justify their repeal. The regulation has been in effect for three years in which OCR, by its own admission, has had limited resources to conduct public outreach. Second, the protections guaranteed by Section 1557 are both continuing and many are new, warranting a public effort to conduct outreach. Third, the notices and taglines were selected as a compromise position, to avoid requiring covered entities to translate large numbers of documents. Fourth, LEP persons are uniquely at risk of facing barriers to knowing and asserting their rights. Lack of uptake of services raises questions about the extent to which the public knows its rights and what covered entities are doing to communicate those rights, as opposed to justifying elimination of notices and taglines.

3. Proposed Repeal of Language Access Plans

We oppose removing all references to language access plans (45 C.F.R. § 92.201(b)(2)) because under the 2016 Final Rule, they are voluntary, not required by the 2016 rule, and only a factor to be considered. Language access plans are not required by Title VI or its regulations, but have long been recognized as a way for a covered entity to ensure it is compliant with Title VI. OCR has required language access plans from covered entities as a key component of Title VI enforcement actions involving LEP individuals since before Executive Order 13166 was issued in 2000. Executive Order 13166 required HHS to create and implement a language access plan for its federally conducted programs and activities. That Executive Order also required HHS to issue Title VI LEP Guidance, which provided multiple factors an entity, could take into consideration when developing a language access plan. As such, repealing the voluntary language removes a tool that HHS has used for enforcement and that covered entities can use to support their

[15] To reduce the burden on covered entities, OCR developed a model nondiscrimination notice that treats compliance with § 92.8 as satisfying the notice requirements under the regulations implementing Title VI, Section 504, Title IX, and the Age Act.

compliance efforts. Covered entities may, as a result, fail to fully plan on how to best meet the needs of LEP patients and customers.

4. Proposed Repeal of Video Interpretation Standards

We oppose the proposed removal of real-time video remote interpreting service requirements for spoken language interpretation. Telephonic communication may be appropriate for certain uses, such as scheduling, but may not be for interpreting information for trauma, mental health, or death. These sensitive matters, in addition to non-verbal cues in the health care setting, cannot be observed or properly communicated via telephone. Video Remote Interpreting has saved costs from in-person interpreting, as there are no minimums, travel time, or cancellation risks, though we believe in-person interpreting is still best for the patient. However, maintaining requirements for real-time video for foreign language interpreters can allow alternatives to in-person interpreting that does not compromise the quality of patient care.

II. Eliminating Section 1557's definition of sex discrimination, including discrimination based on gender identity and sex stereotyping.

he proposed regulation is inconsistent with the purposes of the ACA and the weight of the law, which recognizes that both sexual orientation and gender identity are forms of sex discrimination that are prohibited under current civil rights laws. The proposed rule will endanger the health and well-being of nearly 7 million LGBTQ+ people who live in states without any protections against sexual orientation and gender identity discrimination in public accommodations.[16] Under the proposed regulation, a health care provider could turn these LGBT Americans away when they seek medical care.

California is home to roughly 2.9 million LGBTQ+ individuals,[17] including at least 218,400 transgender patients.[18] Advancing Justice opposes the proposed rule for reasons that it would severely threaten LGBTQ+ patients' access to all forms of health care, create confusion among patients and providers about their rights and obligations, and promote discrimination. The 2016 Final Rule is the product of a lengthy process of deliberation and public input. The rule was developed over the course of six years of study and following two comment periods, with over 25,000 comments from stakeholders, including from Advancing Justice, which were overwhelmingly supportive of inclusion of protections against discrimination based on sex stereotyping and gender identity. HHS engaged stakeholders through listening sessions, participation in conferences, and other outreach prior to taking regulatory action.

[16] The Williams Institute, UCLA School of Law, *LGBT People in the U.S. Not Protected by State Nondiscrimination Statutes* (April 2019) at: https://williamsinstitute.law.ucla.edu/wp-content/uploads/Equality-Act-April-2019.pdf.
[17] The Williams Institute, UCLA School of Law. *LGBT Demographic Data Interactive* (January 2019).
[18] Flores, A.R. et al. *How Many Adults identify as Transgender in the United States?* The Williams Institute (June 2016).

A. Proposed Repeal of 45 C.F.R. § 92.1 Definitions, including Definitions for Discrimination on the Basis of Sex and Gender Identity

We strongly oppose the removal of 45 C.F.R. § 92.1, effectively eliminating federal protections for LGBTQ+ communities and those who do not conform to traditional gender stereotypes. By proposing to eliminate protections against discrimination based on gender identity and sex stereotyping, HHS is contradicting over 20 years of federal case law[19] and clear Supreme Court precedent.[20] The overwhelming majority of courts that have been presented with the question of whether federal sex discrimination laws, such as Section 1557 specifically cover anti-transgender discrimination have firmly ruled that they do.[21] The First Circuit, Sixth Circuit, Seventh Circuit, Ninth Circuit, and Eleventh Circuit have likewise applied federal sex discrimination laws to discrimination against transgender people,[22] consistent with the 2016 Final Rule.

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[19] See, e.g., *Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015); *Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. 2016); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090 (S.D. Cal. Sept. 27, 2017); *Tovar v. Essential Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018); *Boyden v. Conlin*, No. 17-cv264-WMC, 2018 (W.D. Wis. September 18, 2018); *Whitaker v. Kenosha Unified School District*, No. 16-3522 (7th Cir. 2017) (Title IX and Equal Protection Clause); *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal Protection Clause); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011) (Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004) (Title VII); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); *Grimm v. Gloucester County School Board*, No. 4:15-cv-54 (E.D. Va. May 22, 2018); *M.A.B. v. Board of Education of Talbot County*, 286 F. Supp. 3d 704 (D. Md. March 12, 2018).

[20] *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989).

[21] See, e.g., *Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (holding that discrimination against hospital patient based on his transgender status constitutes sex discrimination under Section 1557 of the Affordable Care Act); *Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018) (holding that a Medicaid program's refusal to cover treatments related to gender transition is "text-book discrimination based on sex" in violation of the Affordable Care Act and the Equal Protection Clause of the Constitution); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. 2016) (holding exclusion invalid under the Medicaid Act and the Affordable Care Act); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090 (S.D. Cal. Sept. 27, 2017) (holding that discrimination against transgender patients violates the Affordable Care Act); *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018) (holding that Section 1557 of the Affordable Care Act prohibits discrimination on the basis of gender identity); *Boyden v. Conlin*, No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018) (holding that a state employee health plan refusal to cover transition-related care constitutes sex discrimination in violation of Title VII, Section 1557 of the ACA, and the Equal Protection Clause).

[22] See, e.g. *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (holding that refusal to serve a transgender customer constitutes sex-based discrimination under the Equal Credit Opportunity Act.); *E.E.O.C. v. R.G. & G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560 (6th Cir. 2018) (holding that termination of an employee on the basis of transitioning or transgender status violates Title VII of the Civil Rights Act of 1964); *Whitaker v. Kenosha Unified School Dist.*, 858 F.3d 1034 (7th Cir. 2017) (holding that discrimination against transgender students constitutes sex discrimination under Title IX of the Education amendments Act of 1972 and the Equal Protection Clause of the U.S. Constitution); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (holding that the Gender Motivated Violence Act applied to targeting of a transgender person); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011) (holding that termination of an

These proposed changes are outside the jurisdiction of the Office of Civil Rights and are unrelated to Section 1557 of the ACA. It is inappropriate for these rulemakings to be combined, and it is arbitrary and incorrect for HHS to characterize them as "conforming amendments" without offering any legal, policy, or cost-benefit analysis about them or their impacts on various Center for Medicare and Medicaid Services (CMS) programs. In particular, HHS offers no analysis of the impact these regulations have had during the years--in some cases over a decade--that they have been in effect or the impact of changing them presently.

On the contrary, Section 1557 and the 2016 Final Rule provided many LGBTQ+ people with meaningful health care options where they previously had few or none at all, have helped address the pervasive discrimination LGBTQ+ people often face in health care and coverage settings, and have made it possible for many transgender and cisgender people alike to access essential care. For this reason, Advancing Justice was a huge proponent of HHS clearly stating that discrimination based on sex includes discrimination because of sex stereotyping and gender identity.

III. Proposed Incorporation of Title IX Abortion and Religious Exemptions to Section 1557's Prohibition on Sex Discrimination.

We strongly oppose the proposed incorporation of Title IX exemptions, including abortion and religious exemptions. Such exemptions would undermine the right of individuals to access comprehensive health care services, including reproductive health care, free from discrimination.
There is nothing in the legislative history or language of the regulation itself that permits exceptions to Section 1557's prohibition on sex discrimination. Moreover, existing statutes that allow individuals and entities to refuse to provide certain services are more than sufficient to accommodate religious objections. Those statutes are not without extremely harmful consequences. However, to add additional exemptions to Section 1557 would further marginalize and endanger women's health.

The proposed regulation impermissibly expands exemptions for religiously affiliated providers to deny care on religious grounds without adequately considering the considerable harm this is likely to pose for patients. Religious exemptions affect health outcomes in negative and sometimes life-threatening ways. Health care should be patient-centered and based on standards of care, but that is often not the case for millions of women who receive treatment from religiously affiliated providers and institutions. The health consequences of health care refusals are well documented.

Women--low-income women and women of color in particular--are among the underserved communities who are disproportionately affected by health care refusals, which overwhelmingly involve access to reproductive health care, thereby singling out women for unequal treatment. The Supreme Court has long since held that a woman's

employee based on her gender transition and transgender status constitutes sex-based discrimination in violation of the Equal Protection Clause of the U.S. Constitution.)

ability to control her reproductive life and to become a parent when she has made an affirmative decision to become pregnant is fundamental to her ability to obtain an education and to be economically self-sufficient.[23] Health care refusals based on religious grounds violate evidence-based practices and medical standards of care, undermine women's agency, and lead to worse health outcomes, which could have life-threatening implications. Due to the expansion of religiously-affiliated hospitals and health systems, any exemption would further threaten women's health and perpetuate sex discrimination, including sex stereotyping and gender identity discrimination of LGBTQ+ patients.

Therefore, Advancing Justice strongly opposes the proposed rule. Such health care refusals involving reproductive health care constitute impermissible sex discrimination. All women should be able to make their own reproductive health care decisions based on their own beliefs, not the beliefs of providers or institutions, and all women should have access to the care they need. An organization's religious beliefs should not stand in the way of an individual woman's decision to access the health care that she needs. Thus, the Department should not adopt any religious exemptions to Section 1557's prohibition against sex discrimination.

IV. Conclusion

In conclusion, Advancing Justice strongly opposes the NPRM, and instead favors the 2016 Final Rule currently in place. The proposed changes will have disastrous consequences for LEP patients, LGBTQ+ patients, and persons seeking reproductive health services, which make up some of the most vulnerable and underserved patient communities. Thank you for the opportunity to provide comments to the proposed regulations pursuant to Section 1557 of the ACA. If you have any questions regarding these comments, please contact Doreena Wong (dwong@advancingjustice-la.org) at (213) 241-0271.

Respectfully Submitted,

Doreena Wong
Project Director, Health Access Project

[23] See *Planned Parenthood of Se Pa. v. Casey*, 505 U.S. 833, 876-78 (1992) ("The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."

ASIAN HEALTH SERVICES
ADMINISTRATIVE OFFICES
101 8th Street, Suite 100, Oakland, CA 94607 | 510.735.3100

August 13, 2019

Mr. Roger Severino
Director, Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave. SW, Washington, DC 20201

Re: Nondiscrimination in Health and Health Education Programs and Activities (Section 1557 NPRM), RIN 0945-AA11

Dear Mr. Severino:

Asian Health Services (AHS) thanks the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) for the opportunity to comment on the notice of proposed rulemaking (NPRM) on Section 1557 of the Patient Protection and Affordable Care Act (ACA) ("Health Care Rights Law" or "Section 1557").

Founded in 1974 in Oakland, CA, Asian Health Services provides health, social, and advocacy services for all regardless of income, insurance status, immigration status, language, or culture. Our approach to wellbeing focuses on "whole patient health," which is why we provide more than primary care services, including dental care, mental health, case management and nutrition counseling, in addition to health coverage enrollment, to more than 28,000 active patients of all ages. AHS also recognizes that a patient's health is directly linked to their ability to receive services in a language that they are proficient. Since 73% of our patients are best served in language other than English, AHS provides services in English and over 14 Asian languages: Cantonese, Vietnamese, Mandarin, Khmer, Korean, Tagalog, Mien, Lao, Mongolian, Karen, Karenni, Arabic, Burmese, and American Sign Language. Therefore, we strongly oppose the NPRM's provisions which seek to eliminate and otherwise limit civil rights protections.

Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, and disability. As an organization that is committed to upholding the civil rights of all persons, we strongly oppose the NPRM provisions which seek to eliminate and limit protections for individuals who are limited English proficient, LGBTQ+ persons, persons with disabilities and chronic conditions, and persons needing reproductive health services. Section 1557 addresses not only protections for each protected class covered, but the intersection of those protections. As such, an attack on the civil rights of one group in the NPRM is an attack on the civil rights of all.

AHS and other community health centers focus on low-income and medically-underserved AANHPI populations. We have seen first-hand the importance of providing in-language support in both health literacy *and* health insurance literacy. Language has long presented a significant barrier for AANHPIs attempting to enroll in health insurance. Once enrolled, many LEP individuals face ongoing difficulties understanding their benefits and coverage--in large part due to the fact materials are often not in-language.

Therefore, our comments focus on the NPRM's language access provisions to ensure that persons with limited English proficiency (LEP) have the meaningful access required not only by Section 1557 but also by Title VI of the Civil Rights Act of 1964 (Title VI) and its implementing regulations. As such, we oppose eliminating the language access protections as proposed in the NPRM. In addition, we oppose any other efforts to otherwise eliminate or roll back protections and provisions contained in the 2016

Nondiscrimination in Health Programs and Activities Final Rule (2016 Final Rule) as they apply to other protected classes, including LGBTQ+ persons, women and persons with disabilities. Overall, we urge HHS to withdraw and not finalize this rule.

The proposed rule will deeply impact the community and patients AHS serve. In Alameda County, nearly 45% of the residents speak a language other than English. Among AHS patients, 73% - about 20,519 of 28,147 patients are best served in language other than English.

Language access in health care services and activities particularly impacts Asian Americans (AAs), Native Hawaiians (NH) and Pacific Islanders (PI), given the population's demographics. AAs and NHPIs represent the fastest growing communities in the United States and similarly represent incredible diversity. AAs and NHPIs trace their heritage to nearly 100 different ethnic groups and speak more than 250 different languages. Sixty six percent of AAs speak a language other than English at home and twenty nine percent are LEP, meaning that English is not their primary language and they have a limited ability to read, write, speak or understand English. Twenty-eight percent of NHPIs speak a language other than English at home. Sixty-three percent of Burmese, 45 percent of Nepalese and 44 percent of Bangladeshis are LEP, as are 16 percent of Micronesians. AAs and NHPIs make up twenty-two percent of LEP individuals in the country.

Language barriers to health care are further compounded by immigration and citizenship status, educational attainment and poverty. Sixty percent of Asian Americans are foreign-born, representing every immigration status. Medically underserved AA and NHPI communities—including communities where AAs and NHPIs lack access to health care, have high rates of poverty, and have high numbers of LEP populations—are growing across the country. As of the 2000 Census, there were 282 counties or 13.1% of counties classified as medically underserved or severely underserved AA and NHPI communities.

I. Proposed Subpart A General Provisions

We oppose the proposed changes in § 92.1 - 92.3 that would narrow the scope of application of Section 1557. Section 1557 applies to any health program or activity, any part of which is receiving federal financial assistance or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the ACA. Thus, Section 1557 applies to *all* health programs or activities administered by the Department (as well as other federal Departments) *plus* those established under Title I. Further, similar to Title VI, Section 1557 applies to *all* parts of the covered entity, not only the portion receiving federal financial assistance. In addition, given that the majority of individuals access health care through insurance plans, the provision of health insurance is a "health program or activity" and thus Section 1557 applies to it. The proposed changes run counter to the statutory text and intent of Section 1557 and would limit severely limit its application. We therefore oppose them.

Proposed § 92.5 Enforcement

We oppose the proposed changes to § 92.301 as newly designated § 92.5. OCR incorrectly limits the remedies available under Section 1557, in part by referencing the regulations implementing the cited statutes. One of the goals of Section 1557 was to build and expand on prior civil rights laws such that individuals seeking to enforce their rights would have access to the full range of available civil rights remedies and not be limited to only the remedies provided to a particular protected group under prior civil rights laws. This is why Section 1557 expressly provides individuals access to any and all of the "rights, remedies, procedures, or legal standards available" under the cited civil rights statutes, regardless of the type of discrimination.

II. Proposed Subpart B Specific Applications to Health Programs or Activities

Proposed § 92.101 Meaningful Access for Individuals with Limited English Proficiency

a. Obligations

The proposed § 92.101 inappropriately switches the emphasis from "each individual with limited English proficiency" as provided in the 2016 Final Rule to the covered entity's program or activities. In Section 1557, Congress declared "an individual shall not" be subject to discrimination. Section 1557 regulations cannot offer less protection than the statute that authorizes such regulations. Therefore, the correct emphasis in the 1557 regulations must be on each individual and not programs. As such, this NPRM would weaken meaningful access, runs counter to Congressional intent and the thorough administrative record supporting the 2016 Final Rule, and we oppose it.

b. Specific applications

We appreciate the Department's historical emphasis on ensuring meaningful access for LEP individuals as required by Title VI and regulations and consistent with over four decades of U.S. Supreme Court precedent and enforcement by HHS and the U.S. Dept. of Justice (DOJ). As language access advocates, we have strongly supported Title VI and 2003 HHS LEP Guidance and have provided significant input on how to interpret the 4-factor test to ensure its application results in meaningful access for LEP persons required by Title VI and its regulations. We oppose, however, the codification of the 4-factor test in the Section 1557 regulation for the following two reasons. First, it is already the interpretation of OCR that the 2-factor test in the 2016 Final Rule is consistent with Title VI, the only statute in Section 1557 that prohibits national origin discrimination against LEP individuals. The protections in Section 1557 and its regulations cannot be anything less than those already guaranteed by Title VI. This interpretation negates the claims made by OCR in the current NPRM that it seeks to align Section 1557 with Title VI, as they are already in alignment.

Second, in providing the 2-factor test based upon, informed by and consistent with Title VI, OCR was providing a method of articulating how it would engage in its enforcement review in the health activities and programs context, a specific application of Title VI and newly created by Section 1557. The 2-factor test incorporates the principles in the HHS LEP Guidance and allows OCR to better explain how the factors will be considered in the specific 1557 health activities and programs context giving substantial weight to the nature and importance of the particular communication at issue.

III. Opposition to Current 1557 Provisions Proposed for Repeal or Reconsideration

Overall, we strongly disagree that the nondiscrimination notice, taglines and language access plan language in the 2016 Final Rule were not justified by need, were overly burdensome and created inconsistent requirements. In focusing most significantly on the costs and burdens to covered entities and devoting minimal discussion and analysis to the costs to LEP individuals, OCR is not acting consistent with the balancing principles identified by it in the 2003 HHS LEP Guidance which states "First we must ensure that federally assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English."

a. Proposed Repeal of Nondiscrimination Notice

We oppose the repeal of the requirement that covered entities provide a notice of nondiscrimination that informs the public of their legal rights. The notice requirement is consistent with the long history of civil rights regulations requiring the posting of notice of rights, including Title VI, Section 504, Title IX and the Age Act, which all require that recipients of federal financial assistance notify recipients that they do not discriminate.

OCR has provided no explanation for how individuals will know of their rights and how elimination of notices will not deny LEP individuals, LGBTQ+ persons, women and persons with disabilities meaningful access. Without the notice, members of the public will have limited means of knowing that language services and auxiliary aids and services are available, how to request them, what to do if they face discrimination, that they have the right to file a complaint, and how to file such a complaint. While our patients expect to receive services in their language at AHS, our staff has to spend time with the patients and providers to ensure that the same level of language services are available outside of AHS.

OCR incorrectly asserts that the nondiscrimination notice is redundant of existing civil rights notices under other statutes. Rather, the notice recognizes the fact that individuals may face multiple forms of discrimination and in fact eliminates duplication by consolidating the underlying statutes' notice requirements into one.

b. Proposed Repeal of In-Language Taglines

We strongly oppose the repeal of the requirement for covered entities to provide in-language taglines informing recipients of the availability of language assistance on significant documents because, combined with the elimination of the nondiscrimination notice, the repeal threatens the civil rights of LEP persons. The inclusion of taglines is well-supported by long-standing federal and state regulations, guidance and practice. The use of taglines is a cost-effective approach to ensuring that covered entities are not overly burdened while maintaining access for LEP individuals.

In the absence of fully translated documents, taglines are necessary "to ensure that individuals are aware of their protections under the law, and are grounded in OCR's experience that failures of communication based on the absence of auxiliary aids and services and language assistance services raise particularly significant compliance concerns under Section 1557, as well as Section 504 and Title VI." As such, we oppose the proposal to eliminate them.

c. Proposed Repeal of Video Interpretation Standards

We oppose the removal of technical and training requirements for the use of video remote interpreting services for spoken language interpretation. The type of interpreting during a medical visit should depend on the encounter as telephonic communication may be appropriate for scheduling, but not for interpreting information for trauma, mental health, or death. Non verbal cues in the health care setting or prescription writing cannot be observed via telephone. Further, even with the higher cost in equipment and training, Video Remote Interpreting has saved costs from in person interpreting as there are no minimums, travel time, or cancellation risks, though we believe in-person interpreting is still best for the patient. Keeping the current standard allows providers to determine which technology is appropriate and when an entity uses video, that it is high quality and without lagging.

d. Language Access Plans

We oppose removing all references to language access plans because under the 2016 Final Rule, they are voluntary, not required by the 2016 rule and only a factor to be considered. Language access plans are not required by Title VI or its regulations, but have long been recognized as a way for a covered entity to ensure it is compliant with Title VI. OCR has required language access plans from covered entities as a key component of Title VI enforcement actions involving LEP individuals since before Executive Order 13166 was issued in 2000. Executive Order 13166 also required HHS create and implement a language access plan for its federally conducted programs and activities. That Executive Order also required HHS to issue Title VI LEP Guidance which provided multiple factors an entity could take when developing a language access plan. As such, repealing the voluntary language removes a tool that HHS has used for enforcement and that covered entities can use to support their compliance efforts. Covered entities may, as a result, fail to fully plan on how to best meet the needs of LEP patients and customers.

IV. The Regulatory Impact Analysis is Flawed and Ignores Costs to LEP Individuals

a. The Regulatory Impact Analysis (RIA) is Insufficient and Fails to Justify the Proposals

The NPRM provides a RIA that is wholly insufficient to justify the extensive scope of the proposed changes to language access and entirely fails to identify and to quantify costs to protected individuals. OCR's estimate of the burden to covered entities for compliance with the nondiscrimination notice and tagline requirements is based on voluntary actions and interpretations by covered entities. OCR based the elimination of the notice and taglines on these estimates, but did not consider whether alternatives, such as further clarification about the requirements, was warranted in the form of FAQs or other guidance. That is, OCR failed to consider alternatives to a complete repeal of notices and taglines that could have appropriately balanced the need to inform individuals of their rights while recognizing there may be a difference in the intentions behind the 2016 Final Rule and how covered entities have interpreted it.

Similarly, the majority of the costs are associated with the provision of a single type of document -- the Explanation of Benefits (EOB). OCR did not consider alternatives as to how it would consider enforcement and interpretation of the "significant document" standard with respect to the provision of multiple EOBs sent during a coverage year.

OCR states it has received little evidence that more beneficiaries are seeking language assistance and uses this claim as a justification to remove the notice and taglines. This claim, which relies on reports from health plans, is insufficient to justify their repeal. The regulation has been in effect for three years in which OCR, by its own admission, has had limited resources to conduct public outreach. Second, the protections guaranteed by Section 1557 are both continuing and many are new, warranting a public effort to conduct outreach. Third, the notices and taglines were selected as a compromise position, to avoid requiring covered entities to translate large numbers of documents. Fourth, LEP persons are uniquely at risk of facing barriers to knowing and asserting their rights. Lack of uptake of services raises questions about the extent to which the public knows its rights and what covered entities are doing to communicate those rights, as opposed to justifying elimination of notices and taglines.

As stated above, our staff, mainly nurses, medical assistants, referral clerks and case managers, continue to reassure and advocate on behalf of our patients to ensure they receive health services in their language for nearly ¾ of our total patient population.

b. Language Access Requirements in the 2016 Final Rule Are Justified by Need

OCR has provided no tangible analysis of the costs and burdens of repealing the notice and tagline requirement. Instead, OCR provides only acknowledgment that repeal "may impose costs, such as decreasing access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services." OCR perfunctorily labels the impact as "negligible" while providing no evidentiary basis.

The costs are not only reduced awareness of language services by LEP persons, but also reduced awareness by the general public about their rights as protected by 1557, especially regarding the notices which include information about the broader nondiscrimination requirements of Section 1557. OCR's only acknowledgement of this impact is one statement about the "unknown number of persons are likely not aware of their right to file complaints."

Discrimination on the basis of national origin, which encompasses discrimination on the basis of language, creates unequal access to health care. Language access in health care is just as critical now as when the Civil Rights Act was originally passed in 1964. Over twenty-five million individuals in the United States are LEP. An estimated 19 million LEP adults are insured. Language assistance is necessary for LEP persons to access federally funded programs and activities in the healthcare system. Without

meaningful access, the estimated 25 million individuals who are LEP would be excluded from programs and services they are legally entitled to including nearly 683,000 individuals in Alameda County alone.

HHS seeks comment on continuing unaddressed civil rights barriers, which are significant when it comes to language access. For example, over the past Open Enrollment periods for the Marketplace, language has presented a significant barrier for AAs and NHPIs attempting to enroll in coverage. Once enrolled, many LEP consumers continued to have difficulties understanding their benefits and coverage. For example, AA and NHPI community-based organizations reported cases in which individuals did not know their rights and did not realize they were sent legal notices because notices were not provided in their language. Without enforcement of language assistance services, legal notices and taglines to inform persons of their rights, discrete communities, such as those AAs and NHPIs, with large numbers of LEP individuals will be systematically excluded from opportunities to achieve better health and have their civil rights violated. It is this rationale and strong data record that guided the intent behind including the Section 1557 nondiscrimination provision in the ACA and corresponding incorporation of existing civil rights protections.

For these reasons, AHS opposes the proposed rule and encourages HHS to withdraw it in its entirety. Thank you for the opportunity to comment on the nondiscrimination NPRM.

Sincerely,

Dong Suh
Chief Deputy of Administration

Boulder County

Public Health

Administration

August 13, 2019

The Honorable Secretary Alex Azar
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue, SW
Washington, D.C. 20201

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

Dear Secretary Azar:

Boulder County Public Health (BCPH) appreciates this opportunity to provide comment on the Department of Health and Human Services' (HHS) proposed rule, "Nondiscrimination on Health and Health Education Programs or Activities." Serving a population of over 326,000, Boulder County Public Health's mission is to address social, economic, and environmental conditions to ensure that all people in Boulder County have the opportunity for a healthy life. In addition to providing core public health services, BCPH focuses on the social determinants of health across our community – with a focus on populations experiencing health inequities, such as the LGBTQ+ community.

BCPH strongly opposes the proposed rule and recommends that it be withdrawn. If implemented, the proposed rule would seriously undermine LGBTQ+ patients' access to all forms of health care, sow confusion among patients and providers about their rights and obligations, and promote discrimination.

Specifically, the proposed rule would remove legal protections against discrimination based on sexual identity, gender identity, and sexual stereotypes. It eliminates "gender identity" and "sex stereotypes" from the definition of sex-based discrimination. These significant changes are not supported by the plain language of the Affordable Care Act (ACA) or Congress' intent in enacting this law. If implemented, the rule could allow hospitals to deny care to people who identify as LGBTQ+ and enable insurance companies to deny coverage to people who are transgender.

While the percentage of transgender Coloradans with health insurance increased markedly from 73% in 2011 to 95% in 2018,[1] significant barriers to appropriate, quality care remain. For example, one in three transgender Coloradans in a 2018 survey reported being denied coverage for an LGBTQ+-specific medical service (e.g., gender-affirming care and appropriate health screenings). In the survey, 31% of transgender Coloradans said health providers refused to provide them with care.

Following are some examples and stories from the field that support these survey findings:

- Despite having employer health care coverage, a transgender woman from Boulder County, Colorado, with a significant family history of breast cancer had to struggle with her insurance provider at length, on multiple occasions to obtain a covered breast cancer screening.
- Transgender patients struggle to find medical providers who are trained to manage transgender health and are willing to accept transgender patients. Youth have limited access to health care providers who can prescribe hormones and hormone blockers.

Many transgender people in Boulder County are forced to travel 1-2 hours to find a provider who is well-trained in transgender health care.

- Boulder County Public Health's OASOS (Open and Affirming Sexual Orientation and gender identity Support) Program[2] hears many reports about transgender and gender-nonconforming youth receiving poor or actively disrespectful treatment from health care providers. These include:
    - Having their given names rather than their chosen names shouted out by front desk staff at medical appointments. This "outing" of their status has caused youth to leave their appointments or avoid scheduling appointments altogether.
    - Being referred to as "abnormal" by medical staff and made to wait longer.
    - Being asked inappropriate questions by medical providers about their genitalia and having medical students brought in to "observe" them.
    - Being refused treatment once a doctor learned the patient was transgender.
    - Being placed in an inpatient psychiatric facility to a space matching their assigned gender at birth rather than their current gender identity; being "outed" as transgender to other patients.

Implementation of the proposed rule removing legal protections for transgender persons will exacerbate discrimination, embolden health care providers to deny patient care, and drive transgender people away from preventive health care. The proposed rule runs counter to the ACA's goal of promoting equal access to medically necessary health services.

The ACA's current protections against discrimination based on sex stereotyping and gender identity were 6 years in the making and generated 25,000 stakeholder comments. This exhaustive public process – which was overwhelmingly supportive of protections against discrimination based on sex stereotyping and gender identity – should be accorded deference. We strongly urge the department to withdraw its proposed regulation.

We appreciate the opportunity to comment on this proposed regulation. Please contact OASOS Program Coordinator Heather Crate at hcrate@bouldercounty.org or 303-678-6259 if you have questions or would like additional information.

In health,

Jeffrey J. Zayach, M.S.
Executive Director

[1] One Colorado Education Fund 2018 Survey with 2,572 respondents. See survey and report: "Closing the Gap: The Turning Point for LGBTQ Health" retrieved from www.one-colorado.org.

[2] OASOS aims to increase healthy behaviors and decrease risky behaviors among lesbian, gay, bisexual, transgender, intersex, and questioning (LGBTIQ) youth through support, advocacy, and education.

CPEHN
California Pan-Ethnic Health Network

August 13, 2019

The Honorable Alex M. Azar II
Secretary, U.S. Dept. of Health and Human Services
200 Independence Ave, SW
Washington, D.C. 20201

Mr. Roger Severino
Director, Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave. SW, Washington, DC 20201

Re: Nondiscrimination in Health and Health Education Programs and Activities (Section 1557 NPRM), RIN 0945-AA11

Dear Sec. Azar and Mr. Severino:

On behalf of the California Pan-Ethnic Network (CPEHN) we thank you for the opportunity to comment on the notice of proposed rulemaking (NPRM) on Section 1557 of the Patient Protection and Affordable Care Act (ACA) ("Health Care Rights Law" or "Section 1557").

CPEHN is a statewide multicultural health advocacy organization. Founded over 25 years ago, CPEHN unites communities of color to achieve health and wellness, and to eliminate persistent health inequities. As sponsors of California's language access laws, SB 853 (2003) and SB 223 (2017), we strongly oppose the NPRM's provisions which seek to eliminate and otherwise limit civil rights protections for Californians including Limited English Proficient (LEP), transgender and LGBTQ+.[1] Each day we work with diverse community members who struggle to access the health care they are legally entitled to due to language and cultural barriers. These struggles are well-documented and compounded for individuals with more than one identity: LEP, transgender and LGBTQ+.

Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, and disability. As an organization that is committed to upholding the civil rights of all persons, we strongly oppose the NPRM provisions which seek to eliminate and limit protections for individuals who are limited English proficient, LGBTQ+ persons, persons with disabilities and chronic conditions, and persons needing reproductive health services. Section 1557 addresses not only protections for each protected class covered, but the intersection of those protections. As such, an attack on the civil rights of one group in the NPRM is an attack on the civil rights of all.

[1] SB 853: The Health Care Language Assistance Act: https://cpehn.org/policy-center/cultural-and-linguistic-competency/sb-853-health-care-language-assistance-act

Californians will be negatively harmed by this proposed rule:
The proposed rule would deeply impact the beneficiaries we serve. California's population is one of the most diverse in the country, with almost 60% comprised of communities of color and over 100 different languages spoken. Current statistics show that more than 40% of Californians do not speak English at home, and an estimated 6 to 7 million Californians are limited English proficient (LEP) – meaning they speak English less than "very well." For some populations, such as Vietnamese and Korean speakers, over 60% are limited English proficient, and as a result, they and other LEP individuals are faced with language and cultural barriers when seeking care.[2] When patients are unable to communicate clearly with their health care providers, there is a risk of misdiagnoses and misunderstanding, resulting in lower quality care, and reduced adherence to medication and discharge instructions. These adverse outcomes are unacceptable. As such, we oppose eliminating the language access protections as proposed in the NPRM.

Our comments focus on the NPRM's language access provisions to ensure that persons with limited English proficiency (LEP) have the meaningful access required not only by Section 1557 but also by Title VI of the Civil Rights Act of 1964 (Title VI) and its implementing regulations. In addition, we oppose any other efforts to otherwise eliminate or roll back protections and provisions contained in the 2016 Nondiscrimination in Health Programs and Activities Final Rule (2016 Final Rule) as they apply to other protected classes, including LGBTQ+ persons, women and persons with disabilities. Overall, we urge HHS to withdraw and not finalize this rule.

HSS is overlooking the reasoned process it took to develop regulations for Section 1557: The Department of Health and Human Services (HHS) underwent an extensive process to develop regulations for Section 1557, including a Request for Information, proposed rule and final rule. CPEHN's comments were one of more than 24,875 public comments submitted for the 2016 rule. In our earlier comments to DHS we noted that the "demographics of the United States have increasingly diversified."[3] Without adequate language assistance services, limited English proficient individuals face difficulty enrolling in and navigating health programs and activities. Unfamiliarity with the health care system arises from unfamiliarity with its cultural norms, vocabulary, and procedures. The stories we have heard and seen tell us that Californians with LEP often forgo primary care altogether, as a result of not understanding how to fill out enrollment applications in English or inaccurately translated non-English languages, not understanding the benefits and costs of services in a health plan, or not having the appropriate cultural and language brokers to communicate with English-speaking physicians and pharmacists. These examples are not exhaustive of the daily experiences of individuals who speak English less than very well and who need access to basic health care. They show that linguistically appropriate services—that are also culturally appropriate—are important to help many individuals break through existing communication and information barriers.

I. Proposed Subpart A General Provisions

We oppose the proposed changes in § 92.1 - 92.3 that would narrow the scope of application of Section 1557. Section 1557 applies to any health program or activity, any part of which is receiving federal financial assistance or under any program or activity that is administered by an

[2] 2007 American Community Survey.
[3] 78 Fed. Reg. at 46,559.

Executive Agency or any entity established under Title I of the ACA. Thus, Section 1557 applies to *all* health programs or activities administered by the Department (as well as other federal Departments) *plus* those established under Title I. Further, similar to Title VI, Section 1557 applies to *all* parts of the covered entity, not only the portion receiving federal financial assistance. In addition, given that the majority of individuals access health care through insurance plans, the provision of health insurance is a "health program or activity" and thus Section 1557 applies to it. The proposed changes run counter to the statutory text and intent of Section 1557 and would limit severely limit its application. We therefore oppose them.

Proposed § 92.5 Enforcement

We oppose the proposed changes to § 92.301 as newly designated § 92.5. OCR incorrectly limits the remedies available under Section 1557, in part by referencing the regulations implementing the cited statutes. One of the goals of Section 1557 was to build and expand on prior civil rights laws such that individuals seeking to enforce their rights would have access to the full range of available civil rights remedies and not be limited to only the remedies provided to a particular protected group under prior civil rights laws. This is why Section 1557 expressly provides individuals access to any and all of the "enforcement mechanisms provided for and available under" the cited civil rights statutes, regardless of the type of discrimination.

II. Proposed Subpart B Specific Applications to Health Programs or Activities

Proposed § 92.101 Meaningful Access for Individuals with Limited English Proficiency

a. Obligations

The proposed § 92.101 inappropriately switches the emphasis from "each individual with limited English proficiency" as provided in the 2016 Final Rule to the covered entity's program or activities. In Section 1557, Congress declared "an individual shall not" be subject to discrimination. Section 1557 regulations cannot offer less protection than the statute that authorizes such regulations. Therefore, the correct emphasis in the 1557 regulations must be on each individual and not programs. As such, this NPRM would weaken meaningful access, runs counter to Congressional intent and the thorough administrative record supporting the 2016 Final Rule, and we oppose it.

b. Specific applications

We appreciate the Department's historical emphasis on ensuring meaningful access for LEP individuals as required by Title IV and regulations and consistent with over four decades of U.S. Supreme Court precedent and enforcement by HHS and the U.S. Dept. of Justice (DOJ). As language access advocates, we have strongly supported Title VI and 2003 HHS LEP Guidance and have provided significant input on how to interpret the 4-factor test to ensure its application results in meaningful access for LEP persons required by Title VI and its regulations. We oppose, however, the codification of the 4-factor test in the Section 1557 regulation for the following two reasons. First, it is already the interpretation of OCR that the 2-factor test in the 2016 Final Rule is consistent with Title VI, the only statute in Section 1557 that prohibits national origin

discrimination against LEP individuals. The protections in Section 1557 and its regulations cannot be anything less than those already guaranteed by Title VI. This interpretation negates the claims made by OCR in the current NPRM that it seeks to align Section 1557 with Title VI, as they are already in alignment.

Second, in providing the 2-factor test based upon, informed by and consistent with Title VI, OCR was providing a method of articulating how it would engage in its enforcement review in the health activities and programs context, a specific application of Title VI and newly created by Section 1557. The 2-factor test incorporates the principles in the HHS LEP Guidance and allows OCR to better explain how the factors will be considered in the specific 1557 health activities and programs context giving substantial weight to the nature and importance of the particular communication at issue.

III. Opposition to Current 1557 Provisions Proposed for Repeal or Reconsideration

Overall, we strongly disagree that the nondiscrimination notice, taglines and language access plan language in the 2016 Final Rule were not justified by need, were overly burdensome and created inconsistent requirements. In focusing most significantly on the costs and burdens to covered entities and devoting minimal discussion and analysis to the costs to LEP individuals, OCR is not acting consistent with the balancing principles identified by it in the 2003 HHS LEP Guidance which states "First we must ensure that federally assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English."

a. Proposed Repeal of Nondiscrimination Notice

We oppose the repeal of the requirement that covered entities provide a notice of nondiscrimination that informs the public of their legal rights. The notice requirement is consistent with the long history of civil rights regulations requiring the posting of notice of rights, including Title VI, Section 504, Title IX and the Age Act, which all require that recipients of federal financial assistance notify recipients that they do not discriminate.

OCR has provided no explanation for how individuals will know of their rights and how elimination of notices will not deny LEP individuals, LGBTQ+ persons, women and persons with disabilities meaningful access. Without the notice, members of the public will have limited means of knowing that language services and auxiliary aids and services are available, how to request them, what to do if they face discrimination, that they have the right to file a complaint, and how to file such a complaint.

OCR incorrectly asserts that the nondiscrimination notice is redundant of existing civil rights notices under other statutes. Rather, the notice recognizes the fact that individuals may face multiple forms of discrimination and in fact eliminates duplication by consolidating the underlying statutes' notice requirements into one.

b. Proposed Repeal of In-Language Taglines

We strongly oppose the repeal of the requirement for covered entities to provide in-language taglines informing recipients of the availability of language assistance on significant documents because, combined with the elimination of the nondiscrimination notice, the repeal threatens the

civil rights of LEP persons. The inclusion of taglines is well-supported by long-standing federal and state regulations, guidance and practice. The use of taglines is a cost-effective approach to ensuring that covered entities are not overly burdened while maintaining access for LEP individuals.

In the absence of fully translated documents, taglines are necessary "to ensure that individuals are aware of their protections under the law, and are grounded in OCR's experience that failures of communication based on the absence of auxiliary aids and services and language assistance services raise particularly significant compliance concerns under Section 1557, as well as Section 504 and Title VI." As such, we oppose the proposal to eliminate them.

c. Proposed Repeal of Video Interpretation Standards

We oppose the removal of technical and training requirements for the use of video remote interpreting services for spoken language interpretation. The type of interpreting during a medical visit should depend on the encounter as telephonic communication may be appropriate for scheduling, but not for interpreting information for trauma, mental health, or death. Non-verbal cues in the health care setting or prescription writing cannot be observed via telephone. Further, even with the higher cost in equipment and training, Video Remote Interpreting has saved costs from in person interpreting as there are no minimums, travel time, or cancellation risks, though we believe in-person interpreting is still best for the patient. Keeping the current standard allows providers to determine which technology is appropriate and when an entity uses video, that it is high quality and without lagging.

d. Language Access Plans

We oppose removing all references to language access plans because under the 2016 Final Rule, they are voluntary, not required by the 2016 rule and only a factor to be considered. Language access plans are not required by Title VI or its regulations, but have long been recognized as a way for a covered entity to ensure it is compliant with Title VI. OCR has required language access plans from covered entities as a key component of Title VI enforcement actions involving LEP individuals since before Executive Order 13166 was issued in 2000. Executive Order 13166 also required HHS create and implement a language access plan for its federally conducted programs and activities. That Executive Order also required HHS to issue Title VI LEP Guidance which provided multiple factors an entity could take when developing a language access plan. As such, repealing the voluntary language removes a tool that HHS has used for enforcement and that covered entities can use to support their compliance efforts. Covered entities may, as a result, fail to fully plan on how to best meet the needs of LEP patients and customers.

IV. The Regulatory Impact Analysis is Flawed and Ignores Costs to LEP Individuals

a. The Regulatory Impact Analysis (RIA) is Insufficient and Fails to Justify the Proposals

The NPRM provides a RIA that is wholly insufficient to justify the extensive scope of the proposed changes to language access and entirely fails to identify and to quantify costs to protected individuals. OCR's estimate of the burden to covered entities for compliance with the nondiscrimination notice and tagline requirements is based on voluntary actions and interpretations by covered entities. OCR based the elimination of the notice and taglines on these estimates, but did not consider whether alternatives, such as further clarification about the requirements, was

warranted in the form of FAQs or other guidance. That is, OCR failed to consider alternatives to a complete repeal of notices and taglines that could have appropriately balanced the need to inform individuals of their rights while recognizing there may be a difference in the intentions behind the 2016 Final Rule and how covered entities have interpreted it.

Similarly, the majority of the costs are associated with the provision of a single type of document -- the Explanation of Benefits (EOB). OCR did not consider alternatives as to how it would consider enforcement and interpretation of the "significant document" standard with respect to the provision of multiple EOBs sent during a coverage year.

OCR states it has received little evidence that more beneficiaries are seeking language assistance and uses this claim as a justification to remove the notice and taglines. This claim, which relies on reports from health plans, is insufficient to justify their repeal. The regulation has been in effect for three years in which OCR, by its own admission, has had limited resources to conduct public outreach. Second, the protections guaranteed by Section 1557 are both continuing and many are new, warranting a public effort to conduct outreach. Third, the notices and taglines were selected as a compromise position, to avoid requiring covered entities to translate large numbers of documents. Fourth, LEP persons are uniquely at risk of facing barriers to knowing and asserting their rights. Lack of uptake of services raises questions about the extent to which the public knows its rights and what covered entities are doing to communicate those rights, as opposed to justifying elimination of notices and taglines.

b. Language Access Requirements in the 2016 Final Rule Are Justified by Need

OCR has provided no tangible analysis of the costs and burdens of repealing the notice and tagline requirement. Instead, OCR provides only acknowledgment that repeal "may impose costs, such as decreasing access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services." OCR perfunctorily labels the impact as "negligible" while providing no evidentiary basis.

The costs are not only reduced awareness of language services by LEP persons, but also reduced awareness by the general public about their rights as protected by 1557, especially regarding the notices which include information about the broader nondiscrimination requirements of Section 1557. OCR's only acknowledgement of this impact is one statement about the "unknown number of persons are likely not aware of their right to file complaints."

Discrimination on the basis of national origin, which encompasses discrimination on the basis of language, creates unequal access to health care. Language access in health care is just as critical now as when the Civil Rights Act was originally passed in 1964. Over twenty-five million individuals in the United States are LEP. An estimated 19 million LEP adults are insured. Language assistance is necessary for LEP persons to access federally funded programs and activities in the healthcare system. Without meaningful access, the estimated 25 million individuals who are LEP would be excluded from programs and services they are legally entitled to, including here in California.

c. The NPRM Will Disproportionately Impact Vulnerable Populations

i. AA and NHPIs

Language access in health care services and activities particularly impacts Asian Americans (AAs), Native Hawiians (NH) and Pacific Islanders (PI), given the population's demographics. AAs and NHPIs represent the fastest growing communities in the United States and similarly represent incredible diversity. AAs and NHPIs trace their heritage to nearly 100 different ethnic groups and speak more than 250 different languages. Sixty six percent of AAs speak a language other than English at home and twenty nine percent are LEP, meaning that English is not their primary language and they have a limited ability to read, write, speak or understand English. Twenty-eight percent of NHPIs speak a language other than English at home. Sixty-three percent of Burmese, 45 percent of Nepalese and 44 percent of Bangladeshis are LEP, as are 16 percent of Micronesians. AAs and NHPIs make up twenty-two percent of LEP individuals in the country.

Language barriers to health care are further compounded by immigration and citizenship status, educational attainment and poverty. Sixty percent of Asian Americans are foreign-born, representing every immigration status. Medically underserved AA and NHPI communities—including communities where AAs and NHPIs lack access to health care, have high rates of poverty, and have high numbers of LEP populations—are growing across the country. As of the 2000 Census, there were 282 counties or 13.1% of counties classified as medically underserved or severely underserved AA and NHPI communities.

HHS seeks comment on continuing unaddressed civil rights barriers, which are significant when it comes to language access. For example, over the past Open Enrollment periods for the Marketplace, language has presented a significant barrier for AAs and NHPIs attempting to enroll in coverage. Once enrolled, many LEP consumers continued to have difficulties understanding their benefits and coverage. For example, AA and NHPI community-based organizations reported cases in which individuals did not know their rights and did not realize they were sent legal notices because notices were not provided in their language. Without enforcement of language assistance services, legal notices and taglines to inform persons of their rights, discrete communities, such as those AAs and NHPIs, with large numbers of LEP individuals will be systematically excluded from opportunities to achieve better health and have their civil rights violated. It is this rationale and strong data record that guided the intent behind including the Section 1557 nondiscrimination provision in the ACA and corresponding incorporation of existing civil rights protections.

ii. Latinx

Section 1557 applies longstanding federal civil rights laws that bar discrimination based on race, color, national origin, age, disability, and sex to all health programs and activities that receive federal funding, including ACA health insurance marketplaces, Medicaid and the Children's Health Insurance Program (CHIP). The proposed rule would negatively impact the majority of LEP individuals who are Latino. In a 2018 poll, about 6 in 10 Latino adults reported having trouble communicating with their providers about their health care needs due to language or cultural barriers The nondiscrimination language access protections that the proposed rule seeks to weaken are crucial to minimizing the health care risks LEP Latinos face in the health care system, including avoidable hospital readmissions, lower rates of outpatient follow up, limited use of preventive services, poor medication adherence, and lack of understanding discharge diagnosis and

instructions. Spanish-speaking LEP Latinos are more likely to report experiencing worse health outcomes than Latinos who are monolingual in English or bilingual in English and Spanish.

iv. People with Disabilities & Chronic Conditions

Section 1557 and its 2016 implementing regulations prohibit health insurance companies from discriminating through marketing practices and benefit design. These protections are especially important for people with disabilities and chronic conditions. The proposed rule seeks to exempt most health insurance plans from Section 1557's nondiscrimination protections and eliminate the regulation prohibiting discriminatory benefit design and marketing, which could result in health insurers excluding benefits or designing their prescription drug formularies in a way that limits access to medically necessary care for those living with disabilities and other chronic conditions.

v. Older Adults

U.S. Census data estimates that in 2017, more than 10 million older adults over age 60 speak a language other than English at home and 6 million speak English less than "very well." It is especially critical that older adults have robust language access resources and protections from discrimination. Due to their age and physical barriers, it is unrealistic to expect many LEP seniors to attain full English proficiency.

Specifically in the health care context, four million Medicare beneficiaries - older adults and people with disabilities - are limited English proficient, and 12% of Medicare beneficiaries living in the community report that English is not their primary language. Reports from the Office of Minority Health estimate that almost 2 million Medicare beneficiaries speak languages other than English or Spanish, including over 200,000 beneficiaries who speak Chinese, over 150,000 who speak Vietnamese, and over 140,000 who speak Tagalog. In addition, nearly eight million Medicare beneficiaries are deaf or hard of hearing and four million have blindness or low vision. Over 1.8 million LEP seniors and people with disabilities are also low-income and rely on the tagline and notice requirements in the 2016 implementing regulations to get the information they need across both Medicaid and Medicare.

The risks for older adults who are unable to access health care due to language or other barriers are even greater because most people need more health care as they age. Health care information is complex and can only be communicated effectively in an individual's primary language. Furthermore, older adults may be less inclined to ask for language assistance, out of a fear of inconveniencing others, even if the language assistance is necessary for them to truly understand their health care. In this context, affirmative reminders of one's rights through notices and taglines are critical and help to counter the stigma of asking for help. If an LEP older adult does not understand a statement they receive, is not told or have no notice of how to get help in their primary language, they may not ask for an interpreter, resulting in failing to follow up as necessary or paying for a service when their insurer denies coverage because they are not adequately informed of their right to appeal. Especially for older adults with limited income or high health care needs, the consequences of an erroneous bill or forgoing care can be catastrophic.

vi. LGBTQ+

If finalized, this Proposed rule would severely threaten LGBTQ+ patients' access to all forms of health care, create confusion among patients and providers about their rights and obligations, and promote discrimination. The proposed rule would encourage hospitals to deny care to LGBTQ+ people, and enable insurance companies to deny transgender people coverage for essential health care services that they cover for non-transgender people. By proposing to eliminate protections against discrimination based on transgender status and sex stereotyping, HHS is contradicting over 20 years of federal case law and clear Supreme Court precedent.

Our organization is also opposed to the proposed changes to roll back other, long-standing rules that prohibit discrimination on the basis of gender identity and sexual orientation. These changes are outside of the OCR's jurisdiction and are unrelated to Section 1557 of the ACA. It is not appropriate for these rulemakings to be combined, and it is arbitrary and capricious for HHS to characterize them as "conforming amendments" without offering any legal, policy or cost-benefit analysis about them and their impacts on various CMS programs.

Thank you for the opportunity to comment on the nondiscrimination NPRM.

Sincerely,

Senior Director Policy Analysis/CPEHN

Children's Hospital Colorado
Here, it's different.

August 13, 2019

Luben Montoya
Section Chief, Civil Rights Division
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Nondiscrimination in Health and Health Education Programs or Activities; Docket ID: HHS-OCR-2019-0007

Dear Mr. Montoya:

Thank you for the opportunity to provide feedback on the proposed rule regarding changes to the nondiscrimination provisions under Section 1557 of the Affordable Care Act (ACA). Children's Hospital Colorado (Children's Colorado) respectfully urges the Department to withdraw the proposed rule.

Children's Colorado is one of the nation's leading, not-for-profit pediatric healthcare networks, serving more children than any other healthcare system in our seven-state region. We are also the only freestanding level one pediatric trauma facility in our region, and care for a significant proportion of children with serious injuries, illnesses, and conditions from Colorado, New Mexico, Kansas, Montana, North Dakota, South Dakota, and Wyoming.

We are deeply committed to our mission of improving the health of the children we serve. We believe the proposed changes to ACA Section 1557 would run counter to our mission, by rolling back critical protections against discrimination for the patients we serve and their families. While we oppose the proposed regulation in its entirety, we are particularly concerned about revisions regarding gender identity and language access protections.

We are deeply concerned with the Department's desire to repeal the current definition of sex discrimination, defined as "discrimination on the basis of pregnancy termination, sex stereotyping, and gender identity."[1] By citing "biologically male or female" as the preferred definition of sex, current law is undermined. The ACA rightly banned gender discrimination against LGBTQ people in all kinds of healthcare settings, and the new proposal would erase all reference to protections against discrimination on the basis of sexual orientation, sex stereotyping, and gender identity. While the Department lacks the authority to change the law, this new regulation, if implemented, would confuse patients, providers, and insurers, and make it much harder for many transgender people to access life-saving care. Provider harassment, denials of care, and other forms of discrimination could heighten throughout our state and country.

In recognition of the challenges tied to growing up with an expansive gender identity, our TRUE Center for Gender Diversity at Children's Colorado offers a full array of care designed to meet the needs and goals of gender-diverse children. While we will continue to do all that we can at Children's Colorado to care for our LGBTQ and gender-diverse children and adolescents, we know that a large fraction of these youth still experience refusal for healthcare services at some point during their lives, by no fault of their own. By maintaining the existing regulatory framework, we can help ensure the protection of all young people who rely on our care, and the care of pediatric providers across the state.

Importantly, current regulations also require covered entities to provide to beneficiaries and the public detailed notices of nondiscrimination that include information on how individuals with disabilities may receive auxiliary aids and services and how individuals with limited English proficiency (LEP) may receive translated documents or oral interpretation. Further,

[1] 84 Federal Register No. 115 at 27852

Children's Hospital Colorado
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entities currently must provide taglines regarding the availability of free language services in 15 languages spoken by LEP individuals. The proposed rule calls for a repeal of all provisions relating to "taglines, the use of language access plans, and notices of non-discrimination," explaining that such requirements are unnecessary and "overly burdensome." The existing policy has not imposed any undue burden to our organization. Weakening requirements related to the provision of interpretation and translation services for LEP individuals—including, for example, removing a formal definition for a "qualified" interpreter[2]—sends a signal to certain families that their ability to meaningfully access healthcare is not a priority, which simply does not align with the mission and values of Children's Hospital Colorado.

Current in-person or video interpretation requirements have spurred innovation in the field of telehealth and virtual translation. By requiring "audio-based services" rather than "remote English-language video interpreting services," as the proposed rule suggests, telephone interpretation would likely become the default for many clinical practices because it is less costly.[3] This is concerning to Children's Colorado because our clinicians find video interpreting services invaluable in enhancing the quality of interpretation services for non-English patients and families. With video, the interpreter can see the person for whom they're interpreting and give voice to the non-verbal cues they're getting from the patient and family. When in-person interpretation is unavailable, our clinicians have shared their resounding preference for video over telephone interpretation. Many patients we serve at Children's Colorado speak a language other than English at home, making it vital for providers to use a high-quality option to adequately serve these families.

We believe every child in the United States should have access to high-quality, compassionate healthcare. Access to care that is culturally and linguistically responsive is critical to this goal. We also care about saving costs in the healthcare system. The new regulation, if passed, will jeopardize the health and well-being of our most vulnerable community members, while ratcheting up unnecessary costs driven by medication errors, delayed diagnoses, or other downstream impacts of miscommunication. Such errors jeopardize the quality and safety of healthcare and are ultimately very expensive. Children's Hospital Colorado cannot support policies that deny equitable access to healthcare services that help every child grow up to be healthy and strong. Policies such as this proposed rule compromise our state's potential for success and advancement. So, again, thank you for the opportunity to comment and we respectfully urge withdrawal of the proposed rule.

Sincerely,

/S/ Daniel Hyman

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[2] 84 Federal Register No. 115 at 27860
[3] 84 Federal Register No. 115 at 27868

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

RE: Nondiscrimination in Health and Health Education Programs or Activities, RIN 0945-AA11, Proposed Rule, Fed. Reg. Vol. 84, No. 115, HHS Docket No. HHS-OCR-2019-0007.

The Cities of New York and Chicago, joined by the Cities of Baltimore, Bloomington, Los Angeles, Portland, Providence and Seattle, and the Town of Carrboro (together, the "Signatories") submit this Comment in opposition to Proposed Rule published by the Department of Health and Human Service ("HHS") on June 14, 2019.

THE PROPOSED RULE VIOLATES THE ADMINISTRATIVE PROCEDURE ACT

The APA requires courts to "hold unlawful and set aside agency action, findings, and conclusions that are, among other things, "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A); *see also Motor Vehicle Mfrs. Ass'n of United States v. State Farm Mut. Automobile Ins. Co.*, 463 U.S. 29, 41 (1983).

I. <u>The Proposed Rule Is Not In Accordance With Governing Law</u>.

An agency "does not have the power to adopt a policy that directly conflicts with its governing statute." *Maislin Indus., U.S. v. Primary Steel, Inc.*, 497 U.S. 116, 134-35 (1990); *see also United States v. Mead*, 533 U.S. 218, 228-29 (2001) (agency action cannot be "manifestly contrary to the statute"); *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 n.9 (1984) (courts "must reject administrative constructions which are contrary to clear congressional intent"). Thus, agency action is "not in accordance with law" where it "ignores the plain language of the statute," renders statutory language "superfluous," or "frustrate[s] the policy Congress sought to implement" in the statute. *Pacific Northwest Generating Coop v. Department of Energy*, 580 F.3d 792, 806 (9th Cir. 2009).

The Proposed Rule is in direct conflict with Section 1557 of the ACA in many ways. It conflicts with Section 1557 because it eliminates protections for discrimination based on gender identity and sex stereotyping. It conflicts with Section 1557 because it allows other forms of sex discrimination, such as discrimination based on termination of pregnancy. It conflicts with Section 1557's prohibitions on discrimination based on national origin, as incorporated into Section 1557 through Title VI, by weakening language notice and access requirements. It conflicts with Section 1557 by unlawfully limiting the scope and reach of Section 1557. And it

conflicts with Section 1557's explicit inclusion of enforcement mechanisms available under numerous civil rights laws. As such, the Proposed Rule is "not in accordance with law" and therefore invalid under the APA.

A. The Proposed Rule's Removal of Protections against Discrimination Based on Sex Stereotyping and Gender Identity Conflicts with Section 1557.

Section 1557 provides that "an individual shall not … 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," on the grounds prohibited by Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 ("Title IX") (sex); Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d ("Title VI") (race, color, national origin); the Age Discrimination Act of 1975, 42 U.S.C. § 6101; and Section 794 of Title 29 (Rehab Act)(disability). *See* 42 U.S.C. § 18116. Thus, by its plain terms, Section 1557 was enacted to prevent discrimination in healthcare on any of the grounds recognized by federal civil rights and other statutes.

1. The Proposed Rule Conflicts with Congressional Intent to Protect Transgender and Gender Non-Conforming Individuals from Discrimination in Healthcare.

The ACA was enacted in 2010 "to increase the number of Americans covered by health insurance and decrease the cost of health care." *National Federation of Independent Business v. Sebelius*, 567 U.S. 519, 539 (2012); *see also King v. Burwell*, 135 S. Ct. 2480, 2485 (2015) (the ACA "adopts a series of interlocking reforms designed to expand coverage in the individual health insurance market."); *Morris v. California Physicians' Service*, 918 F.3d 1011, 1016 (9th Cir. 2019) (the purpose of ACA "as demonstrated by the content of its provisions and the implementing regulations, as well as its history, is to broaden access to health care."). One of the ways Congress sought to achieve this goal was through enactment of Section 1557, which aimed to decrease or eliminate many of the barriers felt by classes of individuals who routinely experienced discrimination in health care services, such as higher insurance premiums, denial of coverage for medically necessary procedures, or substandard care. By incorporating the non-discrimination provisions of other civil rights laws into the health care field, Congress sought to prevent discrimination and expand health care to all Americans, regardless of race, color, national origin, sex, age, and disability. As self- implementing, Section 1557 did not require regulations in order to take effect. 42 U.S.C. § 18116(c).

Importantly, by incorporating Title IX's provisions into Section 1557, Congress kept in place exemptions from compliance with the general prohibition against discrimination for covered entities that objected to providing coverage based on religious beliefs, or funding for

abortion services. Thus, Section 1557 struck a balance between protecting health care access for all, including reproductive and sexual health care, and religious liberty.

By allowing blanket discrimination against whole classes of individuals, however, the Proposed Rule tips the balance against health care access and in favor of discrimination, which frustrates the primary and essential purpose of the ACA. *See, e.g.*, *Sebelius*, 567 U.S. at 539. The Supreme Court has held that, under ordinary principles of statutory construction, distinct sections of the ACA must be interpreted in harmony with its overall purpose. *See King*, 135 S. Ct. at 2496 (looking at whole context of statute, Court found that Congress could not have possibly intended to eliminate one of its overarching reforms in a single provision); *see also Morris*, 918 F.3d at 1016 (purpose of ACA "strongly indicates" that provisions must be interpreted and applied in accord with this purpose). The Proposed Rule impermissibly conflicts with the very purpose of Section 1557—to prevent discrimination—and the ACA generally—to expand healthcare access to all Americans.

In 2012, the Department of Health and Human Service's Office of Civil Rights (OCR), the agency responsible for enforcing Section 1557, specifically held that gender identity and gender non-conformance was protected under Section 1557. OCR issued an opinion letter on July 12, 2012, stating that "[w]e agree that Section 1557's sex discrimination prohibition extends to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity and will accept such complaints for investigation." *See* Letter from Leon Rodriguez, Director, Office of Civil Rights, to Maya Rupert, Federal Policy Director, National Center for Lesbian Rights.[1] The letter also provided that "Section 1557 also prohibits sexual harassment or discrimination regardless of the actual or perceived sexual orientation or gender identity of the individual involved." *Id*.

Further advancing this purpose, and after an extensive due diligence period that included a request for information on August 1, 2013, proposed rules issued on September 8, 2015, and a thorough evaluation and response to nearly 25,000 comments, HHS promulgated regulations (the "2016 Regulations), which comprehensively set forth definitions, procedures, notice requirements, and enforcement mechanisms, for the implementation of Section 1557. *See* 45 C.F.R. § 92.1 *et seq*. (May 18, 2016).

The 2016 Regulations defined "on the basis of sex" to include "discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity." *Id*. at § 92.4. Gender identity was defined as "an individual's internal sense of gender, which may be male, female,

[1] Available at https://www.washingtonblade.com/2012/08/07/hhs-affirms-trans-protections-in-health-care-reform.

neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth." In turn, "sex stereotyping" was defined as "stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics" *Id.* While HHS noted that it supported banning discrimination on the basis of sexual orientation as policy, it did not expressly include it in the definition (noting that the law was mixed on this issue), but it did state that discrimination on the basis of sexual orientation was prohibited if it were based on sex stereotyping. 81 Fed. Reg. at 31389-90.

The 2016 Regulations also included a nondiscrimination provisions, stating that "[e]xcept as provided in Title I of the ACA, an individual shall not, on the basis of race, color, national origin, sex, age, or disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any health program or activity to which this part applies." 45 C.F.R. § 92.101(a)(1). In addition, the 2016 Regulations provided that covered entities "shall treat individuals consistent with their gender identity," except that they cannot "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." *Id*. at § 96.206. In other words, the 2016 Regulations made clear that, for example, a transgender male could not be denied service or coverage for ovarian cancer due to the fact that he did not present as a woman. Thus, beyond the incorporation of Title IX, the 2016 Regulations affirmatively prohibited discrimination on the basis of gender identity and transgender status.

The 2016 Regulations emphasized, however, that "[i]nsofar as the application of any requirement under this part would violate applicable Federal statutory protections for religious freedom and conscience, such application shall not be required." *Id*. at § 92.2(b)(2). Accordingly, the 2016 Regulations continued to recognize that religious and moral objections to providing health care coverage and services could be legitimate bases for exemption from Section 1557.

HHS explained that the 2016 Regulations were written to "adopt formally this well-accepted interpretation of discrimination 'on the basis of sex.'" 81 Fed. Reg. 31387-88. HHS looked to other federal agencies, who had previously interpreted sex discrimination to include discrimination on the basis of gender identity, citing opinions from the Department of Labor, Department of Education, Department of Housing and Urban Development, and the Department of Justice. *Id*. at 31387 and note 56. HHS also noted that around the same time that Congress passed the ACA, it also passed two statutes that protected against discrimination on the basis of gender identity. *See* 18 U.S.C 249(a)(2)(A), the Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act (HCPA) (criminalizing actions that cause harms based on persons' actual

or perceived sexual orientation, or gender identity, which in turn is defined as "actual or perceived gender-related characteristics"); 34 U.S.C. 12291(b)(13)(A) (2013), the Violence Against Women Reauthorization Act (adding "gender identity" as a protected characteristic in discrimination provision.). Perhaps most importantly, HHS emphasized that, at the time the ACA was enacted in 2010, federal courts had already interpreted sex discrimination to cover transgender people, and that, since that time, courts had interpreted Section 1557 specifically to cover such discrimination. *Id*. at 31387-90.

In removing these protections, through elimination of the definitions and antidiscrimination provisions, the Proposed Rule is—unlawfully—in direct conflict with Section 1557. The statutory purpose of the ACA generally, and Section 1557 in particular, as further reflected in the thoughtful and comprehensive 2016 Regulations, make clear that Congress intended to include gender identity and transgender status under the definition of "on the basis of sex." Congress did not intend to permit discrimination on the basis of sex for an entire class of individuals, those who are transgender, gender non-conforming, or otherwise non-binary (TGNCBN). Yet that is what the Proposed Rule allows. HHS now claims that Congress intended "sex" to refer solely to a person's biological sex assigned at birth,[2] but it offers no reasonable evidence to support this sudden turn-around, nor adequately explain its decision to reverse course in the face of the exhaustive record before HHS two years ago, when the 2016 Regulations were written.

Moreover, HHS's recent interpretation of Congress's meaning of term "sex," is too narrow in light of the ACA's goal to prohibit discrimination and provide equal access to health care and insurance and the statutory context of Section 1557. This narrow reading contravenes the U.S. Supreme Court's view that the interpretation of statutes "must not negate their own stated purposes," *New York State Dept. of Social Servs. v. Dublino*, 413 U.S. 405, 419–420 (1973) and "must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 51 (1987); *see also Util. Air Regulatory Grp. v. E.P.A.*, 134 S. Ct. 2427, 2441 (2014) (noting the "fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme."). The ACA does, and must, protect all people from discrimination in healthcare, and the Proposed Rule conflicts with this plain Congressional intent.

[2] This position likewise ignores the ever-growing body of scientific data showing that sex is not always accurately assigned at birth. Sex assignment at birth, typically based on reproductive anatomy, often ignores the complexity of factors that determine a person's sex, including "genetic or chromosomal sex, gonadal sex, internal morphological sex, genitalia, hormonal sex, phenotypic sex, assigned sex/gender of rearing, and self-identified sex." Derek Waller, Recognizing Transgender, Intersex, and Nonbinary People in Healthcare Antidiscrimination Law, 103 Minn. L. Rev. 467, 472-79 (2018) (internal citations omitted).

2. The Proposed Rule Conflicts with Precedent Under Title IX and Similar Civil Rights Statutes Holding that Discrimination on the Basis of Sex Includes Gender Identity.

As discussed, Section 1557 incorporates the protections of Title IX, which prohibits discrimination on the basis of sex in federally-funded education programs and activities. *See* 20 U.S.C. § 1681. While Title IX does not contain an explicit definition of discrimination "on the basis of sex" in its text or regulations, courts have commonly interpreted the phrase to include discrimination on the basis of sex stereotyping and gender identity. Notably, Section 1557 explicitly prohibits an interpretation of the statute that would invalidate or limit the rights, remedies, procedures, or legal standards to individuals aggrieved under Title IX, Title VII and other civil rights statutes. The Proposed Rule is an abrupt and unlawful departure from this body of law.

In determining the scope of Title IX's protections against sex discrimination, courts traditionally looked to case law developed under Title VII, which prohibits discrimination "because of sex" in the employment context. *See* 20 U.S.C. §§ 2000e *et seq*. In 1989, the Supreme Court recognized that discrimination "because of sex" under Title VII included sex stereotyping, such that a woman who was denied a promotion because she did not exhibit feminine qualities typically associated with being female, had stated a Title VII discrimination claim. *Price Waterhouse v. Hopkins*, 490 U.S. 228, 251 (1989) ("[I]n forbidding employers to discriminate against individuals because of their sex, Congress intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes."), *superseded by statute*, Civil Rights Act of 1991, Pub. L. No. 102-166, 105 Stat. 1071. In so doing, the Court essentially rejected the reasoning, "and vitiate[d] the precedential value, of earlier Federal appellate court decisions that limited Title VII's coverage of 'sex' discrimination to the anatomical and biological characteristics of sex." 2016 Regulations, 81 Fed. Reg. at 31388.

A majority of appellate courts have held that the sex stereotyping recognized by *Price Waterhouse* extends to transgender individuals or discrimination based on sexual orientation. *See, e.g., EEOC v. R.G. & G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 576 (6th Cir. 2018) (employer violated Title VII when it fired employee for being transgender; "[d]iscrimination on the basis of transgender and transitioning status is necessarily discrimination on the basis of sex"); *Zarda v. Altitude Express, Inc.*, 883 F.3d 100, 132 (2d Cir. 2018) (rehearing en banc) (Title VII prohibits discrimination based on sexual orientation), *cert. granted*, 139 S. Ct. 1599 (2019); *Hively v. Ivy Tech Cmty. Coll. of Ind.*, 853 F.3d 339, 350-52 (7th Cir. 2017) (describing plaintiff's sexual orientation as "the ultimate case of failure to conform to the female stereotype" and holding that sexual orientation discrimination is *per se* sex discrimination under Title VII); *Glenn v. Brumby*, 663 F.3d 1312, 1316-17 (11th Cir. 2011) ("[D]iscrimination against a transgender individual because of her gender-nonconformity is sex discrimination, whether it's described as being on the basis of sex or gender."); *Smith v. City of Salem*, 378 F.3d 566, 572-73

(6th Cir. 2004) (recognizing discrimination based on gender identity or gender non-conformity as actionable sex discrimination under Title VII); *Schwenk v. Hartford*, 204 F.3d 1187, 1202 (9th Cir. 2000) (holding that sex discrimination under Title VII encompasses both biological differences between men and women, and gender identity). *But see Bostock v. Clayton Cty. Bd. of Comm'rs*, 723 F. App'x 964, 965 (11th Cir. 2018) (denying employee's Title VII discrimination claim based on sexual orientation, citing earlier circuit precedent that "forecloses" employee's claim "regardless of whether we think it was wrong"), *cert. granted*, 139 S. Ct. 1599 (2019); *Etsitty v. Utah Transit Auth.*, 502 F.3d 1215, 1220-21 (10th Cir. 2007) (discrimination based on person's status as transsexual was not discrimination "because of sex" under Title VII).[3]

Relying in large part on these Title VII cases, appellate courts have consistently held that Title IX must be construed to include gender identity discrimination. For example, in *Whitaker v. Kenosha Unified School District No. 1*, 858 F.3d 1034, 1039-1047 (7th Cir. 2017), the Seventh Circuit held that discrimination against someone for being transgender is sex discrimination under the sex-stereotyping theory recognized in *Price Waterhouse*, and affirmed a preliminary injunction enjoining a school district from enforcing its policy barring transgender students from using school restrooms matching their gender identities against the plaintiff, a transgender boy. *Id*. at 1039, 1049-50 (policy that subjects transgender person to differential treatment because they are transgender "punishes that individual for his or her gender non-conformance" and is, therefore, form of sex discrimination prohibited by Title IX).

The three other federal appellate courts that have considered this issue under Title IX have likewise held that it protects against gender identity discrimination. *See Doe by & through Doe v. Boyertown Area Sch. Dist.*, 897 F.3d 518, 533-34 (3d Cir. 2018) (concluding that school district's sex-neutral bathroom policy allowing students to use bathrooms that align with gender identity did not discriminate against cisgender students on basis of sex, and further finding that "barring transgender students from restrooms that align with their gender identity would itself pose a potential Title IX violation"), *cert. denied*, 2019 U.S. App. LEXIS 3666; *Dodds v. U.S. Dep't of Educ*., 845 F.3d 217, 221(6th Cir. 2016) (affirming preliminary injunction that required school to allow transgender girl to use girl's bathroom); *G.G. ex rel. Grimm v. Gloucester Cty. Sch. Bd*., 822 F.3d 709, 720-23 (4th Cir. 2016) (Title IX's regulations protected transgender student from discrimination on basis of sex), *vacated and remanded*, 137 S. Ct. 1239 (2017), *dismissed as moot*, 2017 WL 9882602 (Dec. 12, 2017).

[3] On April 22, 2019, the Supreme Court granted certiorari to three of these cases—*Harris*, *Zarda*, and *Bostock*—to address whether Title VII's protections apply to transgender status and sexual orientation. *See* 139 Sp. Ct. 1599.

Against this landscape of Title VII and IX cases, HHS's position that "'sex' under Title IX does not include sexual orientation or gender," 84 Fed. Reg. at 27853, is flat out wrong, and cannot be used as a legitimate basis for writing these protections out of the Proposed Rule. And the hollow arguments put forth by HHS in an attempt to support its position reveal as much.

First, HHS dishonestly asserts that "Congressional activity" in this area "suggests" that sex under Title IX does not include sexual orientation or gender. *Id*. at 853. HHS cites the syllabus in *FDA v. Brown & Williamson Tobacco Corp*., 529 U.S. 120, 122 (2000), for the proposition that when "Congress several times considered and rejected bills" that would have granted the agency authority, "[it] evidenced a clear intent to [reject such authority]." 84 Fed. Reg. at 27853. Then, as evidence of Congress's intent here, HHS cites to: (1) a gender equity bill introduced in 2016 to amend Title IX, which never made it out of committee; and (2) proposed amendments to the Civil Rights Act over the last thirty years that likewise did not proceed past committee (except the Equality Act, which actually passed the House of Representatives in 2019). *Id*. & n. 38, 39.

The examples HHS relies on fail to support its version of Congressional intent. Unlike in *Brown & Williamson*, Congress has not repeatedly "considered and rejected" bills defining sex to include gender identity and sexual orientation; such bills either stalled in committee, or passed. *See also* 18 U.S.C. § 249(a)(2)(A) (the Hate Crimes Prevention Act) and 34 U.S.C. § 12291(b)(13)(A) (the Violence Against Women Reauthorization Act). And the Supreme Court has made clear that mere inaction by Congress is virtually meaningless. *See Whitaker*, 858 F.3d at 1049 ("Congressional inaction is not determinative" since it "'lacks persuasive significance because several equally tenable inferences may be drawn from such inaction, including the inference that the existing legislation already incorporated the offered change.'") (internal citation omitted). Thus, Congressional inaction could just as easily mean that Congress believed that "sex" under Title IX already included gender identity and sexual orientation. Furthermore, had HHS read the actual case and not just the syllabus, it would have known that *Brown & Williamson* actually states that "[w]e do not rely on Congress' failure to act—its consideration and rejection of bills that would have given the FDA this authority—in reaching this conclusion." 529 U.S. at 155. Rather, the Court stressed that its holding was based on the fact that "Congress has enacted several statutes addressing the particular subject of tobacco and health, creating a distinct regulatory scheme," while at the same time "Congress has persistently acted to preclude a meaningful role for *any* administrative agency in making policy on the subject of tobacco and health." *Id*. at 156.

Second, HHS misleadingly exaggerates the existence of a conflict of law, while wrongly implying that the weight of judicial authority aligns with its new interpretation. HHS states that "[w]hile four appellate courts have addressed the issue, a large volume of district court opinions have been inconsistent on the issue." 84 Fed. Reg. at 27855. HHS fails to mention that those

"four appellate courts" all recognized gender identity as a basis for discrimination under Title IX; indeed, it relegates them to a dismissive footnote only. While it is true that several district courts have ruled inconsistently on the issue, HHS impermissibly elevates the value and importance of these cases above the appellate court decisions.

Finally, HHS states that it is repealing the definitions for consistency's sake and to prevent "public confusion," citing the fact that DOJ's current position, as stated in *Franciscan Alliance* and other recent cases, conflicts with the 2016 Regulations. *Id*. at 27854-55, 856. This is nothing more than circular logic: Despite years of "sex" being interpreted to include gender identity and sexual orientation by DOJ, HHS, and the courts, DOJ decides unexpectedly last year to change its position, and HHS now relies on this new position as justification for its actions. This nonsensical explanation does not and cannot save the fact that the new position conflicts with Section 1557 itself. And if consistency were the true goal, it could have easily left untouched HHS and DOJ's prior interpretation. In fact, HHS goes on to say that it is not proposing its own definition of sex "because of the likelihood that the Supreme Court will be addressing the issue in the near future." *Id*. at 27857. Better then, HHS could have avoided even further confusion and litigation by holding off on issuing the Proposed Rule after the Supreme Court granted certiorari on April 22, 2019.

3. The Proposed Rule Conflicts with Case Law Interpreting Section 1557.

Finally, the Proposed Rule conflicts with every court—save one—that has directly considered whether Section 1557 prohibits discrimination based on gender identity and transgender status.

In the first case to address the issue, *Rumble v. Fairview Health Services*, 2015 WL 1197415 (D. Minn. Mar. 16, 2015), a transgender man claimed the local hospital and physicians violated Section 1557, alleging discriminatory treatment due to his transgender status. *Id*. at *3. Since HHS had not yet promulgated the 2016 Regulations, the court looked at the plain statutory language of Section 1557 and its incorporation of the four nondiscrimination statutes. *Id*. The court found that Section 1557 was ambiguous "insofar as each of the four statutes utilizes different standards for determining liability, causation, and a plaintiff's burden of proof." *Id*. at *9. Although it did not expressly find that Section 1557 was ambiguous with regard to the definition of sex, the court looked to agency interpretation—OCR's 2012 Opinion Letter—for guidance. *Id.* at *10. The court found that the OCR letter, while not controlling, was persuasive in "the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements." *Id*. Accordingly, it concluded that discrimination on the basis of sex under Section 1557 included transgender status. *Id*.

Next, in *Prescott v. Rady Children's Hospital*, 265 F. Supp. 3d 1090 (S.D. Cal. 2017), the court found that Section 1557 applied to protect transgender individuals in a lawsuit brought by a mother against a hospital, on behalf of her deceased minor transgender son. *Id.* at 1097. The defendant argued that the claim must be dismissed because the alleged conduct occurred before the 2016 Regulations (defining sex discrimination as including gender identity) had been promulgated, though they were in effect at the time the lawsuit was brought. *Id*. at *1098. The court rejected this claim, finding that Section 1557 affords protection against discrimination on the basis of gender identity "solely on the language of section 1557 itself," and not the 2016 Regulations. To support its finding, the court relied on Title VII and Title IX cases, *supra* at 6-9.

Two cases decided in 2018 from the district court in Wisconsin followed. In *Flack v. Wisconsin Department of Health Services*, 328 F. Supp. 3d 931 (W.D. Wis. 2018), the court granted a preliminary injunction to two plaintiffs who challenged the State of Wisconsin's Medicaid plan, which contained a categorical exclusion from coverage for all "[t]ranssexual surgery" and related procedures and medications. The Court found that the blanket exclusion, which prevented the two plaintiffs from getting medically necessary treatments, did so on the basis of both their assigned sex at birth and their transgender status, holding that "[e]ven accepting defendants' [narrow] definition of sex," the Wisconsin exclusion nevertheless denied plaintiffs coverage because of their natal sex," because the same procedure would be allowed for those seeking if gender matched natal sex, while not if it did not match gender identity. *Id*. at 947. The court concluded that the case was a "straightforward case of sex discrimination." *Id.* at 948.

Shortly thereafter, the same court also upheld a claim under Section 1557 brought by transgender women employees of the State of Wisconsin, wherein the state had excluded procedures and services related to gender reassignment from its health insurance coverage provided to employees. *See Boyden v. Conlin*, 341 F. Supp. 3d 979 (W.D. Wis. 2018). Following the reasoning in *Flack*, the court concluded holding that denying coverage for transsexual surgery fell within the ambit of the ACA's prohibition on "sex discrimination." *Id*. at 995.

Most recently, in *Tovar v. Essentia Health*, 342 F. Supp. 3d 947 (D. Minn. 2018), the Minnesota district court held that the plain language of Section 1557 prohibited discrimination on the basis of gender identity. There, plaintiff alleged that her transgender son was denied coverage for medically necessary care by defendant's health care plan, which categorically excluded all health services related to gender transition. *Id*. at 950-51. Following the Supreme Court's "expansive view" of sex discrimination in *Price Waterhouse v. Hopkins*, 490 U.S. 228, 251 (1989), as well as the decisions of "numerous courts" on the "precise question at issue here" under Section 1557, the court concluded based "solely on the plain, unambiguous language of the statute" that the plaintiff had stated a claim for sex discrimination under the ACA based on gender identity. *Id.* at 953, 957.

Thus, five out of the six cases that have interpreted sex discrimination under Section 1557 have held that it includes discrimination based on gender identity and transgender status.[4] Nevertheless, HHS claims that the Proposed Rule is "necessary," because the 2016 Regulation "is likely not constitutional." 84 Fed. Reg. at 27849. HHS supports this conclusion by relying entirely on *Franciscan Alliance*, despite the fact that it is an outlier and contrary to all of the other court decisions. Indeed, as it did with the Title IX cases that it disagrees with, HHS recognizes only that "other Federal courts have gender identity discrimination cases . . . pending on their dockets," *id*. at 27855, yet fails completely to acknowledge their holdings. HHS cannot escape the legal import of these cases by simply burying its head in the sand and ignoring them, while placing undue importance on a one-off decision it happens to agree with. Such wishful thinking does not eliminate the clear conflict between the Proposed Rule and the body of law interpreting Section 1557.

Furthermore, HHS's position conflates the 2016 Regulations with the statute itself. While *Franciscan Alliance* held that the definition of "on the basis of sex" in the 2016 Regulations went too far, the cases holding that Section 1557 extends to gender identity and transgender status did so on the basis of Section 1557 itself, and not the 2016 Regulations. Therefore, the Proposed Rule does not (and cannot) change the protections against discrimination that are part of Section 1557 as conferred by Congress, and act only to directly conflict with it.

In sum, HHS's attempt to rewrite Section 1557 by removing explicit protections under the 2016 Regulations is not only in direct contrast with existing law, but also marks an unlawful attempt to omit from discrimination protection an entire class of individuals. Congress directed HHS to bar sex discrimination in health care on the basis of sex; and it did so with clear intent to protect all individuals, including those who would encounter discrimination due to their transgender or gender non-conforming status. HHS's Proposed Rule, therefore, is in direct conflict with governing law, plainly violates the APA, *see Maislin Indus. v. Primary Steel, Inc.*, 497 U.S. 116, 134-35 (1990), and is an unlawful attempt to circumvent Congressional intent and well-established legal precedents through rule making.

[4] HHS also cites two consolidated cases from the North Dakota district court alleging that the 2016 Regulations were unlawful, but those cases were stayed in light of the injunction issued in *Franciscan Alliance*. *See Religious Sisters of Mercy v. Burwell*, No. 3:16-cv-386 (D.N.D. Nov. 7, 2016); *Catholic Benefits Ass'n v. Burwell,* No. 3:16-cv-432 (D.N.D. Dec. 28, 2016). HHS cites only to their dockets, however, because there are no published opinions or decisions in these cases.

B. The Proposed Rule's Blanket Removal of Protections For Persons Who Have Terminated a Pregnancy, Are Recovering Therefrom, or Suffering From Resulting Medical Conditions Conflicts With Section 1557.

The Proposed Rule would allow health care providers and other covered entities to invoke blanket abortion and religious objection exemptions from the 2016 Regulations' general prohibition on sex discrimination. Specifically, the Proposed Rule would allow for blanket denials of health care and insurance for persons based upon their termination of a pregnancy, recovery therefrom, or resulting medical conditions, irrespective of competing interests, including the health of people who may require emergency treatments. HHS notes that the statute will not apply if any part of it would "violate, depart from, or contradict definitions, exemptions, affirmative rights, or protections" under a wide range of provider conscience provisions set forth in HHS's recent rule "Statutory Conscience Rights in Health Care."

Essentially, under the Proposed Rule, people in need of abortion or other health care services that violate a provider's religious beliefs could be denied, delayed, or discouraged from seeking necessary care, placing them at risk of serious or life-threatening results in emergencies and other circumstances where the individual's choice of health care provider is limited. Should this lead to restrictions in abortion coverage by health insurers or abortion and related service provision by healthcare providers, the resulting gap in healthcare access would almost certainly disproportionately affect poor and low-income women who are unable to pay out-of-pocket for abortion services.

These proposed changes conflict with Section 1557 for numerous reasons. First, the text of Section 1557 is unambiguously clear as to the exemptions that apply to its antidiscrimination mandates. The statute explicitly extends nondiscrimination protections "except as otherwise provided for in [the] title (or an amendment made by [the] title)." 42 U.S.C. § 18116(a). Second, the Proposed Rule considers an overbroad universe of "conscience protections" separately established by HHS and not sanctioned by any federal laws or regulations. The expanded "conscience protections" would allow anyone "with an articulable connection to a procedure, health service, health program or research activity" to raise these alleged conscience objections. Meaning, the myriad participants in a health care encounter—from intake and billing staff to pharmacists, translators, radiology technicians, and insurance companies—could refuse to participate in service delivery to or provide coverage for patients, even under emergency circumstances. These expanded "conscience protections" would themselves amount to a violation of Section 1557 and the incorporated federal civil rights laws as they are nothing more than a new standard of selective and discriminatory treatment for many of the most vulnerable populations. HHS's rule seeking to expand "conscience protections" is currently being challenged in a California federal court by the city and county of San Francisco, and in a New

York federal court by a coalition of 23 states and municipalities, including signatories of this comment.[5]

Third, while debating the language of Section 1557, Congress considered and rejected broader exemptions similar to those now proposed by HHS. Congress refused to expand the federal conscience clause to prohibit "requir[ing] an individual or institutional health care provider to provide, participate in, or refer for an item or service to which such provider has a moral or religious objection, or require such conduct as a condition of contracting with a qualified health plan. *See, e.g.,* 155 CONG. REC. S13193-01 (2009). Congress also considered and rejected broader religious and moral exemptions in the context of the Women's Health Amendment. *See, e.g.,* 155 CONG. REC. S13193-01 (2009).

Finally, Congress has already included protections in the ACA to address religious concerns. Specifically, Title I of the ACA, in which Section 1557 is found, clearly incorporates existing federal conscience protections. *See e.g.,* 42 U.S.C. § 18023(c)(2)(a)(i) (2010) ("Nothing in this Act shall be construed to have any effect on Federal laws regarding . . . conscience protection."); 42 U.S.C.A. § 18113 (2010) (exemptions for objections to assisted suicide); 42 U.S.C.A. § 18023 (2010) (allowing states to prohibit abortion coverage in the state exchanges); 42 U.S.C. § 18023(c)(1)-(2) (the ACA shall not "preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor").

Additionally, the ACA is already subject to the Religious Freedom Restoration Act (RFRA), and the 2016 Regulations allow for a case-by-case assessment of burdens on a provider's religion pursuant to the RFRA. The 2016 Regulations rejected incorporating Title IX's blanket religious exemption because Title IX is limited to educational institutions, which is significantly different from the health care context. While students and parents typically have a choice about whether to select a religiously affiliated educational institution, individuals' choice of health care provider or health care plan may be limited, especially in cases of emergency and in areas where hospitals are run by religious institutions. Notably, Congress has recognized the importance of ensuring the provision of emergency care to all persons without exception, and mandated that such care must be made available without exception. *See* 42 U.S.C. § 1395dd (hospitals that have an emergency room or department must provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or, if medically warranted, to transfer the person to another facility).

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[5] *State of New York v. U.S. Dep't of Health and Human Srvcs*, Case 1:19-cv-04676 at https://ag.ny.gov/sites/default/files/state_of_new_york_v_hhs_complaint.pdf; *City and County of San Francisco v. Azar*, Case No. 3:19-cv-2405 at https://www.sfcityattorney.org/wp-content/uploads/2019/05/1_Complaint.pdf.

Thus, HHS previously and more appropriately relied upon the RFRA to make individual case-by-base determinations about "whether a particular application of Section 1557 substantially burdened a covered entity's exercise of religion, and if so, whether there were less restrictive alternatives available." This means that, under the 2016 Regulations, there may be some instances in which a provider's religious beliefs will exempt it from providing services to which it objects to an individual, but other instances, based on the facts of a particular case, in which an individual must receive services despite a provider's religious objection.

The RFRA approach better balances the rights of all stakeholders and adheres to the ACA's purpose to provide equal access to health care and insurance; rather than prioritizing the purported religious and moral objections of providers and insurance companies over the rights of patients in need of critical medical care for time-sensitive health conditions. Indeed, the denials, delays, and inadequate medical care that individuals would face due to the assertion of overbroad "conscience objections could inflict significant and in some cases life threatening harm in the healthcare context.

C. The Proposed Rule's Weakening and Elimination of Language Assistance Conflicts with Section 1557.

(1) The Proposed Rule Makes Existing Language Access Mandates Discretionary

The Proposed Rule waters down existing requirements to ensure that low English proficiency ("LEP") individuals have access to translations and interpretation services. Specifically, the Proposed Rule would replace required steps to provide meaningful access "to each LEP individual eligible to be served or likely to be encountered" with a broader test that an "entity" apply a four-factor analysis to determine an organization's obligations to provide language assistance services. Using such a metric in the healthcare context would shift a healthcare entity's focus from providing language access to each individual – consistent with the established standards of patient-centered care – to a looser consideration of language access exclusively on an institutional level.

Section 1557's protections for LEP individuals builds upon pre-existing civil rights law, such as Title VI, which prohibits discrimination on the basis of race, color and national origin in programs and activities receiving federal financial assistance. Under governing U.S. Supreme Court case law, Title VI obligates recipients of Federal financial assistance to provide LEP individuals with meaningful access to Federally funded programs or activities. Section 1557 extends this protection to federally administered programs, and requires that healthcare institutions implement some of the basic standards and practices that are necessary for ensuring equal access to healthcare, regardless of the language patients and their families speak.

The Proposed Rule weakens language access because it will allow increased justifications for institutions to deny individuals language services, even when that information may be critical

to a patient's health and wellbeing. Health care entities will more likely discount LEP individuals when determining whether language access must be provided, and already vulnerable families and communities may experience disruptions and delays in the provision of their health care. Indeed, already marginalized communities are most likely to be neglected under the proposed changes—those who typically have less access to resources in their languages, and are often vulnerable due to their immigration and socio-economic status. Language access discrimination often overlaps with pre-existing barriers to access to health care, such as national origin, race, and color discrimination Thus, the Proposed Rule will put more vulnerable people at risk by making healthcare services more difficult to access or understand.

(2) The Proposed Rule Eliminates Notice and Taglines Requirements

The 2016 Regulations require covered entities to take reasonable steps to provide meaningful access to each LEP individual eligible to be served or likely to be encountered. Requirements also include posting a visibly-sized notice of non-discrimination and the availability of language access services in physical locations where the entity interacts with the public, on the entity's website, as well as in significant publications. The 2016 Regulations also require taglines on such publications, which must be translated into top 15 non-English languages for large-sized publications and top two languages for small-sized publications.

The Proposed Rule would eliminate notice requirements about one's rights to translation services, protections from discrimination, and directions concerning how to file a complaint. These proposed changes would result in a failure to provide meaningful access to language services for LEP individuals. These changes will also deprive persons with communication disabilities, such as individuals who are deaf or hard of hearing and use a foreign sign language as their preferred mode of communication of meaningful access to language services. Under governing U.S. Supreme Court case law, Section 794 of Title 29 (the Rehab Act) obligates recipients of Federal financial assistance to provide persons with disabilities with meaningful access to Federally funded programs or activities.

Ultimately, the Proposed Rule will undoubtedly weaken language access. In fact, in the Proposed Rule, HHS admits that repealing the requirements for taglines may "[decrease] access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services." 84 Fed. Reg. at 27855. When linguistically appropriate care is not available to people who speak English "less than well," patients, providers, and healthcare providers alike are put at risk. Studies have shown that language barriers impede access to health insurance, hinder utilization of health care services, compromise quality of care, and increase the risk of adverse health outcomes among LEP individuals. Cite? LEP individuals are more likely than others to report being in fair or poor health, defer needed medical care, or misunderstand medication instructions.

Essentially, when patients do not know they have the right to an interpreter, do not know how to request an interpreter, or cannot read important notices about their care or insurance, it is much more likely that they will not receive care or service in a language that they can understand. When communication between patients and providers is compromised, healthcare providers are unable to provide adequate patient care, and patients' health is put at risk. Simply put: If individuals do not know they can access language services, they will not access them, and their health will suffer. Thus, because the proposed elimination of the notice and tagline requirements will impede the ability of LEP individuals and persons with communication disabilities to meaningfully access health care and coverage programs and services, these proposed changes violate Section 1557 and the incorporated federal civil rights laws— Title VI and Section 794 of Title 29.

D. The Proposed Rule's Exemption of Numerous Health Care Insurance Entities Conflicts With the Scope of Section 1557.

Adding to protections against discrimination within the U.S. Constitution and federal civil rights laws, Section 1557 is the first civil rights statute to explicitly target discrimination in healthcare, including private insurance. Congress sought to advance the ACA's mission to expand coverage and to increase access to care through Section 1557, which broadly applies to "any health program or activity, any part of which is receiving Federal financial assistance," "any program or activity that is administered by an executive agency," and "any entity established under this title," and specifically enumerates "contracts of insurance" as a form of Federal financial assistance.

A previous regulatory analysis estimated that the 2016 Regulations would cover about 900,000 physicians, 133,343 facilities (such as hospitals and nursing homes), 445,657 clinical laboratories; 1,300 community health centers; 40 health professional training programs; Medicaid and public health agencies in each state and the territories; and at least 180 insurers.

The Proposed Rule severely limits the application of Section 1557 in health insurance by (1) entirely eliminating the definitions section of the 2016 Regulations and no longer defining "covered entity" and "health program or activity;" and (2) interpreting Section 1557 to apply only to an insurer's fully federally-funded or supported operations and those principally engaged in the business of providing healthcare.

Within this narrow scope, the Proposed Rule would entirely exempt Medicare Part B, group health plans established under ERISA, short-term plans, the Federal Employees Health Benefits Program, off-exchange products, and certain non-ACA health care programs administered by HHS from compliance with Section 1557.

The proposed exemptions run directly counter to the underlying statute that explicitly covers all health programs and activities if <u>any part of them</u> is receiving federal funding. The

plain text of Section 1557 includes any and all federal financial assistance by the terms "any health program or activity, . . . that is administered by an Executive Agency or any entity established under this title." Moreover, according to HHS' 2003 LEP guidance, which HHS claims it intends to follow, "coverage extends to a recipient's entire program or activity, *i.e.*, to all parts of a recipient's operations. This is true even if only one part of the recipient receives the federal assistance."[6]

More specifically, the Proposed Rule erroneously excludes ERISA plans from the scope of Section 1557 on the grounds that "such programs do not receive federal financial assistance from HHS and/or the entities operating them are not principally engaged in the business of providing health care." However, Section 1557 explicitly refers to "contracts of insurance," and thereby removes previous uncertainty about when civil rights law protections apply to health insurance coverage. The statute also makes it clear that all health insurers, so long as any part of their program or activity receives federal financial assistance, must not discriminate against individuals on the grounds of race, color, national origin, sex, or disability. Further, employer-sponsored plans, including self-funded group plans, heavily rely on federal financial assistance. In fact, as noted by the Commonwealth Fund, the government's largest expenditure in healthcare coverage outside of Medicare and Medicaid, is its subsidy of employer-sponsored coverage through the favorable tax treatment given to employer-sponsored plans, worth an estimated $146 billion in fiscal year 2018.[7] Health insurance companies, and employer-sponsored plans, also rely on government tax benefits.

HHS's proposal to exclude entities that are "principally or otherwise engaged in the business of providing health insurance," except for their specific operations that receive federal financial assistance, is similarly flawed. HHS seeks to justify this proposal by pointing to the Civil Rights Restoration Act of 1987 (CRRA), which did not explicitly refer to health insurance. However, even if that is true, Section 1557 expands the reach of the CRRA to "insurance contracts." And this was fully within Congress' authority to do so. The federal government has legal authority to regulate all health insurers and insurance plans, relying on the Commerce Clause or setting condition on the expenditure of federal funds. The condition does not have to be limited to activities specifically funded by the federal government so long as it is in pursuit of "the general welfare," related to a national concern, and done unambiguously.[8] Indeed, the federal government has regulated and continues to regulate the health insurance industry,

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[6] Federal Register, Vol. 68, No. 153, "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," August 8, 2003 p. 47313. https://www.govinfo.gov/content/pkg/FR-2003-08-08/pdf/03-20179.pdf

[7] The Joint Committee on Taxation, 2018. "Estimates of Federal Tax Expenditures for Fiscal Years 2018-2022," JCX-81-18. Washington, DC; Congress of the United States, available at https://www.jct.gov/publications.html?func=startdown&id=5148

[8] *South Dakota v. Dole*, 483 U.S. 203, 207 (1987).

including ERISA plans, in numerous aspects. For example, the Health Insurance Portability and Accountability Act of 1996 limits the ability of employer-sponsored health plans to engage in certain risk selection practices, including discriminating on the basis of pre-existing health conditions in determining eligibility for enrollment or level of premiums for plan members. Finally, as explained below in Section II(A)(1), the exemptions are irrational and are contradicted by significant evidence. *See, supra*, at pp. 19-21.

E. The Proposed Rule's Elimination of Mandated Enforcement Mechanisms Conflicts With Section 1557.

The Proposed Rule would eliminate the enforcement mechanisms available to HHS's OCR and protected individuals. However, Section 1557 unambiguously mandates that "the enforcement mechanisms provided for and available under such Title VI, Title IX, section 794, or such Age Discrimination Act shall apply for violations of [Section 1557]." 42 U.S.C. §18816(a). This statutory mandate provides OCR with centralized authority to monitor and enforce civil rights laws in the health care sector.

The Proposed Rule removes most provisions supporting OCR's enforcement authority under the statute, including its power to request information from a covered entity, access the books, records, and facilities of HHS to evaluate compliance of the agency's own programs, order remedial action, ban retaliatory action against an individual making a complaint, and/or take legally permissible disciplinary actions for those in non-compliance, including suspension or termination of funds.

These proposed changes run counter to both the statute and the very purpose of OCR. Indeed, OCR was created to provide the area-specific knowledge and expertise for effective government oversight and civil rights law enforcement in the health sector, which is a specialized industry requiring specialized knowledge. Removing enforcement authorities delegated to OCR under the 2016 Regulations would essentially eliminate the OCR's primary means to serve the mission of the office.

The Proposed Rule would also repeal mandates within the 2016 Regulations that require covered entities to hold themselves accountable under Section 1557, including requirements to designate an employee responsible for coordinating the responsibilities under the 2016 Regulations and to establish grievance procedures that allow individuals to allege discrimination. It would also eliminate a provision explicitly providing a private right of action to individuals who allege discrimination in violation of Section 1557, and a provision that requires covered entities to notify individuals of their rights under Section 1557 and the 2016 Regulations.

In other words, under the Proposed Rule, an individual being discriminated against would no longer be informed of whether and how they can file their grievances or lawsuits. A covered entity would no longer need to take concrete actions to address such grievances.

Combined with removal of much of OCR's enforcement authority, the Proposed Rule would virtually eliminate all avenues that allow the individuals' voices to be heard and enable OCR to hold stakeholders accountable.

Additionally, removing the institutionalized enforcement mechanism that makes it easier for individuals to raise their voices when they believe that their civil rights have been violated will impact populations that have been historically marginalized, already experience significant barriers to health care, and have disproportionately poor health outcomes, including people of color and immigrants. These are the individuals who are least likely to know their rights or how to exercise their rights, and whose limited resources make it difficult to file a lawsuit under the underlying statute or utilize other means to file their grievances and challenge the discrimination they experience.

This proposed regulatory rollback runs directly counter to the clear goal of Section 1557 to provide equal access to health care and insurance and essentially renders the statute meaningless.

II. The Proposed Rule is Arbitrary and Capricious

An agency rule is arbitrary and capricious if the agency has: relied on factors that Congress did not intend it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise. *See Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43-44.

Under the "arbitrary and capricious" standard, HHS is required to examine relevant data and articulate a satisfactory explanation for its action, including a "rational connection between the facts found and the choice made," based upon relevant factors. *See Motor Vehicle Mfrs. Ass'n*, 463 U.S. 29 at 43; *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962). Applying these standards demonstrates that, if finalized, the Proposed Rule would violate the APA.

A. HHS's Explanations for the Proposed Rule Are Not Rational and Run Counter to Significant Evidence.

(1) Arbitrary Exemptions of Certain Health Care Insurance From Section 1557

As previously noted, the Proposed Rule would dramatically limit the scope of the ACA non-discrimination protections, by effectively removing many of the currently covered health care insurance programs from the statute's reach. For the reasons below, HHS's justifications for these exemptions are irrational and unsupported by evidence.

As an initial matter, determining the civil rights obligations of insurers and employers based on whether the federal government provides financial assistance directly through subsidies or indirectly through tax benefits is illogical, especially since disparities for racial minorities[9] and foreign-born individuals[10] in obtaining employer-sponsored insurance continue to exist. The ACA was instrumental in reducing racial, ethnic, sex, and disability-based disparities in health insurance coverage. Indeed, studies have found that after the implementation of the ACA: people of color experienced large coverage gains, with an 11 percentage point decline in the uninsured rates for Hispanics and Asians and 8 percentage point decline for Blacks and American Indians, compared to Whites (5 percentage points);[11] the number of uninsured women fell from 19 million in 2010 to 11 million in 2016[12] -- notably the uninsurance rate for Latinas, decreased by more than 10 percentage points from 30.4% in 2013 to 19.9% in 2017 (4.8% for White women during the same period).[13] However, this progress would not have been possible without the robust non-discrimination protections in Section 1557. It is imperative that such protection continue to be extended to all types of health insurance plans. The Proposed Rule's reduced scope of application would violate the goal of ACA broadly and Section 1557 to expand equal access to health care.

HHS arbitrarily limits which entities should be considered "covered entities" and subject to non-discrimination mandates based on the reasoning that "[h]ealth insurance is distinct from health care." This flawed judgment ignores two important facts. First, a person's access to health care is often dramatically limited by their access to, or lack of access to, adequate health insurance coverage. Prior to the enactment of the ACA, health insurers could effectively restrict coverage for certain classes of people through decisions about issuance, cost-sharing, and benefit-design—tactics that the ACA was designed to prevent by requiring guaranteed issue, renewability, and coverage of essential health benefits, and by prohibiting pre-existing condition exclusions.

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[9] Waidmann, T. A., Garrett, B., & Hadley, J. (2004). Explaining Differences in Employer Sponsored Insurance Coverage by Race, Ethnicity, and Immigrant Status. Economic Research Initiative on the Uninsured Working Paper, 42.

[10] Buchmueller, T. C., Lo Sasso, A. T., Lurie, I., & Dolfin, S. (2007). Immigrants and employer-sponsored health insurance. Health Services Research, 42(1p1), 286-310.

[11] Artiga S., Orgera K., Damico A (2019). Changes in Health Coverage by Race and Ethnicity since Implementation of the ACA, 2013-2017. Kaiser Family Foundation Issue Brief, available at https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-implementation-of-the-aca-2013-2017/

[12] Gunja M.Z., Collins S.R., Doty M.M., Beutel S. (2017). How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care. The Commonwealth Fund Issue Brief, available at https://www.commonwealthfund.org/publications/issue-briefs/2017/aug/how-affordable-care-act-has-helped-women-gain-insurance-and

[13] National Partnership for Women & Families Fact Sheet, 2018. "Women's Health Coverage: Stalled Progress," analysis based on the U.S. Census Bureau's 2018 Current Population Survey Annual Social and Economic Supplement. http://www.nationalpartnership.org/our-work/resources/health-care/womens-health-coverage-sources-and-rates-of-insurance.pdf

Next, depending upon life, work, economic and social circumstances, individuals can move fluidly across health insurance markets, being insured for some period through the public programs such as Medicaid, then getting employer sponsored coverage and later becoming self-employed. According to a Health Affairs study, one in four Americans changed their health insurance coverage at least once in 2015. After omitting the newly insured, the three most common reasons for churning were job-related insurance changes, loss of eligibility for Medicaid or ACA marketplace subsidies, and inability to afford a previous plan.[14] Given the frequency of insurance "churning," meaningful civil rights protections for individuals accessing health insurance cannot be achieved without granting the same protections regardless of their insurance types or products. Under the Proposed Rule, the same person protected from discrimination if insured through Medicaid might not receive comparable protections through employer-sponsored coverage. Section 1557's protections were not designed to be subject to the "luck of the draw" of selecting coverage in the "right" insurance market. Thus, it is vital that Section 1557 continue to apply to all health programs and activities that interact with individuals at various points in their overall pursuit of health insurance and health care services.

(2) Arbitrary Removal of Termination of Pregnancy, Recovery Therefrom and Related Medical Conditions as Forms of Sex Discrimination

As noted above, HHS now claims that, under Section 1557, Congress intended "sex" to refer solely to a person's biological sex assigned at birth, but offers no reasonable evidence to support this this policy shift nor adequately explains its decision to reverse course in the face of the exhaustive record previously before HHS, when the 2016 Regulations were written. In addition to running counter to governing law, this policy reversal conflicts with the interpretation of Title IX by other federal agencies. In fact, since 2012, the Department of Education has recognized and enforced discrimination against students and employees based upon termination of pregnancy, recovery therefrom and resulting medical conditions as sex discrimination under Title IX in the education settings.[15]

This conflict is notable because, within the same Proposed Rule, HHS justifies removing gender identity as a form of sex discrimination because such a reading it is inconsistent with those of other federal agencies. *See* Proposed Rule at p. 27856. Using HHS's erroneous logic,

[14] Sommers, B. D., Gourevitch, R., Maylone, B., Blendon, R. J., & Epstein, A. M. (2016). Insurance churning rates for low-income adults under health reform: lower than expected but still harmful for many. Health Affairs, 35(10), 1816-1824.

[15] 34 C.F.R. § 106.40(b) (defining sex discrimination to reach discrimination against students on "the basis of such student's termination of pregnancy or recovery therefrom."); § 106.51(b)(6) (barring employment discrimination with respect to "[g]ranting and return from leaves of absences for termination of pregnancy); § 106.57(b)(prohibiting illicit discrimination against employees or prospective employees "on the basis of termination of pregnancy or recovery therefrom."); *see generally*, Office for Civil Rights, Pregnant or Parenting? Title IX Protects You from Discrimination at School, U.S. Dep't of Educ. http://www2.ed.gov/about/offices/list/ocr/docs/dclknow-rights-201306-title-ix.html.

termination of pregnancy, recovery therefrom and resulting medical conditions should continue to be considered sex discrimination in the health care and insurance context under Section 1557 to align with the regulations of another federal agency governing the provision of education and employment in education settings. HHS's conflicting justifications for the removal of various forms of sex discrimination from the 2016 Regulations are clearly not rational.

(3) Arbitrary Elimination of Language Access Requirements

HHS contends that the 2016 Regulations concerning language access must be eliminated in their entirety because the notice and tagline requirements were inconsistent with those required by other components of HHS, and provided relatively minimal benefit to LEP individuals.[16] For the reasons set forth below, HHS's explanation is irrational and runs counter to significant evidence.

There is a Need for Robust Language Access Regulations in Healthcare

The importance of addressing the language needs of LEP individuals is prevalent throughout the United States. The Migration Policy Institute estimates that 25.1 million people in the U.S. are considered LEP, and nearly 20% of them are U.S.-born citizens.[17] The ACA has proven to be instrumental in supporting LEP individuals in obtaining health insurance coverage. In fact, the insurance coverage rate among LEP individuals has increased from 61.7% in 2010 to 74.8% in 2017, with a noticeable jump in 2014, when various ACA insurance expansion provisions went into effect.[18] However, a disproportionately large percentage of LEP individuals remain uninsured (25.2% vs. 7.5% according to the 2017 ACS data), and targeted outreach and assistance are crucial in closing the coverage gap within this population. Given the high need, the government has a duty to ensure that LEP individuals receive appropriate language assistance services when they seek insurance coverage, utilize benefits, or receive health care services.[19]

[16] Proposed Rule at p. 27852

[17] Migration Policy Institute (MPI) tabulations from the U.S. Census Bureau's 1990 and 2000 Decennial Censuses and 2010 and 2013 American Community Surveys (ACS), Migration Policy Institute, July 2015. https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states (Between 1990 and 2013, the LEP population in the U.S. grew 80% from nearly 14 million (6% of the total U.S. population) to 25.1 million (8%)).

[18] SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files, State Health Compare, SHADAC, University of Minnesota, accessed on June 28, 2019, available at http://statehealthcompare.shadac.org/table/15/health-insurance-coverage-type-by-limited-english-proficiency#1/5,4,1,10,86,9,8,6,18,19/24/29,30

[19] NY State of Health: The Official Health Plan Marketplace, 2019 Open Enrollment Report, May 2019. https://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202019%20Open%20Enrollment%20Report_0.pdf

The Proposed Rule Runs Contrary To Long-Standing Federal Guidance To Ensure Meaningful Access

Notice and Taglines Requirements

HHS contends that the notice and tagline requirements in the 2016 Regulations must be eliminated entirely because they are inconsistent with those required by other components of HHS, and provided relatively minimal benefit to LEP individuals. However, in HHS's own Language Access Plan, the agency notes that the taglines in non-English languages are used to inform LEP clients of their right to free language services and the nondiscrimination practices of the relevant agency. Further, the Department of Justice's guidance for federally conducted or assisted programs explicitly recognizes that "[w]hen…an LEP individual does not know about the availability of language assistance services, [they] will be less likely to participate in or benefit from an agency's programs and services," that notices and taglines serve as a temporary measure to promote better language access when documents deemed "vital" have yet to be translated, and that "agencies should provide notice about its language assistance services in languages LEP persons will understand."

Language Access Plans

The Proposed Rule also would eliminate the provision that allows HHS to consider whether the covered entity has an effective written language access plan. However, developing and implementing an effective written language access plan is an important factor in evaluating a covered entity's compliance under the 2016 Regulations, and is crucial to providing effective language access services in a sustainable manner.

Removing the consideration of whether an entity has an effective written language access plan evaluating a covered entity's compliance means that entities will be disincentivized from devising systematic plans to guarantee access, which provide the architecture necessary to evaluate and apply a systematically equal delivery of service across an institution and its service population. Ad hoc provision of language services results in inequality and a reduction in the quality of language access available, which negatively affects both patients with LEP and healthcare systems.

Moreover, similar to Section 1557, Federal Executive Order 13166 (EO13166) requires federal agencies to implement a system and plan to ensure improved access to services for LEP individuals, and New York State Executive Order 26 (EO26) requires state agencies to appoint a Language Access Coordinator and publish a language access plan. A recent independent analysis of the EO26 concluded that such mandates would benefit both NYS LEP residents and government agencies and improve access to and quality of services provided by state agencies. In addition, the report concluded that the EO would reduce health disparities among LEP

populations, without materially affecting the operations of the covered entities.[20] The 2016 Regulations encourage health insurers, researchers, and health care providers to take similar action to accommodate LEP individuals' language needs. The proposal to remove this consideration could discourage use of an important planning tool that helps entities better comply with the law and ensure that language access services are implemented in a cost-efficient manner to benefit both LEP individuals and covered entities themselves.

The Proposed Rule Eliminates or Weakens Major Tools that Facilitate Language Access, Which Will Result in Negative Health Outcomes.

HHS also proposes eliminating the current remote video interpreting standards and instead includes standards only for remote audio interpreting services. However, because healthcare institutions are increasingly relying on remote video interpretation services, it is vital that there are high standards for any language service provider that provides medical interpretation. The removal of standards for remote video interpretation means that healthcare institutions will have a compromised ability to budget for high quality video remote interpretation. Indeed, the rapid development and integration of new technologies into the delivery of interpretation continue to expand the availability and lower costs for video remote interpretation.

The proposed change further eliminates "qualified" from the proposed description of interpreters and translators that can provide language services under the law, and eliminates "above average familiarity with" from the definition. This weakens the qualifications required of language service providers that provide interpretation and translations for healthcare institutions, thereby jeopardizing the quality of communication possible between providers and LEP patients. Also, the use of underqualified language service providers can result in negative patient outcomes and miscommunications that can result in liability for the institution and increased costs due to inefficiencies such as unnecessary tests and procedures. In short, by undermining this valuable tool for effective communication, the Proposed Rule undermines access to quality healthcare for individuals with LEP.

B. HHS Failed to Consider Important Aspects of the Problem Underlying the Proposed Rule.

(1) HHS Failed To Account For The Need to Address Existing Discrimination in Health Care And The Resulting Negative Impact on Health Care Outcomes

[20] New York Lawyers for the Public Interest, Letter to U.S. Department of Health and Human Services Office for Civil Rights, RE: Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities, October 1, 2013. https://nylpi.org/wp-content/uploads/bsk-pdf-manager/33_NYLPI_section_1557_comments_final_hardcopy.pdf

Section 1557 will have a detrimental and far-reaching impact on the health of LGBQ and TGNCNB people, women, and our communities. Indeed, HHS' futile distinction between health insurance and health care ignores the direct role of insurers in care access and health outcomes. HHS also disregards the deleterious impact of discrimination on care access and health, particularly where, as here, the discrimination is state-sanctioned.

For patients across the United States who lack state and local protections against discrimination based on gender identity and termination of pregnancy, the Proposed Rule poses a significant threat to their dignity and general and emergency health care needs. In short, the Proposed Rule would permit health care providers and insurance companies— who are not being asked to cover or participate in abortion procedures or gender affirming care or transitions— to refuse to provide treatment or coverage for basic and essential medical care which is, without exception, made available to other persons. HHS essentially contends that such refusal of care is warranted and lawful if a health care provider or insurance company takes issue with a person's gender identity or the fact that they have undergone an abortion procedure.

In fact, an analysis of HHS complaints before the nationwide preliminary injunction issued in *Franciscan Alliance* found that the majority of complaints filed with HHS's OCR under the 2016 Regulations addressed denials of medical care or insurance coverage for generally available healthcare services— and unrelated to gender affirming care or gender transition. For example, a health care provider could refuse to treat a patient for the flu solely based on the person's gender identity or refuse to accept a new transgender patient in favor of a person who is not transgender. Furthermore, under the Proposed Rule, women could be denied preventative and emergency care medical care or insurance coverage solely because they have terminated a pregnancy, are recovering therefrom or are suffering from a medical condition related to an abortion. Even survivors of sexual assault, particularly women of color who already experience difficulty in accessing reproductive health care, would experience less support in accessing pregnancy termination related to their assault.

In addition, the Proposed Rule would eliminate the prohibition on categorical denials, automatic exclusions, and limited coverage for gender-affirming care. Gender-affirming care is medically necessary and, in many cases, life-saving for TGNCNB people.[21] It includes a range of treatments, such as hormone replacement therapy, breast augmentation/reconstruction, mastectomy, facial feminization, voice training, or genital surgery,[22] and mental health care for

[21] World Professional Association for Transgender Health (WPATH), *Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.* ("Position Statement") (Dec. 21, 2016) ("The medical procedures attendant to gender affirming/confirming surgeries are not 'cosmetic' or 'elective' or 'for the mere convenience of the patient.' These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed condition.")

[22] WPATH, The Standards of Care, 9-10 (2012).

gender dysphoria. The country's leading medical associations have affirmed almost uniformly that access to these services leads to better overall health outcomes and should be deemed medically necessary.[23]

The protections afforded by Section 1557 to LGBQ and TGNCNB people have served as a critical tool in closing the healthcare gap facing many members of these communities. However, under the Proposed Rule, health care providers could roll back their protections or discontinue their compliance efforts that are already underway under the 2016 Regulations, leading to further deleterious healthcare outcomes for this population.

Even with protections under other federal laws and robust legal protections in place in states and localities, discrimination in the healthcare setting remains an unfortunate reality for transgender residents of our localities. The inability to obtain such medical care under the Proposed Rule will further marginalize LGBQ and TGNCNB communities that already experience rampant discrimination in health care settings, inhibiting care-seeking and reducing the availability of culturally competent and affirming health care. [24] Studies consistently show that transgender people face high rates of discrimination when seeking health care. According to the Report of the 2015 U.S. Transgender Survey, which included 27,715 participants, 25% of respondents reported experiencing a problem with their insurance in the past year that was directly related to their gender identity, including being denied health care coverage; and 23% of respondents did not see a doctor when they needed care because of fear of being mistreated.[25]

The risk of adverse health outcomes is compounded by the likelihood that some TGNCNB persons unable to obtain gender-affirming care through their insurance will engage in risky behaviors in order to meet their health needs. For example, sharing used needles for hormone injections place TGNCNB people at greater risk for HIV.[26] Other risky behaviors may include taking a higher hormone dosage than prescribed, purchasing hormones through unsafe underground markets, or injecting dangerous substances, like silicone, to bring one's body in line with the one's innate sense of their gender.[27]

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[23] https://transcendlegal.org/medical-organization-statements

[24] Jaime M. Grant, Lisa A. Mottet, Justin Tanis, National Gay and Lesbian Task Force & National Center for Transgender Equality, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*, 6 (2011) https://transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf.

[25] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality.

[26] Neumann, M. S., PhD., Finlayson, T. J., PhD., Pitts, N. L., B.S., & Keatley, J., M.S.W. (2017). Comprehensive HIV prevention for transgender persons. *American Journal of Public Health, 107*(2), 207-212.

[27] Sevelius, J. M. (2013). Gender affirmation: A framework for conceptualizing risk behavior among transgender women of color. *Sex Roles, 68*(11-12), 675-689.

Reduced access to mental health services for TGNCNB people resulting from the rule is also concerning given astounding rates of mental health issues among TGNCNB persons that result from interpersonal and systemic discrimination. According to the 2015 U.S. Transgender Survey, 40% of those surveyed had attempted suicide in their lifetime, compared to an estimated 4.6% of the general U.S. population. Thirty-nine percent of respondents experienced serious psychological distress in the month prior to completing the survey (based on the Kessler 6 Psychological Distress Scale) compared to an estimated five percent of the U.S. population.[28] A meta-synthesis of 42 studies of suicidality among transgender populations similarly found lifetime suicidal ideation among 56% of participants, with 29% attempting suicide.[29] In addition, LGBTQ youth disproportionately experience mental and behavioral health challenges compared to their heterosexual/cisgender peers. According to the NYC data, they are more likely to feel sad or hopeless (50% vs. 25%), more likely to attempt suicide (20% vs. 6%), more likely to drink alcohol (35% vs. 20%) and twice as likely to misuse both prescription and illicit drugs (16% vs. 8%).[30] By rolling back civil rights protections of the population already reluctant to seek care, the Proposed Rule could further exacerbate mental health disparities between LGBTQ youth and their heterosexual/cisgender peers as they may face additional barriers in accessing care without meaningful anti-discrimination protections in place.

Ultimately, by eliminating rigorous rules that require federally assisted health programs to respect and promote rights of the individuals that our civil rights laws were intended to support, the Proposed Rule will likely increase these individuals' social isolation and lead to poorer health outcomes. In contrast, a recent study found that state-level policies providing protections to transgender people from discrimination in schools and the ability to change name and gender on identifying documents led to better mental health, less alcohol consumption, and more recent health care utilization among transgender individuals.[31] In addition, gender-affirming care has been shown to improve mental health disorders, including depression, anxiety, and gender dysphoria, and promote overall patient well-being.[32]

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[28] James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality. 2016. https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF.

[29] Adams N, Hitomi M, Moody C. Varied reports of adult transgender suicidality: synthesizing and describing the peer-reviewed and gray literature. *Transgend Health*. 2017; 2(1):60-75.

[30] June 19, 2019 testimony to New York City Council Committees on Youth Services and Mental Health, Addiction and Disabilities, Oversight – Mental Health Services for LGBTQ Youth. Testimony delivered by: Ashe McGovern, J.D. Executive Director, NYC Unity Project, Senior Policy Advisor, LGBTQ Initiatives; Hillary Kunins, MD, MPH, MS, Executive Deputy Commissioner, Division of Mental Hygiene, New York City Department of Health and Mental Hygiene

[31] Steve N. Du Bois et al., *Examining Associations Between State-Level Transgender Policies and Transgender Health*, 3:1 TRANSGENDER HEALTH 220-224 (2018).

[32] *See, e.g.*, WPATH, Position Statement (Dec. 21, 2016).

(2) HHS Failed To Account For Population Health Implications

Reduced health care access flowing from the Proposed Rule also has significant population health implications, including in compromising HIV prevention efforts. In 2017, approximately 38,700 people living in the U.S. were diagnosed with HIV, and transgender people received an HIV diagnosis at a rate three times higher than the national average.[33] People at risk for HIV must have access to pre-exposure prophylaxis (PrEP), which reduces the risk of sexual transmission of HIV by well over 90%. For persons with HIV, retention in care not only enables them to live healthy lives, but is a necessary component of ending the epidemic, as persons with an undetectable viral load for six months or longer who remain on treatment cannot transmit HIV through sex. Secretary Azar himself said ensuring PrEP access was "a major step" in the administration's promise to end the HIV epidemic in America by 2030.[34]

Crucial to ensuring everyone's access to HIV prevention and treatment tools, however, is not only the affordability and availability of drugs and healthcare services but also an inclusive care environment. Research has established a negative association between the impact of perceived discrimination and adherence to HIV antiretroviral therapy,[35] underscoring the importance to individual and community health of culturally competent and gender-affirming health care services to persons living with, or at risk of, HIV.

Similarly, delays in accessing testing and treatment for sexually transmitted infections (STIs)—for which many transgender persons are at higher risk as compared to the general population—will compound the already alarming rates of STIs nationally and locally. There were 2.3 million recorded cases of chlamydia, gonorrhea, and syphilis in the U.S. in 2017—the highest number ever on record.[36] Research has shown that STI rates are often highest among populations whose access to health services are the most limited.[37] In a recent study of HIV and STIs among transgender youth ages 15-24, respondents who reported having a provider knowledgeable on transgender health were significantly more likely to report being tested for

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[33]CDC. HIV among transgender people. 2019. Available at www.cdc.gov/hiv/group/gender/transgender/index.html Accessed July 1, 2019.

[34] HHS Press Office, "Trump Administration Secures Historic Donation of Billions of Dollars in HIV Prevention Drugs", May 9, 2019. https://www.hhs.gov/about/news/2019/05/09/trump-administration-secures-historic-donation-of-billions-of-dollars-in-hiv-prevention-drugs.html

[35] Turan, B., Rogers, A. J., Rice, W. S., Atkins, G. C., Cohen, M. H., Wilson, T. E., . . . Weiser, S. D. (2017). Association between perceived discrimination in health care settings and HIV medication adherence: Mediating psychosocial mechanisms. *AIDS and Behavior, 21*(12), 3431-3439.

[36] Centers for Disease Control and Prevention. NCHHSTP Newsroom: 2018 STD Prevention Conference. https://www.cdc.gov/nchhstp/newsroom/2018/2018-std-prevention-conference.html. Published August 28, 2018.

[37] Geisler WM, Chyu L, Kusunoki Y, et al. Health insurance coverage, health-care-seeking behaviors, and genital chlamydia infection prevalence in sexually active young adults. Sex Transm Dis. 2006 Jun;33(6):389-96.

HIV and STIs.[38] Protecting against gender discrimination is thus integral to protecting and promoting community health. Thus, HHS's proposal to reduce health care access by TGNCNB individuals—a group known to have high rates and risk factors for HIV—is irresponsible and entirely counter to the federal initiative to end the HIV epidemic, which would not be possible without prompt diagnosis, use of PrEP, viral suppression, and community support to achieve plan goals. In addition, if people of color are denied or dissuaded from receiving necessary prophylaxis, screening, and treatment for HIV and other STIs, existing disparities will widen—once again, undermining the federal administration's plan to end the HIV epidemic.

(3) HHS Failed To Account For The Cost Savings Attributable to the 2016 Regulations

HHS's cost assessment fails to account for cost-savings attendant to persons receiving timely and appropriate health care and averting the downstream costs of untreated health conditions. With respect to language access mandates, while it is true that a significant investment of resources is required, the failure to do so can be extremely costly to a healthcare system and to the people it serves. Furthermore, it has been shown that medically necessary health care for transgender individuals is cost-saving by reducing the risk of negative "end points," such as depression, suicidality, substance abuse, drug abuse, and HIV.[39] Averted HIV infections from appropriate prophylaxis, testing, and treatment can save tens of millions of dollars in medical costs attendant to HIV, including costs for daily medication and treatment of opportunistic infection, with the medical costs saved by avoiding just one HIV infection in the U.S. being conservatively estimated at $229,800 (2015 USD).[40] And each new HIV infection is a step backwards in the federal plan to end the epidemic.

Moreover, gender-affirming care is cost-effective and, when averaged with a pool of insured people, is typically less expensive than routine procedures, like those connected with childbirth.[41] Employers report very low costs from including coverage for gender-affirming care,

[38] Sharma, A., Kahle, E., Todd, K., Peitzmeier, S., & Stephenson, R. (2019). Variations in testing for HIV and other sexually transmitted infections across gender identity among transgender youth. *Transgender Health, 4*(1), 46-57.
[39] Padula WV, Heru S, Campbell JD. Societal implications of health insurance coverage for medically necessary services in the U.S. transgender population: a cost-effectiveness analysis. *J Gen Intern Med.* 2016;31(4):394-401.
[40] Oh P, Pascopella L, Barry P, Flood J. A system synthesis of direct costs to treat and manage tuberculosis disease applied to California, 2015. *BMC Research Notes*. 2017;10(434):1-7.
[41] *See* Letter from WPATH to Roger Severino, Director, Office of Civil Rights (OCR), U.S. Department of Health and Human Services (HHS) (Aug. 15, 2017).

with many employers reporting no costs at all.[42] For example, a study on San Francisco's coverage of gender affirming care found that the cost was negligible.[43]

However, public and private health insurance companies exclude transition-related health care from coverage, even in cases when a physician determines them medically necessary for a patient.[44] In the 2015 LGBT Health and Human Services Needs Assessment Survey ("2015 survey"), which examined the nexus between economic insecurity and health for TGNCNB New Yorkers, 61.3% of nearly 4000 respondents reported that their insurance does not cover transition-related care.[45] Based upon multiple studies, Lambda Legal has noted that denials of insurance coverage for medically necessary care can cause serious harm to TGNCNB people, including depression, suicide, or potentially harmful self-surgery or self-medication.[46]

Covering care improves people's life opportunities and capacity for self-sufficiency. Without access to these vital surgical, hormonal or other treatments, fewer TGNCNB individuals will be able to change their identity documents. This inability to have identity documents that match one's gender identity and expression will make employment, travel, housing and other social needs much harder to navigate for TGNCNB individuals.[47] These barriers also contribute to longer term economic instability for a population that experiences poverty at a much higher rate than non-TGNCNB populations. According to the 2015 Survey, TGNCNB respondents were twice as likely to be in poverty than non-transgender respondents.[48]

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[42] Jody L. Herman, Williams Institute, *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans* (Sept. 2013) https://williamsinstitute.law.ucla.edu/wp-content/uploads/Herman-Cost-Benefit-of-Trans-Health-Benefits-Sept-2013.pdf.

[43] Economic Impact Assessment, Gender Nondiscrimination in Health Insurance, State of California (2012), available at https://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf.

[44] Lambda Legal, "Creating Equal Access to Quality Health Care for Transgender Patients: Transgender Affirming Hospital Policies," Revised May 2016. https://www.lambdalegal.org/sites/default/files/publications/downloads/fs_20160525_transgender-affirming-hospital-policies.pdf May 2016

[45] Somjen Frazer and Erin Howe, "Transgender Health and Economic Insecurity: A report from the 2015 LGBT Health and Human Services Needs Assessment Survey," Empire State Pride Agenda: New York, NY. http://strengthinnumbersconsulting.com/wp-content/uploads/2017/06/TG-health-and-economic-insecurity-report-FINAL.pdf

[46] Lambda Legal, "Creating Equal Access to Quality Health Care for Transgender Patients: Transgender Affirming Hospital Policies," Revised May 2016. https://www.lambdalegal.org/sites/default/files/publications/downloads/fs_20160525_transgender-affirming-hospital-policies.pdf May 2016

[47] Somjen Frazer and Erin Howe, "Transgender Health and Economic Insecurity: A report from the 2015 LGBT Health and Human Services Needs Assessment Survey," Empire State Pride Agenda: New York, NY, p. 8. http://strengthinnumbersconsulting.com/wp-content/uploads/2017/06/TG-health-and-economic-insecurity-report-FINAL.pdf

[48] Somjen Frazer and Erin Howe, "Transgender Health and Economic Insecurity: A report from the 2015 LGBT Health and Human Services Needs Assessment Survey," Empire State Pride Agenda: New York,

Ultimately, improving access to medically necessary treatment of gender dysphoria, including the wide range of services to bring a transgender person's body into congruence with their gender, will improve an array of health and economic outcomes for TGNCNB persons.

(4) HHS Failed To Account For The Administrative Burdens And Significant The Proposed Rule Will Impose On States And Cities

HHS is silent regarding the negative financial impact the Proposed Rule will have on state and local health departments. In fact, additional human and financial resources will be needed for community outreach and other programming to combat increases in LGBQ and TGNCNB-related stigma and discrimination. Moreover, public health clinics may have increases in patient volume and in uncompensated care. And this is to say nothing of the resources required to counter any increases in HIV, STIs, or other diseases resulting from the Proposed Rule.

HHS HAS NOT COMPLIED WITH EXECUTIVE ORDER 13132, THE TREASURY GENERAL APPROPRIATIONS ACT, OR EXECUTIVE ORDER 12866.

Executive Order 13132

As explained above, HHS's failure to consider all aspects of the problem – specifically, the significant costs that the Proposed Rule would shift to state and local governments – violates the APA. In addition, HHS has violated the APA by failing to consider and evaluate the federal implications. The requirement that HHS consider the costs to state and local governments and federalism implications associated with the Proposed Rule violates not only the APA but also Section 6 of Executive Order 13132, which mandates that:

> no agency shall promulgate any regulation that has federalism implications, that imposes substantial direct compliance costs on State and local governments, . . . unless (1) funds necessary to pay the direct costs incurred by the State and local governments in complying with the regulation are provided by the Federal Government; or (2) the agency, prior to the formal promulgation of the regulation, (a) consulted with State and local officials early in the process of developing the proposed regulation; (b) in a separately identified portion of the preamble to the regulation as it is to be issued in the Federal Register, provides to the Director of the Office of Management and Budget (OMB) a federalism summary impact statement, which consists of a description of the extent of the agency's prior consultation with State and local officials, a summary of the nature of their concerns and the agency's position supporting the need to issue the regulation,

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NY. http://strengthinnumbersconsulting.com/wp-content/uploads/2017/06/TG-health-and-economic-insecurity-report-FINAL.pdf

> and a statement of the extent to which the concerns of State and local officials have been met; and (c) makes available to the [OMB] Director any written communications submitted to the agency by State and local officials.

Exec. Order No. 13,132, 64 Fed. Reg. 43,255 (Aug. 10, 1999)

HHS ignores this requirement, stating in conclusory fashion and without data, analysis or any other evidentiary support, that the Proposed Rule "does not have federalism implication and does not impose substantial direct compliance costs on State and local governments."[49] HHS is incorrect.

As explained above, the Proposed Rule will require states and local governments to expend additional human and financial resources for community outreach and other programming to combat increases in LGBQ and TGNCNB-related stigma and discrimination. Moreover, public health clinics may have increases in patient volume and in uncompensated care, and resources would be required to counter any increases in HIV, STIs, or other diseases resulting from the Proposed Rule. This could force state and local governments to make significant expenditures to protect the health and well-being of their residents. *See id*.

Moreover, the Proposed Rule has federalism implications. Policies and regulations that have federal implications include those that have substantial direct effects on States and local governments, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.[50]

In addition to violating the federal civil rights laws incorporated into Section 1557, the Proposed Rule also runs counter to the U.S. Constitution and other federal laws. Specifically, the proposal to permit health care insurance companies and providers to deprive persons of health care coverage and services due to their race, national origin, color, sex and disability status is a violation of the Equal Protection Clause of the Fourteenth Amendment. Further, the proposal to remove enforcement mechanisms through which persons may challenge a discriminatory denial of health care services and insurance is a violation the Due Process Clause of the Fifth and Fourteenth Amendments. Finally, HHS's proposal to allow providers to deprive certain persons of medical care, despite the existence of emergency circumstances, is a direct violation of the Emergency Medical Treatment & Labor Act.[51]

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[49] Proposed Rule at p. 20592

[50] Exec. Order No. 13,132, 64 Fed. Reg. 43,255 (Aug. 10, 1999).

[51] 42 U.S.C. § 1395dd (requiring hospitals that have an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or, if medically warranted, to transfer the person to another facility).

Notably, pursuant to Section 1557, Congress explicitly specified that the statute may not be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under Title VI, Title VII, or Title IX, in part, or to supersede State laws that provide additional protections against discrimination on any basis set forth in Section 1557.[52] However, as set forth above, the Proposed Rule seeks to set new regulations implementing Section 1557 that would ignore the very mandates within the statute. In addition, the protections under Section 1557 are similar to those available in other states and localities, including New York State Human Rights Law, New York City Human Rights Law, and Chicago Human Rights Law.

For example, both New York State and New York City have a Human Rights Law prohibiting discrimination on the basis of gender identity and gender expression.[53] Chicago's Human Rights Ordinance likewise prohibits discrimination on the basis of gender identity and gender expression. *See* Chicago Mun.Code § 2-160-010 *et seq*. And in 2016, the NYC Commission on Human Rights published legal enforcement guidance explicitly prohibiting employers from offering employee benefits that discriminate on the basis of gender identity, and NYC laws prohibit discrimination in public accommodations, health care, and other settings.[54]

The Signatories are committed to prohibiting unlawful discrimination in all of our local programs, including the administration of health insurance which serves the fundamental purpose of ensuring that vital health care services are broadly available to all individuals throughout the country. In addition, NYC upholds a sexual and reproductive justice framework in city programs and services. We recognize that sexual and reproductive justice exists only when all people have the power and resources to make healthy decisions about their bodies, sexuality, and reproduction. This framework includes the right to: choose to have or not have children; choose the conditions under which to give birth or create a family; care for one's children with necessary social support in a safe and healthy environment; and control one's own body and self-expression, free from any form of sexual, reproductive, or gender based oppression.

The Proposed Rule poses a serious impediment to these protections by giving license to health insurers and providers to discriminate against our residents by excluding coverage of medically necessary care in violation of Section 1557 and federal civil rights laws. Due to the compliance costs and federalism concerns implicated by the Proposed Rule, a federalism summary impact statement should be provided.

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[52] 42 U.S.C. 18116(b).

[53] NYS Human Rights Law § 296(2)(a) (prohibiting health care entities and providers from withholding or denying health care services to any person because of their sexual orientation, gender identity or expression, or the marital status of any person); N.Y.C. Admin. Code § 8-107.

[54] 10 N.Y.C.R.R. § 405.7 (c)(2) (prohibiting discrimination against patients in NYC health care facilities based on sexual orientation, gender, gender identity, and marital status).

The Treasury General Appropriations Act of 1999

HHS does not address the affirmative obligations imposed on it by the Treasury General Appropriations Act of 1999. That Act provides that:

> before implementing policies and regulations that may affect family well-being, an agency shall assess whether the action — (1) strengthens or erodes the stability or safety of the family and, particularly, the marital commitment; (2) strengthens or erodes the authority and rights of parents in the education, nurture, and supervision of their children; (3) helps the family perform its functions, or substitutes governmental activity for the function; (4) increases or decreases disposable income or poverty of families and children; (5) is warranted because the proposed benefits justify the financial impact on the family; (6) may be carried out by State or local government or by the family; and (7) establishes an implicit or explicit policy concerning the relationship between the behavior and personal responsibility of youth, and the norms of society.

Pub. L. No. 105–277, §654(c)(1-7), 112 Stat. 2681- 528-30 (1998).

Because HHS has not assessed the impact of the Proposed Rule on family well-being in any fashion, the Proposed Rule should not be finalized.

Executive Order 12866

Finally, HHS's assertion that the Proposed Rule is compliant with the Regulatory Flexibility Act is incorrect and incomplete. For the reasons discussed above, contrary to HHS's analysis, implementation of the Proposed Rule would impose an administrative and financial burden on states and localities. *See, supra*, at p. 31.

For all of the reasons set forth above, the Signatories object to the Proposed Rule and call on HHS to withdraw it.

Sincerely,

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August 13, 2019

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid, Office for Civil Rights, Office of the Secretary
Via Electronic Submission

Re: *Nondiscrimination in Health and Health Education Programs or Activities*
Docket RIN 0945-AA11; Docket Number: HHS-OCR-2019-0007

The City of New York (NYC) submits the following comment in response to Docket RIN 0945-AA11 ("Proposed Rule"). NYC's Department of Social Services, Department of Health and Mental Hygiene, Health and Hospitals Corporation, Commission on Human Rights, Mayor's Office of Immigrant Affairs, and Mayor's Office for People with Disabilities contributed to this comment.

Overview and Proposed Rule Changes

The Proposed Rule published by the U.S. Department of Health and Human Services (HHS) changes, without legitimate basis, regulations implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA) (42 U.S.C. §18116) (Section 1557). Under Section 1557, Congress prohibited discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on the following existing and long-standing Federal civil rights laws and explicitly applies them to health programs and activities for which any part is federally funded: Title VI of the Civil Rights Act of 1964 (Title VI), Title IX of the Education Amendments of 1972 (Title IX), Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 794 of Title 29. Section 1557 also incorporates the enforcement mechanisms under those civil rights laws for violations of the statute. Section 1557 has been in effect since its enactment in 2010, and HHS issued the final rule implementing Section 1557 in May 2016 (2016 Regulations).

HHS submits the Proposed Rule seeking to substantially limit the scope of Section 1557 and eliminate or significantly revise key sections of the 2016 Regulations. Indeed, the Proposed Rule amounts to one of the most sweeping proposed regulations in history by aiming to strip away civil rights protections for tens of millions of individuals in the U.S. seeking access to health insurance and health care services.

HHS maintains that it is "committed to ensuring the civil rights of all individuals who access or seek to access health programs or activities of covered entities."[1] However, the proposed changes signal to the contrary by eliminating essential protections against discrimination that are mandated by Section 1557 and other federal civil rights laws, and contravening the Congressional intent for the ACA to expand access to affordable, quality health care across health insurance markets. Essentially, entities would be permitted to withhold health care

[1] Proposed Rule at 27846.

insurance and benefits as well as health care services from persons based upon their race, color, national origin, sex, age, or disability.

Specifically, HHS proposes to significantly narrow the reach of the statute by exempting numerous health care insurance plans, employee benefit programs, and even certain HHS-administered programs from nondiscrimination mandates even though they receive substantial federal funding. The Proposed Rule would also eliminate protections against discriminatory actions that Congress specifically intended to address through Section 1557 by:

- stripping away language access protections for individuals with Limited English Proficiency (LEP) and individuals with communication disabilities;
- creating blanket religious objection exemptions to allow insurance entities and health care providers and staff to deny health care services and coverage to persons, irrespective of emergencies or limited medical care options, if they seek, have had, are recovering from, or are experiencing a medical condition related to an abortion; and
- sanctioning discrimination and removing broad protections against lesbian, gay, bisexual, and queer (LGBQ) and transgender, gender non-conforming, non-binary (TGNCNB) individuals in accessing healthcare and prohibiting discrimination by healthcare and insurance providers.

Indeed, the Proposed Rule is the latest in a series of assaults on LGBQ and TGNCNB individuals as well as reproductive and pregnancy-related rights. This includes the so-called "conscience" rules that give medical professionals license to discriminate and refuse to provide reproductive, gender-affirming, and other medically necessary care; attempts to diminish a transgender persons' identity and access to medically necessary healthcare; the release of Department of Justice guidance stating Title VII does not protect individuals from discrimination on the basis of gender identity; and the Title X gag rule that interferes with reproductive health care providers ability to practice medicine.

These crusades against women, people with reproductive health care needs, and LGBQ and TGNCNB individuals is legally infirm and an affront to the basic human right to self-determination. That the Proposed Rule would eliminate protections under Section 1557 for women who make up half the U.S. population, more than 9.7 million lesbian, gay, and bisexual people, and approximately 1.3 million transgender people in the U.S.[2] – groups that already experience high levels of discrimination in health care settings and have resulting decreased access to medical care and markedly poor health outcomes compared to the general population – is all the more repugnant.

[2] Gallup, *In U.S., Estimate of LGBT Population Rises to 4.5%* (May 22, 2018) at https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx?g_source=link_NEWSV9&g_medium=TOPIC&g_campaign=item_&g_content=In%2520U.S.%2c%2520Estimate%2520of%2520LGBT%2520Population%2520Rises%2520to%25204.5% ; *see also* Andrew Flores et al., Williams Inst., UCLA Sch. of Law, How Many Adults Identify as Transgender in the United States? (2016) at https://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf;

Finally, the Proposed Rule seeks to gut Section 1557 by eliminating enforcement mechanisms that Congress mandated explicitly in the statute and HHS implemented through the 2016 Regulations. These mechanisms— grievance procedures and the investigation and enforcement authority held by HHS's Office for Civil Rights (OCR)— ensure health care entities are in compliance with the nondiscrimination mandates of Section 1557 and that people have redress when they are not. Through these changes, the Proposed Rule would roll back the ability of people to seek appropriate and affirming medical care, impede the ability of persons to access and advocate for health care, and increase the likelihood that they could be denied, delayed, or discouraged from seeking necessary medical care they are entitled to receive. Such circumstances would place individuals at risk of serious or life-threatening results in emergencies and other circumstances where the individual's choice of health care provider is limited.

Ultimately, the Proposed Rule would reverse the progress HHS has historically made in advancing its mission of enhancing the health and well-being of the U.S. public; albeit prior to recent attempts to stigmatize and discriminate against certain populations.

For the reasons that follow, we urge HHS to withdraw the Proposed Rule in its entirety because it is unlawful. Specifically, the Proposed Rule should not be finalized because it is: (1) not in accordance with governing law; (2) arbitrary and capricious; and (3) does not comply with Executive Order 13132, the Treasury General Appropriations Act, 1999, Public Law 105-277, and Executive Order 12866.

I. THE PROPOSED RULE VIOLATES THE ADMINISTRATIVE PROCEDURE ACT BECAUSE IT IS NOT IN ACCORDANCE WITH GOVERNING LAW.

An agency "does not have the power to adopt a policy that directly conflicts with its governing statute."[3] Thus, agency action is "not in accordance with law" where it "ignores the plain language of the statute," renders statutory language "superfluous," or "frustrate[s] the policy Congress sought to implement" in the statute.[4] Section 1557, the underlying statute of the Proposed Rule, broadly mandates that except as otherwise provided for in the statute or amendments thereto, an individual shall not, on the grounds prohibited under title VI of the Civil Rights Act of 1964 (Title VI), title IX of the Education Amendments of 1972 (Title IX), the Age Discrimination Act of 1975, or section 794 of title 29 (Section 794), 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, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement

[3] *Maislin Indus., U.S. v. Primary Steel, Inc.*, 497 U.S. 116, 134-35 (1990); *see also United States v. Mead*, 533 U.S. 218, 228-29 (2001) (agency action cannot be "manifestly contrary to the statute"); *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 n.9 (1984) (courts "must reject administrative constructions which are contrary to clear congressional intent").

[4] *Pacific Northwest Generating Coop v. Department of Energy*, 580 F.3d 792, 806 (9th Cir. 2009).

mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection.[5]

The ACA has three primary goals: to make affordable health insurance available to more people, to expand the Medicaid program, and to support innovative medical care delivery methods to lower the costs of health care.[6] Pursuant to the foremost goal of the ACA, Section 1557 applies existing federal civil rights laws to health programs and facilities receiving Federal financial assistance to protected classes of people from discrimination based on race, color, national origin, sex, age, or disability. The Proposed Rule's interpretation of Section 1557 contradicts the statute and the ACA's explicit purposes.

Section 1557's Broad Nondiscrimination Mandates For Any Federally-Funded Health Program or Activity

Adding to protections against discrimination within the U.S. Constitution and federal civil rights laws, Section 1557 is the first civil rights statute to explicitly target discrimination in healthcare, including private insurance.[7] Congress sought to advance the ACA's mission to expand coverage and to increase access to care through Section 1557, which broadly applies to "any health program or activity, any part of which is receiving Federal financial assistance," "any program or activity that is administered by an executive agency," and "any entity established under this title," and specifically enumerates "contracts of insurance" as a form of Federal financial assistance.

A previous regulatory analysis estimated that the 2016 Regulations would cover about 900,000 physicians, 133,343 facilities (such as hospitals and nursing homes), 445,657 clinical laboratories; 1,300 community health centers; 40 health professional training programs; Medicaid and public health agencies in each state and the territories; and at least 180 insurers.

The Proposed Rule severely limits the application of Section 1557 in health insurance by (1) entirely eliminating the definitions section of the 2016 Regulations and no longer defining "covered entity" and "health program or activity;" and (2) interpreting Section 1557 to apply only to an insurer's fully federally-funded or supported operations and those principally engaged in the business of providing healthcare.

Within this narrow scope, the Proposed Rule would entirely exempt Medicare Part B, group health plans established under ERISA, short-term plans, the Federal Employees Health Benefits Program, off-exchange products, and certain non-ACA health care programs administered by HHS from compliance with Section 1557.

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[5] 42 U.S.C. §18116(a)(1).
[6] U.S. Centers for Medicare & Medicaid Services, "Affordable Care Act" at https://www.healthcare.gov/glossary/affordable-care-act/
[7] Valarie K. Blake, Civil Rights as Treatment for Health Insurance Discrimination, Wisconsin Law Review, March 26, 2019. http://wisconsinlawreview.org/civil-rights-as-treatment-for-health-insurance-discrimination/

The proposed exemptions run directly counter to the underlying statute that explicitly covers all health programs and activities if any part of them is receiving federal funding. The plain text of Section 1557 includes any and all federal financial assistance by the terms "any health program or activity, . . . that is administered by an Executive Agency or any entity established under this title." Moreover, according to HHS' 2003 LEP guidance, which HHS claims it intends to follow, "coverage extends to a recipient's entire program or activity, *i.e.*, to all parts of a recipient's operations. This is true even if only one part of the recipient receives the federal assistance."[8]

More specifically, the Proposed Rule erroneously excludes ERISA plans from the scope of Section 1557 on the grounds that "such programs do not receive federal financial assistance from HHS and/or the entities operating them are not principally engaged in the business of providing health care."[9] However, Section 1557 explicitly refers to "contracts of insurance," and thereby removes previous uncertainty about when civil rights law protections apply to health insurance coverage. The statute also makes it clear that all health insurers, so long as any part of their program or activity receives federal financial assistance, must not discriminate against individuals on the grounds of race, color, national origin, sex, or disability. Further, employer-sponsored plans, including self-funded group plans, heavily rely on federal financial assistance. In fact, as noted by the Commonwealth Fund, the government's largest expenditure in healthcare coverage outside of Medicare and Medicaid, is its subsidy of employer-sponsored coverage through the favorable tax treatment given to employer-sponsored plans, worth an estimated $146 billion in fiscal year 2018. [10] Health insurance companies, and employer-sponsored plans, also rely on government tax benefits.

HHS's proposal to exclude entities that are "principally or otherwise engaged in the business of providing health insurance," except for their specific operations that receive federal financial assistance, is similarly flawed. HHS seeks to justify this proposal by pointing to the Civil Rights Restoration Act of 1987 (CRRA), which did not explicitly refer to health insurance.[11] However, even if that is true, Section 1557 expands the reach of the CRRA to "insurance contracts." And this was fully within Congress' authority to do so. The federal government has legal authority to regulate all health insurers and insurance plans, relying on the Commerce Clause or setting condition on the expenditure of federal funds. The condition does not have to be limited to activities specifically funded by the federal government so long as it is in pursuit of "the general welfare," related to a national concern, and done unambiguously.[12] Indeed, the federal government has regulated and continues to regulate the health insurance

[8] Federal Register, Vol. 68, No. 153, "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," August 8, 2003 p. 47313. https://www.govinfo.gov/content/pkg/FR-2003-08-08/pdf/03-20179.pdf

[9] Proposed Rule at p. 27863.

[10] The Joint Committee on Taxation, 2018. "Estimates of Federal Tax Expenditures for Fiscal Years 2018-2022," JCX-81-18. Washington, DC; Congress of the United States, available at https://www.jct.gov/publications.html?func=startdown&id=5148

[11] Proposed Rule at p. 27863.

[12] *South Dakota v. Dole*, 483 U.S. 203, 207 (1987).

industry, including ERISA plans, in numerous aspects. For example, the Health Insurance Portability and Accountability Act of 1996 limits the ability of employer-sponsored health plans to engage in certain risk selection practices, including discriminating on the basis of pre-existing health conditions in determining eligibility for enrollment or level of premiums for plan members. Finally, as explained below in Section II, the HHS's exemptions for these entities are irrational and are contradicted by significant evidence. *See, supra,* at pp. 19-21.

Section 1557, Title IX, and Title VII Prohibitions Against Sex Discrimination- Gender Identity and Sex Stereotyping

The 2016 Regulations interpret Section 1557 as prohibiting discrimination based upon gender identity and sex stereotyping. The Proposed Rule would remove these protections and permit health insurers, health care providers and other covered entities to engage in this discrimination, based upon HHS's erroneous assessment.

However, there is ample support for HHS to continue its interpretation that Section 1557 prohibits discrimination based on gender identity and sex stereotyping. For its definition of sex, Section 1557 incorporates Title IX, and Federal courts have repeatedly interpreted Title IX and Title VII and protections against sex discrimination to prohibit gender identity discrimination.[13] In addition, the Equal Employment Opportunity Commission interprets and enforces Title VII's prohibition of sex discrimination as forbidding "any employment discrimination based on gender identity or sexual orientation. These protections apply regardless of any contrary state or local laws."[14] Notably, Section 1557 mandates that nothing within the statute shall be construed to

[13] *See, e.g.*, *Glenn v. Brumby*, 663 F.3d 1312, 1317 (11th Cir. 2011) ("[D]iscrimination against a transgender individual because of her gender-nonconformity is sex discrimination, whether it's described as being on the basis of sex or gender."); *Smith v. City of Salem*, 378 F.3d 566, 575 (6th Cir. 2004) ("[A] label, such as 'transsexual,' is not fatal to a sex discrimination claim where the victim has suffered discrimination because of his or her gender non-conformity."); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213, 215–16 (1st Cir. 2000) (holding that a transgender individual made a claim for sex discrimination under the Equal Credit Opportunity Act). In the upcoming term, the Supreme Court will review whether sex discrimination under Title VII includes gender identity. *Zarda v. Altitude Express, Inc.*, 883 F.3d 100, 108 (2d Cir. 2018), *cert. granted sub nom. Altitude Exp., Inc. v. Zarda*, 139 S. Ct. 1599 (2019); *See also, Prescott v. Rady Children's Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1099 (S.D. Cal. 2017) ("Because Title VII, and by extension Title IX, recognize that discrimination on the basis of transgender identity is discrimination on the basis of sex, the Court interprets the ACA to afford the same protections."); *see also Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 951 (W.D. Wis. 2018) (holding that denial of medically necessary treatments on the basis of transgender status amounts to discrimination on the basis of sex in violation of the ACA); *Whitaker By Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1048 (7th Cir. 2017), *cert. dismissed sub nom. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ. v. Whitaker ex rel. Whitaker*, 138 S. Ct. 1260 (2018) ("By definition, a transgender individual does not conform to the sex-based stereotypes of the sex that he or she was assigned at birth.") (citing *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989)).

[14] Equal Employment Opportunity Commission (EEOC), *What You Should Know About EEOC and the Enforcement Protections for LGBT Workers*, https://www.eeoc.gov/eeoc/newsroom/wysk/enforcement_protections_lgbt_workers.cfm#examples (last visited July 9, 2019); *see, e.g.*, Macy v. Holder, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, *12

invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under Title VII.[15]

Despite this robust body of authority supporting the 2016 Regulations, HHS premises its Proposed Rule change on a single federal trial court's nationwide preliminary injunction in an ongoing case, *Franciscan Alliance, Inc. v. Burwell*.[16] That court's decision did not require HHS to make any regulatory changes, was not made on the merits, and both the preliminary order and any final decision are appealable. HHS's reliance upon *Franciscan Alliance* is misplaced because four appellate courts have held that Title IX must be construed to include gender identity discrimination.[17] Ignoring those precedents, the court in *Franciscan Alliance* erroneously stated that no federal court or agency had concluded sex should be defined to include gender identity.[18] Furthermore, the *Franciscan Alliance* court's conclusion that Title IX extends only to the binary, biological differences between cisgender men and women[19] is at odds with federal appellate precedents establishing that Title IX is meant to combat, not reinforce, sex stereotypes.[20]

(Apr. 20, 2012) ("intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination based on sex and such discrimination therefore violates Title VII.").

[15] 42 U.S.C. 18116(b).

[16] 84 *Fed. Reg.* 27846-27895, 27849 (June 14, 2019), https://www.federalregister.gov/documents/2019/06/14/2019-11512/nondiscrimination-in-health-and-health-education-programs-or-activities. (citing *Franciscan Alliance, Inc. v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016)).

[17] See e.g., *Whitaker v. Kenosha Unified School District No. 1*, 858 F.3d 1034, 1039-1047 (7th Cir. 2017); *Doe by & through Doe v. Boyertown Area Sch. Dist.*, 897 F.3d 518, 533-34 (3d Cir. 2018) (concluding that school district's sex-neutral bathroom policy allowing students to use bathrooms that align with gender identity did not discriminate against cisgender students on basis of sex, and further finding that "barring transgender students from restrooms that align with their gender identity would itself pose a potential Title IX violation"), *cert. denied*, 2019 U.S. App. LEXIS 3666; *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217, 221(6th Cir. 2016) (affirming preliminary injunction that required school to allow transgender girl to use girl's bathroom); *G.G. ex rel. Grimm v. Gloucester Cty. Sch. Bd.*, 822 F.3d 709, 720-23 (4th Cir. 2016) (Title IX's regulations protected transgender student from discrimination on basis of sex), *vacated and remanded*, 137 S. Ct. 1239 (2017), *dismissed as moot*, 2017 WL 9882602 (Dec. 12, 2017).

[18] *Franciscan Alliance, Inc.*, 227 F. Supp. 3d at 689.

[19] *Id.* at 688.

[20] *See, e.g.*, *Whitaker*, 858 F.3d at 1039 (7th Cir. 2017) (holding that transgender student demonstrated a likelihood of success on his Title IX claim on a theory of sex stereotyping); *Wolfe v. Fayetteville, Arkansas Sch. Dist.*, 648 F.3d 860, 867 (8th Cir. 2011) (holding that to recover under Title IX, plaintiff had to prove "the harasser intended to discriminate against him 'on the basis of sex,' meaning the harassment was motivated by either [his] gender or *failure to conform with gender stereotypes*")(emphasis added); *Doe v. E. Haven Bd. of Educ.*, 200 F. App'x 46, 48 (2d Cir. 2006) (holding that Title IX supports a claim of sex discrimination where the alleged conduct included "verbal abuse that reflects sex-based stereotypes").

Section 1557, Title IX, and Title VII Prohibitions Against Sex Discrimination- Pregnancy, False Pregnancy, Termination Of Pregnancy, Or Recovery Therefrom, And Childbirth Or Related Medical Conditions

The Proposed Rule would allow health care providers and other covered entities to invoke blanket abortion and religious objection exemptions from the 2016 Regulations' general prohibition on sex discrimination. Specifically, although the 2016 Regulations allow for a case-by-case assessment of burdens on a provider's religion pursuant to the Religious Freedom Restoration Act (RFRA), the Proposed Rule would extend it further and allow for blanket denial of service provision based upon the assertion of alleged religious and moral beliefs, irrespective of competing interests, including the health of people who may require emergency treatments.

Essentially, the proposed change means, due solely to a provider or insurer's purported religious or moral beliefs, persons in need of the termination of a pregnancy or other health care services to treat critical medical conditions resulting from that procedure could be denied, delayed, or discouraged from seeking necessary care completely. These refusals of care will ultimately place them at risk of serious or life-threatening conditions in emergencies and circumstances where the individual's choice of health care provider is limited. Should this lead to restrictions in health insurance coverage for abortions or the provision of related medical services, the resulting gap in healthcare access would almost certainly disproportionately affect poor and low-income women who are unable to pay out-of-pocket for abortion services and other medical services.[21]

These proposed changes conflict with Section 1557 for numerous reasons. First, the text of Section 1557 is unambiguously clear as to the exemptions that apply to its antidiscrimination mandates. The statute explicitly extends nondiscrimination protections "except as otherwise provided for in [the] title (or an amendment made by [the] title)." 42 U.S.C. § 18116(a). Second, the Proposed Rule considers an overbroad universe of "conscience protections" separately established by HHS and not sanctioned by any federal laws or regulations. The expanded "conscience protections" would allow anyone "with an articulable connection to a procedure, health service, health program or research activity" to raise these alleged conscience objections. Meaning, the myriad of participants in a health care encounter—from intake and billing staff to pharmacists, translators, radiology technicians, and insurance companies—could refuse to participate in service delivery to or provide coverage for patients, even under emergency circumstances. These expanded "conscience protections" would themselves amount to a violation of Section 1557 and the incorporated federal civil rights laws as they are nothing more than a new standard of selective and discriminatory treatment for many of the most vulnerable populations. HHS's rule seeking to expand "conscience protections" is being challenged in a California federal court by the city and county of San Francisco, and in a New York federal court by a coalition of 23 states and municipalities, including NYC.[22]

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[21] https://www.kff.org/womens-health-policy/issue-brief/coverage-for-abortion-services-in-medicaid-marketplace-plans-and-private-plans/

[22] *State of New York v. U.S. Dep't of Health and Human Srvcs*, Case 1:19-cv-04676 at https://ag.ny.gov/sites/default/files/state_of_new_york_v_hhs_complaint.pdf; *City and County of San Francisco v. Azar*, Case No. 3:19-cv-2405 at https://www.sfcityattorney.org/wp-content/uploads/2019/05/1_Complaint.pdf.

Third, while debating the language of Section 1557, Congress considered and rejected broader exemptions similar to those now proposed by HHS. Congress refused to expand the federal conscience clause to prohibit "requir[ing] an individual or institutional health care provider to provide, participate in, or refer for an item or service to which such provider has a moral or religious objection, or require such conduct as a condition of contracting with a qualified health plan.[23] Congress also considered and rejected broader religious and moral exemptions in the context of the Women's Health Amendment.[24]

Finally, Congress has already included protections in the ACA to address religious concerns. Specifically, Title I of the ACA, in which Section 1557 is found, clearly incorporates existing federal conscience protections.[25]

Section 1557, Title VI and Section 794 of Title 29, Prohibitions Against Restricting Meaningful Access And Effective Communication To Obtain Health Care

(1) The Proposed Rule Weakens Language Access

The Proposed Rule waters down existing requirements on covered entities that ensure that LEP individuals have access to translations and interpretation services. Specifically, the Proposed Rule would replace required steps to provide meaningful access "to each LEP individual eligible to be served or likely to be encountered" with a broader test that an "entity" apply a four-factor analysis to determine an organization's obligations to provide language assistance services. While this test may have value in certain circumstances, using this metric in the healthcare context would shift a healthcare entity's focus from providing language access *to each individual* as a matter of their right– consistent with the established standards of patient-centered care – to a looser consideration of language access on an institutional level.

The protections for LEP individuals encoded in Section 1557 build upon pre-existing civil rights law, such as Title VI, which prohibits discrimination on the basis of race, color and national origin in programs and activities receiving federal financial assistance. Under governing U.S. Supreme Court case law, Title VI obligates recipients of federal financial assistance to provide LEP individuals with meaningful access to federally funded programs or activities. Section 1557 is the only law extending this protection to federally administered programs and requires that healthcare institutions implement some of the basic standards and practices that are necessary to ensure every individual has equal access to health insurance and healthcare, regardless of the language patients and their families speak.

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[23] See, e.g., 155 CONG. REC. S13193-01 (2009).
[24] *See, e.g.*, 155 CONG. REC. S13193-01 (2009).
[25] *See e.g.*, 42 U.S.C. § 18023(c)(2)(a)(i) (2010) ("Nothing in this Act shall be construed to have any effect on Federal laws regarding . . . conscience protection."); 42 U.S.C.A. § 18113 (2010) (exemptions for objections to assisted suicide); 42 U.S.C.A. § 18023 (2010) (allowing states to prohibit abortion coverage in the state exchanges); 42 U.S.C. § 18023(c)(1)-(2) (the ACA shall not "preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor").

The proposed changes will allow increased justifications for institutions to deny individuals language services, even when that information may be critical to a patient's health and wellbeing. Such a change will mean that the needs of LEP individuals are more likely to be discounted when determining whether language access must be provided. Notably, the communities most likely to be neglected under the proposed changes would be those that are already marginalized as speakers of languages of lesser diffusion, who typically have less access to resources in their languages, and are often vulnerable due to their immigration and socio-economic status.

(2) The Proposed Rule Eliminates Notice And Taglines Requirements

The 2016 Regulations require covered entities to take reasonable steps to provide meaningful access to each LEP individual and persons with communication disabilities eligible to be served or likely to be encountered. Requirements include posting a visibly-sized notice of non-discrimination and the availability of language access services in physical locations where the entity interacts with the public, on the entity's website, as well as in significant publications. The 2016 Regulations also require taglines on such publications, which must be translated into the top 15 non-English languages for large-sized publications and the top two languages for small-sized publications.

The Proposed Rule would eliminate notice requirements about one's rights to translation and interpretation services, protections from discrimination, and directions concerning how to file a complaint. These proposed changes would result in a failure to provide meaningful access to language services for LEP individuals.

In addition, the changes would deprive persons with communication disabilities— such as individuals who are deaf or hard of hearing, use a foreign sign language as their preferred mode of communication, and read in a language other than English— with meaningful access to language services. HHS's suggested exemption from the auxiliary aids and services requirement for covered entities with fewer than 15 employees"[26] would similarly place an undue access barrier on individuals with sensory, manual and communication disabilities. Under governing U.S. Supreme Court case law, Section 794 of Title 29 (the Rehab Act) obligates recipients of Federal financial assistance to provide persons with disabilities with meaningful access to federally funded programs or activities.[27]

Even when LEP individuals have health insurance and/or access health care services, they often do not receive adequate translation and interpretation services, with particularly significant gaps in outpatient primary care and mental health services.[28] Research has shown that LEP individuals

[26] Federal Register, Vol. 84, No. 115, "Nondiscrimination in Health and Health Education Programs or Activities," RIN 0945–AA11, p. 27867.
[27] *Alexander v. Choate*, 469 U.S. 287, 301 (1985) (an otherwise qualified handicapped individual be provided with meaningful access to the benefit that the grantee offers…; to assure meaningful access, reasonable accommodations in the grantees program or benefit may have to be made).
[28] New York City Mayor's Task Force on Immigrant Health Care Access, Improving Immigrant Access to Health Care in New York City: a Report from the Mayor's Task Force on Immigrant Health Care Access, 2015. https://www1.nyc.gov/assets/cidi/downloads/pdfs/immigrant_health_task_force_report.pdf

who need but do not receive adequate interpretation services have low satisfaction with interpersonal aspects of health care services received.[29] The Proposed Rule would deter LEP individuals from seeking health care services and needed medical treatment and exacerbate health disparities for this population.

When linguistically appropriate care is not available to people who speak English "less than well," patients and healthcare providers alike are put at risk. Studies have shown that language barriers impede access to health insurance,[30] hinder utilization of health care services,[31] compromise quality of care, [32] and increase the risk of adverse health outcomes among LEP individuals. LEP individuals are more likely than others to report being in fair or poor health, defer needed medical care, or misunderstand medication instructions.[33] Even HHS admits that repealing the requirements for taglines may "[decrease] access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services."[34]

Essentially, when patients do not know they have the right to an interpreter, do not know how to request an interpreter, or cannot read important notices about their care or insurance, it is much more likely that they will not receive care or services in a language that they can understand. When communication between patients and providers is compromised, healthcare providers are unable to provide adequate patient care, and patients' health is put at risk. Because the proposed elimination of the notice and tagline requirements will impede the ability of LEP individuals and persons with communication disabilities to meaningfully access health care and coverage programs and services, these proposed changes violate existing federal law, specifically Section 1557, Title VI and Section 794 of Title 29.

Section 1557- Enforcement Mechanisms

The Proposed Rule would eliminate the enforcement mechanisms available to HHS's OCR and protected individuals. However, Section 1557 unambiguously mandates that "the enforcement mechanisms provided for and available under such Title VI, Title IX, section 794, or such Age Discrimination Act shall apply for violations of [Section 1557]." 42 U.S.C. §18816(a). This statutory mandate provides OCR with centralized authority to monitor and enforce civil rights laws in the health care sector.

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[29] D.W. Baker , R. Hayes, and J.P. Fortier, "Interpreter Use and Satisfaction with Interpersonal Aspects of Care for Spanish-Speaking Patients," Medical Care 36 , no. 10 (1998): 1461 –1470.
[30] Kaiser Family Foundation, August 2012, "Overview of Health Coverage for Individuals with Limited English Proficiency." https://www.kff.org/wp-content/uploads/2013/01/8343.pdf
[31] New York City Mayor's Task Force on Immigrant Health Care Access, Improving Immigrant Access to Health Care in New York City: a Report from the Mayor's Task Force on Immigrant Health Care Access, 2015. https://www1.nyc.gov/assets/cidi/downloads/pdfs/immigrant_health_task_force_report.pdf
[32] D.W. Baker , R. Hayes, and J.P. Fortier, "Interpreter Use and Satisfaction with Interpersonal Aspects of Care for Spanish-Speaking Patients," Medical Care 36 , no. 10 (1998): 1461 –1470.
[33] Ku, L., & Flores, G. (2005). Pay now or pay later: providing interpreter services in health care. Health Affairs, 24(2), 435-444.
[34] Federal Register, Vol. 84, No. 115, "Nondiscrimination in Health and Health Education Programs or Activities," RIN 0945–AA11, p. 27882.

The Proposed Rule removes most provisions supporting OCR's enforcement authority under the statute, including its power to request information from a covered entity, access the books, records, and facilities of HHS to evaluate compliance of the agency's own programs, order remedial action, ban retaliatory action against an individual making a complaint, and/or take legally permissible disciplinary actions for those in non-compliance, including suspension or termination of funds. These proposed changes run counter to both the statute and the very purpose of OCR. Indeed, OCR was created to provide the area-specific knowledge and expertise for effective government oversight and civil rights law enforcement in the health sector, which is a specialized industry requiring specialized knowledge. Removing enforcement authorities delegated to OCR under the 2016 Regulations would essentially eliminate OCR's primary means to serve the mission of the office.

The Proposed Rule would also repeal mandates within the 2016 Regulations that require covered entities to hold themselves accountable under Section 1557, including requirements to designate an employee responsible for coordinating the responsibilities under the 2016 Regulations and to establish grievance procedures that allow individuals to allege discrimination. It would also eliminate a provision explicitly providing a private right of action to individuals who allege discrimination in violation of Section 1557, and a provision that requires covered entities to notify individuals of their rights under Section 1557 and the 2016 Regulations. In other words, under the Proposed Rule, an individual being discriminated against would no longer be informed of whether and how they can file their grievances or lawsuits. A covered entity would no longer need to take concrete actions to address such grievances. Combined with removal of much of OCR's enforcement authority, the Proposed Rule would virtually eliminate all avenues that allow the individuals' voices to be heard and enable OCR to hold stakeholders accountable.

This proposed change runs directly counter to the clear goal of Section 1557 to provide equal access to health care and insurance and essentially renders the statute meaningless. Additionally, removing the enforcement mechanisms that make it easier for individuals to raise their voices when they believe that their civil rights have been violated will impact populations that have been historically marginalized, already experience significant barriers to health care, and have disproportionately poor health outcomes, including people of color and immigrants.

II. THE PROPOSED RULE VIOLATES THE ADMINISTRATIVE PROCEDURE ACT BECAUSE IT IS ARBITRARY AND CAPRICIOUS.

Under the "arbitrary and capricious" standard, HHS is required to examine relevant data and articulate a satisfactory explanation for its action, including a "rational connection between the facts found and the choice made," based upon relevant factors.[35] An agency rule is arbitrary and capricious if the agency has: relied on factors that Congress did not intend it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed

[35] *See Motor Vehicle Mfrs. Ass'n*, 463 U.S. 29 at 43; *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962).

to a difference in view or the product of agency expertise.[36] Applying these standards demonstrates that, if finalized, the Proposed Rule would violate the APA.

A. HHS Failed to Consider Important Aspects of the Problem Underlying the Proposed Rule.

(1) HHS Failed To Account For The Need to Address Existing Discrimination in Health Care And The Resulting Negative Impact on Health Care Outcomes

Eliminating gender identity and abortion anti-discrimination protections from the ambit of Section 1557 will have a detrimental and far-reaching impact on the health of LGBQ and TGNCNB people, women, and our communities. Indeed, HHS' futile distinction between health insurance and health care ignores the direct role of insurers in care access and health outcomes. HHS also disregards the deleterious impact of discrimination on care access and health, particularly where, as here, the discrimination is state-sanctioned.

For patients across the United States who lack state and local protections against discrimination based on gender identity and termination of pregnancy, the Proposed Rule poses a significant threat to their dignity and general and emergency health care needs. In short, the Proposed Rule would permit health care providers and insurance companies— who are not being asked to cover or participate in abortion procedures or gender affirming care or transitions— to refuse to provide treatment or coverage for basic and essential medical care which is, without exception, made available to other persons.

In fact, an analysis of HHS complaints before the nationwide preliminary injunction issued in *Franciscan Alliance* found that the majority of complaints filed with HHS's OCR under the 2016 Regulations addressed denials of medical care or insurance coverage for generally available healthcare services— and unrelated to gender affirming care or gender transition.[37] For example, a health care provider could refuse to treat a patient for the flu solely based on the person's gender identity or refuse to accept a new transgender patient in favor of a person who is not transgender. Furthermore, under the Proposed Rule, women could be denied preventative and emergency care medical care or insurance coverage solely because they have terminated a pregnancy, are recovering therefrom or are suffering from a medical condition related to an abortion. Even survivors of sexual assault, particularly women of color who already experience difficulty in accessing reproductive health care,[38] would experience less support in accessing pregnancy termination related to their assault.

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[36] *See Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43-44.

[37] Sharita Gruberg and Frank J. Bewkes, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial*, Center for American Progress (Mar. 7, 2018) https://cdn.americanprogress.org/content/uploads/2018/03/06122027/ACAnondiscrimination-brief2.pdf

[38] Dehlendorf, C. & Weitz, T. (2011). Access to Abortion Services: A Neglected Health Disparity. Journal of Health Care for the Poor and Underserved 22(2), 415-421. Johns Hopkins University Press. Retrieved July 8, 2019, from Project MUSE database.

In addition, the Proposed Rule would eliminate the prohibition on categorical denials, automatic exclusions, and limited coverage for gender-affirming care. Gender-affirming care is medically necessary and, in many cases, life-saving for TGNCNB people.[39] It includes a range of treatments, such as hormone replacement therapy, breast augmentation/reconstruction, mastectomy, facial feminization, voice training, or genital surgery,[40] and mental health care for gender dysphoria. The country's leading medical associations have affirmed almost uniformly that access to these services leads to better overall health outcomes and should be deemed medically necessary.[41]

The protections afforded by Section 1557 to LGBQ and TGNCNB people have served as a critical tool in closing the healthcare gap facing many members of these communities. However, under the Proposed Rule, health care providers could roll back their protections or discontinue their compliance efforts that are already underway under the 2016 Regulations, leading to further deleterious healthcare outcomes for this population.

Even with protections under other federal laws and robust legal protections in place in NYS and NYC, discrimination in the healthcare setting remains an unfortunate reality for transgender New Yorkers. The inability to obtain such medical care under the Proposed Rule will further marginalize LGBQ and TGNCNB communities that already experience rampant discrimination in health care settings, inhibiting care-seeking and reducing the availability of culturally competent and affirming health care. [42] Studies consistently show that transgender people face high rates of discrimination when seeking health care. According to the Report of the 2015 U.S. Transgender Survey, which included 27,715 participants, 25% of respondents reported experiencing a problem with their insurance in the past year that was directly related to their gender identity, including being denied health care coverage; and 23% of respondents did not see a doctor when they needed care because of fear of being mistreated.[43]

The risk of adverse health outcomes is compounded by the likelihood that some TGNCNB persons unable to obtain gender-affirming care through their insurance will engage in risky behaviors in order to meet their health needs. For example, sharing used needles for hormone

[39] World Professional Association for Transgender Health (WPATH), *Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.* ("Position Statement") (Dec. 21, 2016) ("The medical procedures attendant to gender affirming/confirming surgeries are not 'cosmetic' or 'elective' or 'for the mere convenience of the patient.' These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed condition.")
[40] WPATH, The Standards of Care, 9-10 (2012).
[41] https://transcendlegal.org/medical-organization-statements
[42] Jaime M. Grant, Lisa A. Mottet, Justin Tanis, National Gay and Lesbian Task Force & National Center for Transgender Equality, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*, 6 (2011) https://transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf.
[43] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality.

injections place TGNCNB people at greater risk for HIV.[44] Other risky behaviors may include taking a higher hormone dosage than prescribed, purchasing hormones through unsafe underground markets, or injecting dangerous substances, like silicone, to bring one's body in line with the one's innate sense of their gender.[45]

Reduced access to mental health services for TGNCNB people resulting from the rule is also concerning given astounding rates of mental health issues among TGNCNB persons that result from interpersonal and systemic discrimination. According to the 2015 U.S. Transgender Survey, 40% of those surveyed had attempted suicide in their lifetime, compared to an estimated 4.6% of the general U.S. population. 39% percent of respondents experienced serious psychological distress in the month prior to completing the survey compared to an estimated 5% percent of the U.S. population.[46] A meta-synthesis of 42 studies of suicidality among transgender populations similarly found lifetime suicidal ideation among 56% of participants, with 29% attempting suicide.[47] In addition, LGBTQ youth disproportionately experience mental and behavioral health challenges compared to their heterosexual/cisgender peers. According to the NYC data, they are more likely to feel sad or hopeless (50% vs. 25%), more likely to attempt suicide (20% vs. 6%), more likely to drink alcohol (35% vs. 20%) and twice as likely to misuse both prescription and illicit drugs (16% vs. 8%).[48] By rolling back civil rights protections of the population already reluctant to seek care, the Proposed Rule could further exacerbate mental health disparities between LGBTQ youth and their heterosexual/cisgender peers as they may face additional barriers in accessing care without meaningful anti-discrimination protections in place.

Ultimately, by eliminating rigorous rules that require federally assisted health programs to respect and promote the rights of the individuals that our civil rights laws were intended to support, the Proposed Rule will likely increase these individuals' social isolation and lead to poorer health outcomes. In contrast, a recent study found that state-level policies providing protections to transgender people from discrimination in schools and the ability to change name and gender on identifying documents led to better mental health, less alcohol consumption, and more recent health care utilization among transgender individuals.[49] In addition, gender-

[44] Neumann, M. S., PhD., Finlayson, T. J., PhD., Pitts, N. L., B.S., & Keatley, J., M.S.W. (2017). Comprehensive HIV prevention for transgender persons. *American Journal of Public Health, 107*(2), 207-212.
[45] Sevelius, J. M. (2013). Gender affirmation: A framework for conceptualizing risk behavior among transgender women of color. *Sex Roles, 68*(11-12), 675-689.
[46] James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality. 2016. https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF.
[47] Adams N, Hitomi M, Moody C. Varied reports of adult transgender suicidality: synthesizing and describing the peer-reviewed and gray literature. *Transgend Health*. 2017; 2(1):60-75.
[48] Testimony delivered on June 19, 2019 to the New York City Council Committees on Youth Services and Mental Health, Addiction and Disabilities, Oversight – Mental Health Services for LGBTQ Youth. Testimony delivered by: Ashe McGovern, J.D. Executive Director, NYC Unity Project, Senior Policy Advisor, LGBTQ Initiatives; Hillary Kunins, MD, MPH, MS, Executive Deputy Commissioner, Division of Mental Hygiene, New York City Department of Health and Mental Hygiene
[49] Steve N. Du Bois et al., *Examining Associations Between State-Level Transgender Policies and Transgender Health*, 3:1 TRANSGENDER HEALTH 220-224 (2018).

affirming care has been shown to improve mental health disorders, including depression, anxiety, and gender dysphoria, and promote overall patient well-being.[50]

(2) HHS Failed To Account For Population Health Implications

Reduced access to health care resulting from the Proposed Rule also has significant population health implications, including in compromising HIV prevention efforts. In 2017, approximately 38,700 people living in the U.S. were diagnosed with HIV, and transgender people received an HIV diagnosis at a rate three times higher than the national average.[51] People at risk for HIV must have access to pre-exposure prophylaxis (PrEP), which reduces the risk of sexual transmission of HIV by well over 90%. For persons with HIV, retention in care not only enables them to live healthy lives, but is a necessary component of ending the epidemic, as persons with an undetectable viral load for six months or longer who remain on treatment cannot transmit HIV through sex. Secretary Azar himself said ensuring PrEP access was "a major step" in the administration's promise to end the HIV epidemic in America by 2030.[52] Crucial to ensuring everyone's access to HIV prevention and treatment tools, however, is not only the affordability and availability of drugs and healthcare services but also an inclusive care environment. Research has established a negative association between the impact of perceived discrimination and adherence to HIV antiretroviral therapy,[53] underscoring the importance of culturally competent and gender-affirming health care services to persons living with, or at risk of, HIV to the health of individuals and communities.

Similarly, delays in accessing testing and treatment for sexually transmitted infections (STIs)—for which many transgender persons are at higher risk as compared to the general population—has population health implications. In 2017, there were 2.3 million recorded cases of chlamydia, gonorrhea, and syphilis in the U.S.—the highest number ever on record.[54] In NYC, there were 23,459 reported cases of gonorrhea in 2017, nearly double the number reported in 2010, and 71,830 cases of chlamydia. Research has shown that STI rates are often highest among populations whose access to health services are the most limited.[55] In a recent study of HIV and STIs among transgender youth ages 15-24, respondents who reported having a provider knowledgeable on transgender health were significantly more likely to report being tested for

[50] *See, e.g.*, WPATH, Position Statement (Dec. 21, 2016).
[51] CDC. HIV among transgender people. 2019. Available at www.cdc.gov/hiv/group/gender/transgender/index.html Accessed July 1, 2019.
[52] HHS Press Office, "Trump Administration Secures Historic Donation of Billions of Dollars in HIV Prevention Drugs", May 9, 2019. https://www.hhs.gov/about/news/2019/05/09/trump-administration-secures-historic-donation-of-billions-of-dollars-in-hiv-prevention-drugs.html
[53] Turan, B., Rogers, A. J., Rice, W. S., Atkins, G. C., Cohen, M. H., Wilson, T. E., . . . Weiser, S. D. (2017). Association between perceived discrimination in health care settings and HIV medication adherence: Mediating psychosocial mechanisms. *AIDS and Behavior, 21*(12), 3431-3439.
[54] Centers for Disease Control and Prevention. NCHHSTP Newsroom: 2018 STD Prevention Conference. https://www.cdc.gov/nchhstp/newsroom/2018/2018-std-prevention-conference.html. Published August 28, 2018.
[55] Geisler WM, Chyu L, Kusunoki Y, et al. Health insurance coverage, health-care-seeking behaviors, and genital chlamydia infection prevalence in sexually active young adults. Sex Transm Dis. 2006 Jun;33(6):389-96.

HIV and STIs.[56] Protecting against gender discrimination is thus integral to protecting and promoting community health. In addition, if people of color are denied or dissuaded from receiving necessary prophylaxis, screening, and treatment for HIV and other STIs, existing disparities will widen— again, undermining the federal goal to end the HIV epidemic.

(3) HHS Failed To Account For The Cost Savings Attributable to the 2016 Regulations

HHS argues that the Proposed Rule will save costs, however, HHS's cost assessment fails to account for the cost-savings attendant to persons receiving timely and appropriate health care and averting the downstream costs of untreated health conditions.

With respect to language access mandates, while it is true that significant investment of resources are required, the failure to do so can be extremely costly to our healthcare system and to the people it serves. Studies have found that immigrants exhibited higher health care costs if there were language barriers between them and health care providers. Most of these increased costs were attributable to using more health care services and goods that could have been avoided with efficient communication.[57] Trained professional interpreters and bilingual health care providers positively affect LEP patients' satisfaction, quality of care, and outcomes, and can be ultimately more cost-effective.[58]

Furthermore, it has been shown that medically necessary health care for transgender individuals is cost-saving by reducing the risk of negative "end points," such as depression, suicidality, substance abuse, drug abuse, and HIV.[59] Averted HIV infections from appropriate prophylaxis, testing, and treatment can save tens of millions of dollars in medical costs attendant to HIV, including costs for daily medication and treatment of opportunistic infection, with the medical costs saved by avoiding just one HIV infection in the U.S. being conservatively estimated at $229,800 (2015 USD).[60] And each new HIV infection is a step backwards in the federal plan to end the epidemic.

Moreover, gender-affirming care is cost-effective and, when averaged with a pool of insured people, is typically less expensive than routine procedures, like those connected with childbirth.[61] Employers report very low costs from including coverage for gender-affirming care,

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[56] Sharma, A., Kahle, E., Todd, K., Peitzmeier, S., & Stephenson, R. (2019). Variations in testing for HIV and other sexually transmitted infections across gender identity among transgender youth. *Transgender Health, 4*(1), 46-57.

[57] Bischoff, A., & Denhaerynck, K. (2010). What do language barriers cost? An exploratory study among asylum seekers in Switzerland. *BMC health services research, 10*, 248. doi:10.1186/1472-6963-10-248

[58] Flores, G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review. *Medical care research and review, 62*(3), 255-299.

[59] Padula WV, Heru S, Campbell JD. Societal implications of health insurance coverage for medically necessary services in the U.S. transgender population: a cost-effectiveness analysis. *J Gen Intern Med*. 2016;31(4):394-401.

[60] Oh P, Pascopella L, Barry P, Flood J. A system synthesis of direct costs to treat and manage tuberculosis disease applied to California, 2015. *BMC Research Notes*. 2017;10(434):1-7.

[61] *See* Letter from WPATH to Roger Severino, Director, Office of Civil Rights (OCR), U.S. Department of Health and Human Services (HHS) (Aug. 15, 2017).

with many employers reporting no costs at all.[62] For example, a study on San Francisco's coverage of gender affirming care found that the cost was negligible.[63]

Despite the ample evidence supporting the cost-effectiveness of gender affirming health care and the increasing number of jurisdictions and plans moving to embrace such care due to the protections afforded under Section 1557, public and private health insurance companies continue to exclude gender-affirming health care from coverage, even in cases when a physician determines that they are medically necessary for a patient.[64] In the 2015 LGBT Health and Human Services Needs Assessment Survey ("2015 survey"), which examined the nexus between economic insecurity and health for TGNCNB New Yorkers, 61.3% of nearly 4000 respondents reported that their insurance does not cover transition-related care.[65]

Covering care improves people's life opportunities and capacity for self-sufficiency. Without access to these vital surgical, hormonal or other treatments, fewer TGNCNB individuals will be able to change their identity documents. While NYC has eliminated surgical-related requirements for changing gender identity on ID documents, many jurisdictions have not. This inability to have identity documents that match one's gender identity and expression will make employment, travel, housing and other social needs much harder to navigate for TGNCNB individuals.[66] These barriers also contribute to longer term economic instability for a population that experiences poverty at a much higher rate that non TGNCNB populations. According to the 2015 Survey, TGNCNB respondents were twice as likely to be in poverty than cisgender respondents.[67]

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[62] Jody L. Herman, Williams Institute, *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans* (Sept. 2013) https://williamsinstitute.law.ucla.edu/wp-content/uploads/Herman-Cost-Benefit-of-Trans-Health-Benefits-Sept-2013.pdf.

[63] Economic Impact Assessment, Gender Nondiscrimination in Health Insurance, State of California (2012), available at https://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf.

[64] Lambda Legal, "Creating Equal Access to Quality Health Care for Transgender Patients: Transgender Affirming Hospital Policies," Revised May 2016. https://www.lambdalegal.org/sites/default/files/publications/downloads/fs_20160525_transgender-affirming-hospital-policies.pdf May 2016

[65] Somjen Frazer and Erin Howe, "Transgender Health and Economic Insecurity: A report from the 2015 LGBT Health and Human Services Needs Assessment Survey," Empire State Pride Agenda: New York, NY. http://strengthinnumbersconsulting.com/wp-content/uploads/2017/06/TG-health-and-economic-insecurity-report-FINAL.pdf

[66] Somjen Frazer and Erin Howe, "Transgender Health and Economic Insecurity: A report from the 2015 LGBT Health and Human Services Needs Assessment Survey," Empire State Pride Agenda: New York, NY, p. 8. http://strengthinnumbersconsulting.com/wp-content/uploads/2017/06/TG-health-and-economic-insecurity-report-FINAL.pdf

[67] Somjen Frazer and Erin Howe, "Transgender Health and Economic Insecurity: A report from the 2015 LGBT Health and Human Services Needs Assessment Survey," Empire State Pride Agenda: New York, NY. http://strengthinnumbersconsulting.com/wp-content/uploads/2017/06/TG-health-and-economic-insecurity-report-FINAL.pdf

(4) HHS Failed To Account For The Administrative Burdens And Significant Costs The Proposed Rule Will Impose On States And Cities

HHS is silent regarding the negative financial impact the Proposed Rule will have on state and local health departments. In fact, additional human and financial resources will be needed for community outreach and other programming to combat increases in LGBQ and TGNCNB-related stigma and discrimination. Moreover, public health clinics, including the NYC Health Department's eight Sexual Health Clinics, may have increases in patient volume and in uncompensated care. And this is to say nothing of the resources required to counter any increases in HIV, STIs, or other diseases resulting from the Proposed Rule.

B. HHS's Explanations for the Proposed Rule Are Not Rational and Run Counter to Significant Evidence.

(1) Arbitrary Exemptions of Certain Health Care Insurance From Section 1557

As previously noted, the Proposed Rule would dramatically limit the scope of the ACA non-discrimination protections, by effectively removing many of the currently covered health care insurance programs from the statute's reach. For the reasons below, HHS's justifications for these exemptions are irrational and unsupported by evidence.

As an initial matter, determining the civil rights obligations of insurers and employers based on whether the federal government provides financial assistance directly through subsidies or indirectly through tax benefits is illogical, especially since disparities for racial minorities and foreign-born individuals in obtaining employer-sponsored insurance continue to exist. The ACA was instrumental in reducing racial, ethnic, sex, and disability-based disparities in health insurance coverage. Indeed, studies have found that after the implementation of the ACA: people of color experienced large coverage gains, with an 11 percentage point decline in the uninsured rates for Hispanics and Asians and 8 percentage point decline for Blacks and American Indians, compared to Whites (5 percentage points); the number of uninsured women fell from 19 million in 2010 to 11 million in 2016 – notably the uninsurance rate for Latinas, decreased by more than 10 percentage points from 30.4% in 2013 to 19.9% in 2017 (4.8% for White women during the same period). However, this progress would not have been possible without the robust non-discrimination protections in Section 1557. Thus, it is imperative that such protections continue to be extended to all forms of health insurance plans. The Proposed Rule's reduced scope of application would violate the goal of the ACA and Section 1557 to expand equal access to health care.

HHS arbitrarily limits which entities should be considered "covered entities" and subject to non-discrimination mandates based on the reasoning that "[h]ealth insurance is distinct from health care." This flawed judgment ignores two important facts. First, a person's access to health care is often dramatically limited by their access to, or lack of access to, adequate health insurance

coverage. Prior to the enactment of the ACA, health insurers could effectively restrict coverage for certain classes of people through decisions about issuance, cost-sharing, and benefit-design—tactics that the ACA has been designed to prevent by requiring guaranteed issue, renewability, and coverage of essential health benefits, and by prohibiting on pre-existing condition exclusions.

Second, HHS ignores the fact that, depending upon life, work, economic and social circumstances, individuals can move fluidly across health insurance markets, being insured for some period through the public options such as Medicaid, then getting employer sponsored coverage and possibly later becoming self-employed. According to a Health Affairs study, one in four Americans changed their health insurance coverage at least once in 2015. After omitting the newly insured, the three most common reasons for churning were job-related insurance changes, loss of eligibility for Medicaid or ACA marketplace subsidies, and inability to afford a previous plan. [68] Given the frequency of insurance "churning," meaningful civil rights protections for individuals accessing health insurance cannot be achieved without granting the same protections regardless of their insurance types or products. Under the Proposed Rule, the same persons protected from discrimination if insured through Medicaid might not receive comparable protections through employer-sponsored coverage. Section 1557's protections were not designed to be subject to the "luck of the draw" of selecting health insurance coverage in the "right" insurance market. Thus, it is vital that Section 1557 continue to apply to all health programs and activities that interact with individuals at various points in their overall pursuit of health insurance and health care services.

(2) Arbitrary Removal of Termination of Pregnancy, Recovery Therefrom and Related Medical Conditions as Forms of Sex Discrimination

HHS claims that, under Section 1557, Congress intended "sex" to refer solely to a person's biological sex assigned at birth, but offers no reasonable evidence or explanation to support this this policy shift. In addition to running counter to governing law, this policy reversal conflicts with the interpretation of Title IX by other federal agencies. In fact, since 2012, the Department of Education has recognized and enforced discrimination against students and employees based upon termination of pregnancy, recovery therefrom and resulting medical conditions as sex discrimination under Title IX in the education settings.[69]

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[68] Sommers, B. D., Gourevitch, R., Maylone, B., Blendon, R. J., & Epstein, A. M. (2016). Insurance churning rates for low-income adults under health reform: lower than expected but still harmful for many. Health Affairs, 35(10), 1816-1824.

[69] 34 C.F.R. § 106.40(b) (defining sex discrimination to reach discrimination against students on "the basis of such student's termination of pregnancy or recovery therefrom."); § 106.51(b)(6) (barring employment discrimination with respect to "[g]ranting and return from leaves of absences for termination of pregnancy); § 106.57(b)(prohibiting illicit discrimination against employees or prospective employees "on the basis of termination of pregnancy or recovery therefrom."); *see generally*, Office for Civil Rights, Pregnant or Parenting? Title IX Protects You from Discrimination at School, U.S. Dep't of Educ. http://www2.ed.gov/about/offices/list/ocr/docs/dclknow-rights-201306-title-ix.html.

This conflict is notable because, within the same Proposed Rule, HHS justifies removing gender identity as a form of sex discrimination because such a reading it is inconsistent with those of other federal agencies.[70] Using HHS's erroneous logic, termination of pregnancy, recovery therefrom and resulting medical conditions should continue to be considered sex discrimination in the health care and insurance context under Section 1557 to align with the regulations of another federal agency. HHS's conflicting justifications for the removal of various forms of sex discrimination from the 2016 Regulations are not rational.

(3) Arbitrary Elimination of Language Access Requirements

For the reasons set forth below, HHS's explanation for removing various language access requirements are irrational and runs counter to significant evidence.

NYC's Experience Providing Services to its Linguistically Diverse Population Demonstrates the Need for Robust Language Access Regulations in Healthcare

NYC is the largest and most culturally and linguistically diverse city in the United States, and its economic, cultural, and civic vitality depend on our immigrant communities. Of the City's 8.6 million residents, 3.1 million are immigrants (37.1% of the city's population). More than 200 languages are spoken by NYC residents across the five boroughs and approximately half of all New Yorkers speak a language other than English at home.[71] One in four – or two million New Yorkers – are considered LEP.[72] Protecting the well-being of all New Yorkers entails improving public health and emergency preparedness, as well as engagement across all communities. These, in turn, require clear communications with and trust in the government and healthcare institutions.

As a result of NYC's diversity, we have a unique understanding of how critical it is to ensure language access, particularly for essential services like healthcare. The city has found that language access is a fundamental requirement for meaningful access to healthcare. In fact, when LEP individuals are denied quality language services, they are less likely to seek preventative care, return to a healthcare institution for follow up care, comply with medical prescriptions, and are more susceptible to adverse outcomes. Furthermore, when an LEP individual must rely on unqualified staff, their own limited use of English, or a family member as an interpreter, they are less likely to share vulnerable but medically critical information, and the risk of miscommunication is high.

[70] *See* Proposed Rule at p. 27856.
[71] U.S. CENSUS BUREAU. *QuickFacts New York city, New York*. (2000) https://www.census.gov/quickfacts/fact/table/newyorkcitynewyork/AGE295218.
[72] New York City Mayor's Office of Immigrant Health, State of Our Immigrant City: MOIA Annual Report for Calendar Year 2018, March 2019. https://www1.nyc.gov/assets/immigrants/downloads/pdf/moia_annual_report%202019_final.pdf

NYC advances English language learning and expanded language access for New Yorkers with LEP.[73] Since 2017, NYC requires that City agencies translate their most-commonly-distributed materials into ten languages, ensure all people have access to interpretation services when obtaining City services, and provide notification of free interpretation.[74] NYC's experience demonstrates that any minor administrative costs associated with printing information in additional languages is largely overshadowed by the benefits our communities receive when people are able to obtain the care they need.

NYC's experience with improving language access aligns with the broad efforts of the healthcare industry to improve outcomes. Over the last two decades, the healthcare industry has increasingly focused on the delivery of patient- and family-centered care as central components of quality care, patient safety, and health equity. This shift has been reflected in and driven by evolving requirements under the Joint Commission and the HHS standards for Culturally and Linguistically Appropriate Services. These initiatives are essential to advancing language access, and are also necessary to limit exposure to potential liabilities.

Nationwide, 25.1 million people are considered LEP and nearly 20% of them are U.S.-born citizens.[75] While the ACA has proven to be instrumental in supporting LEP individuals in obtaining health insurance coverage,[76] a disproportionately large percentage of LEP individuals remain uninsured,[77] and targeted outreach and assistance are crucial in closing the coverage gap within this population. Given the high need, the government has a duty to ensure that LEP individuals receive appropriate language assistance services when they seek insurance coverage, utilize benefits, or receive health care services.[78]

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[73] "State of Our Immigrant City: MOIA Annual Report for Calendar Year 2018," New York City Mayor's Office of Immigrant Affairs (2019), https://www1.nyc.gov/assets/immigrants/downloads/pdf/moia_annual_report%202019_final.pdf.

[74] Local Law 30 (2017)

[75] Migration Policy Institute (MPI) tabulations from the U.S. Census Bureau's 1990 and 2000 Decennial Censuses and 2010 and 2013 American Community Surveys (ACS), Migration Policy Institute, July 2015. https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states (Between 1990 and 2013, the LEP population in the U.S. grew 80% from nearly 14 million (6% of the total U.S. population) to 25.1 million (8%)).

[76] SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files, State Health Compare, SHADAC, University of Minnesota, accessed on June 28, 2019, available at http://statehealthcompare.shadac.org/table/15/health-insurance-coverage-type-by-limited-english-proficiency#1/5,4,1,10,86,9,8,6,18,19/24/29,30 (the insurance coverage rate among LEP individuals has increased from 61.7% in 2010 to 74.8% in 2017, with a noticeable jump in 2014, when various ACA insurance expansion provisions went into effect).

[77] 2017 ACS data (25.2% vs. 7.5%)

[78] NY State of Health: The Official Health Plan Marketplace, 2019 Open Enrollment Report, May 2019. https://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202019%20Open%20Enrollment%20Report_0.pdf

The Proposed Rule Contradicts Long-Standing Federal Guidance To Ensure Meaningful Access

Notice and Taglines Requirements

HHS contends that the notice and tagline requirements in the 2016 Regulations must be eliminated entirely because they are inconsistent with those required by other components of HHS, and provided relatively minimal benefit to LEP individuals.[79] However, in HHS's own Language Access Plan, the agency notes that the taglines in non-English languages are used to inform LEP clients of their right to free language services and the nondiscrimination practices of the relevant agency. [80] Further, the Department of Justice's guidance for federally conducted or assisted programs explicitly recognizes the following: "[w]hen…an LEP individual does not know about the availability of language assistance services, [they] will be less likely to participate in or benefit from an agency's programs and services;"[81]that notices and taglines serve as a temporary measure to promote better language access when documents deemed "vital" have yet to be translated; and that "agencies should provide notice about its language assistance services in languages LEP persons will understand."[82]

Thus, while federal agencies may have differing requirements regarding the content of notices and taglines, there is certainly agreement that the notices and taglines are necessary to provide meaningful access to health care and effective communication to LEP individuals. Eliminating these requirements entirely contradicts long-standing federal guidance.

Language Access Plans

The Proposed Rule also would eliminate a regulatory provision that allows HHS to consider whether the covered entity has an effective written language access plan. However, developing and implementing an effective written language access plan is an important factor in evaluating a covered entity's compliance under the 2016 Regulations, and is crucial to providing effective language access services in a sustainable manner.

Removing the consideration of whether an entity has an effective written language access plan when evaluating a covered entity's compliance means that entities will be disincentivized from devising systematic plans to guarantee access, which helps establish the infrastructure necessary to evaluate and apply equitable delivery of service across an institution and its service population. Ad hoc provision of language services results in inequality and a reduction in the quality of language services, which negatively affects both patients with LEP and healthcare systems.

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[79] *See* Proposed Rule at p. 27852

[80] The Department of Health and Human Services, Language Access Plan 2013, p. 13. https://www.hhs.gov/sites/default/files/open/pres-actions/2013-hhs-language-access-plan.pdf

[81] U.S. Department of Justice, "Common Language Access Questions, Technical Assistance, and Guidance for Federally Conducted and Federally Assisted Programs," August 2011, p. 6. https://www.lep.gov/resources/081511_Language_Access_CAQ_TA_Guidance.pdf

[82] LEP.gov Federal Interagency website, https://www.lep.gov/faqs/faqs.html#Two_EO13166_FAQ

Moreover, similar to Section 1557, Federal Executive Order 13166 (EO13166) requires federal agencies to implement a system and plan to ensure improved access to services for LEP individuals, and New York State Executive Order 26 (EO26) requires state agencies to appoint a Language Access Coordinator and publish a language access plan. A recent independent analysis of the EO26 concluded that such mandates would benefit both NYS LEP residents and government agencies and improve access to and quality of services provided by state agencies. In addition, the report concluded that the EO would reduce health disparities among LEP populations, without materially affecting the operations of the covered entities.[83] The 2016 Regulations encourage health insurers, researchers, and health care providers to take similar action to accommodate LEP individuals' language needs. The proposal to remove this consideration could discourage use of an important planning tool that helps entities better comply with the law and ensure that language access services are implemented in a cost-efficient manner to benefit both LEP individuals and covered entities themselves.

The Proposed Rule Eliminates or Weakens Major Tools that Facilitate Language Access, Which Will Result in Negative Health Outcomes.

HHS also proposes eliminating the current remote video interpreting standards and instead include standards only for remote audio interpreting services. However, because healthcare institutions are increasingly relying on remote video interpretation services, it is vital that there are high standards for any language service provider that provides medical interpretation. The removal of standards for remote video interpretation means that healthcare institutions will have a compromised ability to budget for high quality video remote interpretation. We also note that the rapid development and integration of new technologies into the delivery of interpretation continue to expand the availability and lower costs for video remote interpretation.

The proposed change further eliminates "qualified" from the proposed description of interpreters and translators that can provide language services under the law, and eliminates "above average familiarity with" from the definition. This weakens the qualifications required of language service providers that provide interpretation and translations for healthcare institutions, thereby jeopardizing the quality of communication possible between providers and patients. Also, the use of underqualified language service providers can result in negative patient outcomes and miscommunication that can result in liability for the institution and increased costs due to inefficiencies such as unnecessary tests and procedures. In short, by undermining this valuable tool for effective communication, the Proposed Rule undermines access to quality healthcare for individuals with LEP.

[83] New York Lawyers for the Public Interest, Letter to U.S. Department of Health and Human Services Office for Civil Rights, RE: Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities, October 1, 2013. https://nylpi.org/wp-content/uploads/bsk-pdf-manager/33_NYLPI_section_1557_comments_final_hardcopy.pdf

III. HHS HAS NOT COMPLIED WITH EXECUTIVE ORDER 13132, THE TREASURY GENERAL APPROPRIATIONS ACT, OR EXECUTIVE ORDER 12866.

Executive Order 13132

As explained above, HHS's failure to consider all aspects of the problem – specifically, the significant costs that the Proposed Rule would shift to state and local governments – violates the APA. *See, supra*, at p. 19. In addition, HHS has violated the APA by failing to consider and evaluate the federal implications of the Proposed Rule. The requirement that HHS consider the costs to state and local governments and federalism implications associated with the Proposed Rule violates not only the APA but also Section 6 of Executive Order 13132, which mandates that:

> no agency shall promulgate any regulation that has federalism implications, that imposes substantial direct compliance costs on State and local governments, . . . unless (1) funds necessary to pay the direct costs incurred by the State and local governments in complying with the regulation are provided by the Federal Government; or (2) the agency, prior to the formal promulgation of the regulation, (a) consulted with State and local officials early in the process of developing the proposed regulation; (b) in a separately identified portion of the preamble to the regulation as it is to be issued in the Federal Register, provides to the Director of the Office of Management and Budget (OMB) a federalism summary impact statement, which consists of a description of the extent of the agency's prior consultation with State and local officials, a summary of the nature of their concerns and the agency's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of State and local officials have been met; and (c) makes available to the [OMB] Director any written communications submitted to the agency by State and local officials.

Exec. Order No. 13,132, 64 Fed. Reg. 43,255 (Aug. 10, 1999)

HHS ignores this requirement, stating in conclusory fashion and without data, analysis or any other evidentiary support, that the Proposed Rule does not have federalism implication and does not impose substantial direct compliance costs on State and local governments.[84] HHS is incorrect.

As explained above, the Proposed Rule will require states and local governments to expend additional human and financial resources for community outreach and other programming to combat increases in LGBQ and TGNCNB-related stigma and discrimination.[85] Moreover, public health clinics may have increases in patient volume and in uncompensated care, and resources would be required to counter any increases in HIV, STIs, or other diseases resulting from the

[84] *See* Proposed Rule at p. 27886.
[85] *See, supra*, at p. 19.

Proposed Rule. This could force state and local governments to make significant expenditures to protect the health and well-being of their residents. [86]

Moreover, the Proposed Rule has federalism implications. Policies and regulations that have federal implications include those that have substantial direct effects on States and local governments, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.[87]

In addition to violating the federal civil rights laws incorporated into Section 1557, the proposed changes also run counter to the U.S. Constitution and other federal laws. Specifically, the proposal to permit health care insurance companies and providers to deprive persons of health care coverage and services due solely to their race, national origin, color, sex, or disability status is a violation of the Equal Protection Clause of the Fourteenth Amendment. Further, the proposal to remove enforcement mechanisms through which persons may challenge a discriminatory denial of health care services and insurance is a violation the Due Process Clause of the Fifth and Fourteenth Amendments. Finally, HHS's proposal to allow providers to deprive certain persons of medical care, despite the existence of emergency circumstances, is a direct violation of the Emergency Medical Treatment & Labor Act.[88]

Notably, pursuant to Section 1557, Congress explicitly specified that the statute may not be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under Title VI, Title VII, or Title IX, in part, or to supersede State laws that provide additional protections against discrimination on any basis set forth in Section 1557.[89] However, as set forth above, the Proposed Rule seeks to set new regulations implementing Section 1557 that would ignore the very mandates within the statute.

In addition, the some of the protections provided by Section 1557 are similar to those available New York State Human Rights Law and New York City Human Rights Law. Both New York State and New York City have a Human Rights Law prohibiting discrimination on the basis of gender identity and gender expression.[90] Further, in 2016, the NYC Commission on Human Rights published legal enforcement guidance explicitly prohibiting employers from offering employee benefits that discriminate on the basis of gender identity, and NYC laws prohibit discrimination in public accommodations, health care, and other settings.[91]

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[86] *See id*.
[87] Exec. Order No. 13,132, 64 Fed. Reg. 43,255 (Aug. 10, 1999).
[88] 42 U.S.C. § 1395dd (requiring hospitals that have an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or, if medically warranted, to transfer the person to another facility).
[89] 42 U.S.C. 18116(b).
[90] NYS Human Rights Law § 296(2)(a) (prohibiting health care entities and providers from withholding or denying health care services to any person because of their sexual orientation, gender identity or expression, or the marital status of any person); N.Y.C. Admin. Code § 8-107.
[91] 10 N.Y.C.R.R. § 405.7 (c)(2) (prohibiting discrimination against patients in NYC health care facilities based on sexual orientation, gender, gender identity, and marital status).

NYC is committed to prohibiting unlawful discrimination in all of our programs, including, to the extent it has the authority to do so, the administration of health insurance which serves the fundamental purpose of ensuring that vital health care services are broadly available to all individuals throughout the country. In addition, NYC upholds a sexual and reproductive justice framework in city programs and services. We recognize that sexual and reproductive justice exists only when all people have the power and resources to make healthy decisions about their bodies, sexuality, and reproduction. This framework includes the right to: choose to have or not have children; choose the conditions under which to give birth or create a family; care for one's children with necessary social support in a safe and healthy environment; and control one's own body and self-expression, free from any form of sexual, reproductive, or gender based oppression.

The Proposed Rule poses a serious impediment to these protections by giving license to health insurers and providers to discriminate against New Yorkers by excluding coverage of medically necessary care in violation of Section 1557 and federal civil rights laws.

Due to the compliance costs and federalism concerns implicated by the Proposed Rule, a federalism summary impact statement should be provided.

The Treasury General Appropriations Act of 1999

HHS does not address the affirmative obligations imposed on it by the Treasury General Appropriations Act of 1999. That Act provides that:

> before implementing policies and regulations that may affect family well-being, an agency shall assess whether the action — (1) strengthens or erodes the stability or safety of the family and, particularly, the marital commitment; (2) strengthens or erodes the authority and rights of parents in the education, nurture, and supervision of their children; (3) helps the family perform its functions, or substitutes governmental activity for the function; (4) increases or decreases disposable income or poverty of families and children; (5) is warranted because the proposed benefits justify the financial impact on the family; (6) may be carried out by State or local government or by the family; and (7) establishes an implicit or explicit policy concerning the relationship between the behavior and personal responsibility of youth, and the norms of society.

Pub. L. No. 105–277, §654(c)(1-7), 112 Stat. 2681- 528-30 (1998).

Because HHS has not assessed the impact of the Proposed Rule on family well-being in any fashion, the Proposed Rule should not be finalized.

Executive Order 12866

Finally, HHS's assertion that the Proposed Rule is compliant with the Regulatory Flexibility Act is incorrect and incomplete. For the reasons discussed above, contrary to HHS's analysis, implementation of the Proposed Rule would impose an administrative and financial burden on states and localities.

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August 13, 2019

VIA ELECTRONIC SUBMISSION

Secretary Alex Azar
U.S. Department of Health and Human Services
Herbert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Mr. Roger Severino
Director
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave. S.W.
Washington, DC 20201

RE: Docket ID HHS-OCR-2019-0007, RIN 0945-AA11, Nondiscrimination in Health and Health Education Programs or Activities

Dear Secretary Azar and Mr. Severino:

The Colorado Center on Law and Policy submits these comments on the proposed rule, "Nondiscrimination in Health and Health Education Programs or Activities," (proposed rule) on Section 1557 of the Affordable Care Act.[1]

The Colorado Center on Law and Policy uses research, legislation, administrative advocacy and litigation to remove the systemic barriers that impede Coloradans experiencing economic hardship. Discrimination against individuals on the basis of race, color, national origin, disability, age and gender is perhaps the greatest single barrier to better health and wellbeing. The proposed rule will harm individuals who seek to access coverage and health care, especially those who already face particular barriers to care, and is inconsistent both with Section 1557 of

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

the Affordable Care Act (ACA) and the overall goal of the ACA of ensuring greater access to coverage and health care services.

Opening the door to discrimination against specific groups harms all of us, eroding the health of Colorado's workforce, our schools and our communities. We urge that that the 2016 final rule remain in effect and that this proposed rule be withdrawn.

I. Justifications given for revising the final rule are inadequate and contrary to existing law and guidance.

The legal case most discussed as a basis for revision is a federal district court ruling, *Franciscan Alliance v. Azar*, though that ruling is merely one of several issued by district courts on the protections outlined by the final rule.[2] With the matter not yet settled in the courts, it is at best premature to revise regulations. Moreover, changes in the proposed rule go significantly outside the subject matter of *Franciscan Alliance*, significantly reducing protections for immigrant populations and people with disabilities despite the absence of legal justification.

Franciscan Alliance is given greater weight than is clearly justified. On top of that, the proposed rule fails to accurately characterize the emerging case law on disparate impact cases and the private right of action under Section 1557. Section 1557 explicitly makes a broad set of remedies available to any person who has been subject to discrimination: remedies available include any and all of the "rights, remedies, procedures, or legal standards available" under the four civil rights statutes.[3] The proposed rule, including newly designated § 92.5, contradicts the statute and emerging case law.

The proposed rule also undermines the ACA more generally and its goals of broader access to affordable care. By reversing decades of policies that allowed entities to refuse coverage to women and people with pre-existing conditions, the ACA has helped expand the pool of covered individuals and spread costs so that women, seniors, LGBTQ individuals, and those with chronic conditions can get needed care and are not disproportionately burdened by health care expenses. Despite attempts at repeal, the ACA remains good law and large majorities of Americans

[2] *See generally Franciscan Alliance v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016). *Prescott v. Rady Children's Hosp.*, 265 F. Supp. 3d 1090 (S.D. Cal. 2017), *Flack v. Wisconsin Dept. of Health Srvs*., 18-cv-309, 2018 WL 3574875 (W.D. Wis. Jul. 25, 2018), *Flack v. Wis. Dep't of Health Servs*., No. 18-cv-309-wmc, 2019 U.S. Dist. LEXIS 68824 *3 (W.D. Wis. Apr. 23, 2019), *Boyden v. Conlin*, No. 17-cv264-WMC, 2018 (W.D. Wis. September 18, 2018), *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018).

[3] 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.].

continue to support provisions ranging from guaranteed issue to premium subsidies to the creation of exchanges.[4]

In numerous areas, the proposed rule creates opportunities for confusion or inconsistency, such as the decision to repeal essential definitions ((§ 92.4), the four-factor test (§ 92.101(b)(1)) or internally inconsistent language about receipt of federal financial assistance (FFA). By making it difficult for entities to know how to comply, for states to regulate, and for individuals to assert their rights, the proposed rule, if finalized, would fail to meet its essential function as a tool for enforcement.

We do not agree that the proposed rule would decrease financial burdens imposed by the final rule. The proposed rule cites E.O. 13765, which announces the Administration's authority to exercise authority to counter aspects of the ACA that financially burden individuals, families, patients, and recipients of health care services.[5] The proposed rule would in fact increase financial burdens on individuals and states with measures that would increase the likelihood that individuals in certain groups would have less access to needed services and pay more out-of-pocket for services, that states and entities would see greater rates of uncompensated care, and that state regulators would have greater challenges in enforcing existing law.

II. The proposed rule limits the application and enforcement of the nondiscrimination protections, without justification: § 92.3 Scope of Application and § 92.5 Enforcement Mechanisms

A. Scope of Application

The expansive language of Section 1557 of the ACA, applies nondiscrimination requirements to an array of programs and activities, as follows:

> "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title [1] (or amendments). 42 USC 18116(a).

No changes have occurred since passage of the law that would justify exempting carriers or their products from the nondiscrimination regulations. HHS requests responses regarding the scope of coverage and appears to propose that its recommended definition of "health care" be used to limit the plain meaning of the broad terms used – "any health program or activity" – that the statute employs.

[4] *Six Charts About Public Opinion on the Affordable Care Act*, Kaiser Family Foundation. Jul 19, 2019. https://www.kff.org/health-reform/poll-finding/6-charts-about-public-opinion-on-the-affordable-care-act/
[5] 82 FR 8351 (Jan. 24, 2017).

If finalized, the rule would allow national carriers for short-term plans to sell plans that exclude coverage for maternity benefits or certain pre-existing conditions, creating additional challenges for Colorado regulators in enforcing state-specific requirements. Destabilization of the individual market could occur in states that permit the offer of discriminatory short-term plans. To prevent destabilization of the individual market – as well as higher federal burdens that would result from higher premiums and accordingly larger tax credits – broad application of nondiscrimination protections is necessary.

Ambiguous language about the application of rules to Qualified Health Plans (QHPs) increases the risk that carriers will take inconsistent actions, adding to burdens on state regulators and increasing out-of-pocket costs for enrollees. We oppose any narrowing of the scope of protections and believe any narrowing would be an abuse of discretion by HHS.

B. Enforcement Mechanisms

The final rule establishes that meaningful access is viewed from an individual perspective, so that individuals who fit into multiple groups can get a single remedy that meets their needs. The final rule aligns with the plain language of the statute, which lists the four civil rights statutes that provide the grounds for a discrimination claim and goes on to say as follows: "The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection." 42 USC 18116(a). Since violations of the subsection involve discrimination against an individual – who may have a claim deriving from both race and gender, or any other combination of bases – it would be absurd and impracticable to limit remedies by basis. We oppose any limitation on remedies available to individuals.

III. The proposed rule harms LGB and transgender individuals: § 92.4 Definitions

Individuals who identify as LGBT already experience harsh or discriminatory treatment from providers at much greater rates than the general population. The 2016 rule clarified that providers cannot refuse treatment to someone based on their gender identity, and required coverage of medically-necessary services, including gender-affirming care. The proposed rule weakens those protections, removing gender identity from the definition of sex discrimination and opening the door to carriers excluding certain services. The rule would also allow a provider to deny any type of treatment – from a broken bone to a pap smear - to a gender non-conforming individual. Consistent with the findings of courts in areas outside of health, current regulations

prohibit discrimination based on sex stereotypes, and bar providers from denying treatment to individuals who do not conform to stereotypes of masculinity or femininity.[6]

The more than 20,000 adult Coloradans who identify as transgender[7] have made coverage gains since the ACA was passed, with many more individuals enrolled in coverage. However, according to individuals polled in 2018 by One Colorado Education Fund, almost a third still say they don't have access to LGBTQ-competent providers, and a third were denied LGBTQ-related services in 2018,[8] strongly suggesting that much more work is needed to enforce current protections. The percentage reporting poor mental health in the previous month is almost four times as high as the general public. National data shows that 23 percent of individuals were refused treatment due to their gender identity, and 29 percent did not get medical care because they feared mistreatment or discrimination.[9]

Removing existing protections will make care still less accessible for the 4.6 percent of Coloradans who identify as LGBTQ.[10] Greater enforcement of current protections is needed, and we oppose changes to treatment of gender and gender identity in the final rule.

IV. The proposed rule undercuts the work of the ACA to improve women's access to affordable care and would allow discrimination against women on the basis of pregnancy. § 92.4 Definitions

Before the ACA, women paid more than men for their insurance and were often unable to find coverage for necessary services. For example, in 2011, in the individual market, 62 percent of individuals did not have plans that covered maternity care.[11] The costs could be overwhelming, with a 2007 Thompson Healthcare study noting that costs associated with pregnancy and childbirth exceeded $8,800.[12]

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[6] The following cases are a small sampling of the available case law. *EEOC v. R.G. & G.R. Harris Funeral Homes*, No. 16-2424 (6th Cir. Mar. 7, 2018); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005); Smith v. City of Salem, 378 F.3d 566 (6th Cir. 2004).

[7] Flores, A., Herman, J., Gates, G. Brown, T. *How Many Adults Identify as Transgender in the United States?* Williams Institute, June 2016. Available at: https://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf

[8] *Closing the Gap: The Turning Point for LGBTQ Health*. One Colorado Education Fund. (June 2019). https://one-colorado.org/wp-content/uploads/2019/05/Closing_The_Gap_2018-LGBTQ-Health-Assessment_FINAL_5.17.19.pdf

[9] Mirza, S.A., Rooney,C., *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for American Progress, (Jan. 18, 2018),

[10] Williams Institute, *LGBT Data and Demographics*. https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT&area=8#density

[11] Sarah Lueck, Ctr. on Budget & Policy Priorities, *If Essential Health Benefit Standards Are Repealed, Health Plans Would Cover Little*, (Mar. 23, 2017), https://www.cbpp.org/blog/if-essential-health-benefits-standards-are- repealed-health-plans-would-cover-little.

[12] Thomson Healthcare, submitted to March of Dimes. *The Healthcare Costs of Having a Baby*. https://www.marchofdimes.org/partner-the-healthcare-costs-of-having-a-baby.pdf

The 2016 final rule made clear that sex discrimination under Section 1557 includes discrimination on the basis of pregnancy, termination of pregnancy, childbirth or related conditions. The proposed rule attempts to curtail these protections, despite the plain language of Section 1557 that grounds available under the four civil rights acts pertain to discrimination in health care. Title IX specifically prohibits discrimination based on pregnancy, a term which includes termination of pregnancy. Moreover, language in the proposed rule creates confusion regarding federal enforcement.

The proposed rule would have a disproportionate impact on women of color, who face greater barriers to pregnancy-related care, including discrimination and harassment, and experience high rates of pregnancy-related complications. Black women with advanced degrees have poorer outcomes than white women who lack a high school diploma. The impact on infant outcomes is significant, with infants born to black women in Colorado significantly more likely to be premature or low birth-weight, even after adjusting for education and income.[13] Discrimination on this basis has clear, long-term economic and social costs.

We strongly oppose changes in the proposed rule that remove explicit protections for an individual who needs care after a pregnancy is terminated through miscarriage or abortion or for an individual that has pregnancy-related complications, and that sow confusion regarding enforcement of protections based on pregnancy generally.

V. The proposed rule harms Coloradans with Limited English Proficiency: § 92.201 Meaningful Access for Individuals with Limited English Proficiency

Nationally, 25 million people have limited English proficiency (LEP). Discrimination based on having a primary language other than English is considered discrimination on the basis of national origin. Section 1557 of the ACA builds on existing protections in the Civil Rights Act that require meaningful access for those with LEP to federally-funded programs, helping to ensure that all individuals can get information they need to access coverage and care.

According to the American Community Survey, 6.53% of Colorado's residents have limited English proficiency (LEP), many of whom have public insurance,[14] with the most common languages spoken in Colorado being Spanish, Vietnamese, Chinese, Korean and Russian.[15] That is a significant fraction of the state population and one for which more, rather than fewer, efforts should be marshaled. Finalization of the proposed rule would compound existing economic barriers; people who are not English-proficient constitute one in ten working-aged adults and are more likely to be in low-wage jobs.[16] Because of lower wages, they are more likely to experience poverty-related health disparities and have fewer affordable health care options. In addition, seniors who did not grow up in the United States are particularly likely to face

[13] Gunn, D., *Why Is It So Risky to be a Black Mother?* The Colorado Trust. (Sept. 4, 2018). https://www.coloradotrust.org/content/story/why-it-so-risky-be-black-mother
[14] Limited English Proficient Map. 2015. LEP.gov
[15] Appendix A: Top 15 Languages by State. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf
[16] Dews, F. Six questions about Limited English proficient (LEP) Workforce. *Brookings Institute.* 2014.

language-related obstacles to getting care. These barriers limit access to health care for themselves and family members, and make it difficult to discuss and assess options and ask questions.

The proposal, if finalized, would roll back the requirement for taglines on significant documents, resulting in inadequate guidance for entities that must comply with the statutory language of Section 1557 and – because of the lack of clarity – the imposition of greater burdens on state regulators. In the absence of taglines, LEP individuals would have less of an opportunity to understand their rights and get information about health coverage and services that are available to them. Furthermore, without these taglines, people may not be able to understand notices that inform individuals about changes in their coverage. This not only leads to underutilization of necessary services – which exacerbates already present health disparities – but also undermines access to due process in the form of grievances and appeals.

Language access can save lives. In a 2007 study, more than half of adverse events that occurred to LEP patients in US hospitals were attributed to communication errors, and of those events, nearly half resulted in physical harm.[17] Research also indicates that that language barriers result in increased readmission through Emergency Departments post-hospitalization, potentially increasing costs for both facilities and patients.[18]

The Administration's given reason for the change in rule is that printing costs are excessive and requirements are burdensome. This fails to take into account costs related to uncompensated care, medical error, and the greater disease burden that results from lack of access to a regular source of care. When documents are not widely translated, taglines are in fact a cost-effective method of ensuring that recipients have access to important communications. Removing the requirement in rule would make it more difficult for entities to know whether they are in compliance with federal law in the ACA and Section VI of the Civil Rights Act.

VI. The proposed rule would reduce individuals' access to nondiscriminatory treatment by removing notice requirements. § 92.8 Notice Requirements.

The final rule requires that covered entities notify the public that they: do not discriminate on any basis covered by Section 1557; extend assistance to people with disabilities and LEP and how that assistance can be obtained; and offer grievance procedures and information on how to file a complaint with the Office of Civil Rights. Public posting in physical settings and on an entity's website is an inexpensive and efficient way to communicate essential information. By preventing individuals from easily accessing information about their rights, the proposed rule will reduce

[17] Divi, C., Koss, R., Schmaltz, S., Loeb, J. Language proficiency and adverse events in U.S. hospitals, a pilot study. Int. J. Qual. Health C., 2007; 19:60-67

[18] Ngai, K.M., Grudzen, C.R., Lee, L., Tong, VY., Richardson, L.D., Fernandez, A. The Association Between Limited English Proficiency and Unplanned Emergency Department Revisit Within 72 Hours. *Annals of Emergency Medicine.* 2014.

access to coverage and care for people with disabilities and LEP and will undermine public understanding of the importance of nondiscriminatory access, a key component of the ACA.

VII. The proposed rule would allow discriminatory plan benefit design, despite demonstrated risks for Coloradans with disabilities: § 92.207 Nondiscrimination in health-related insurance and other health-related coverage

Although carriers must provide coverage to enrollees who have pre-existing conditions or disabilities, they have used plan benefit design to steer those enrollees to other plans. The prohibition in the final rule against discriminatory plan benefit design and discriminatory marketing helps prevent such actions. The danger of such actions is clear from our work assessing plans in Colorado.

In the first years after passage of the ACA, one Colorado carrier placed all HIV drugs, including generics, on the most costly tier. In 2019, advocates undertook a broader scan that encompassed more conditions and found that multiple carriers structured formularies in such a way that people with certain disabilities faced the enormous financial burden of having to spend several thousand dollars out of pocket in just the first few months of the year. Coloradans for whom we advocate have spoken persuasively about the impact of these costs, including rationing of necessary medications, high debt incurrence, and increased disability.

CCLP and other advocates have worked for several years with the Colorado Division of Insurance to address instances of discriminatory plan benefit design, specifically formulary design that puts a disproportionate financial burden on people with disabilities, including HIV, multiple sclerosis, and other conditions.[19] Our organization has also worked to address instances where discrimination has affected access to coverage and care. We been able to reach positive resolutions in part because the final rule provides clear, useful standards for state agencies. Rescinding those standards in rule, as proposed, would compound the difficulty of addressing similar instances of discrimination.

Significantly, the definition of essential health benefits in regulation includes the requirement that plan benefit design is nondiscriminatory, emphasizing that the content of a plan and how it is structured are inextricable. 45 CFR 156.110(d). We strongly oppose any effort to weaken or remove the prohibition on discriminatory plan benefit design.

Conclusion

We reiterate our opposition to the proposed rule, which is presented without sound legal or factual basis and would create unnecessary confusion and ambiguity, burden state regulators,

[19] Pray, B. T*he View from Colorado: Discrimination, High-Priced Drugs, and Tough Questions for State Regulators.* Health Affairs, Nov. 5, 2018. https://www.healthaffairs.org/do/10.1377/hblog20181101.598360/full/

impose greater financial burden on individuals seeking coverage and health care, and limit many Americans' ability to achieve better health.

Thank you for your close attention to these comments. Please contact Bethany Pray should you need further information.

Very truly yours,

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August 13, 2019

Department of Health and Human Services
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Washington, DC 20201

Re: Comments on HHS Proposed Rule on Nondiscrimination in Health and Health Education Programs or Activities (RIN 0945–AA11)

Dear OCR Director Roger Severino:

On behalf of the Massachusetts Medicaid and CHIP programs (MassHealth), I am writing to provide comments on the HHS Proposed Rule[1] on Nondiscrimination in Health and Health Education Programs or Activities, and its associated proposed conforming changes, as published in the Federal Register on June 14, 2019. 84 FR 27860 (the Proposed Rule). The Proposed Rule substantially revises HHS' regulations under Section 1557 of the Patient Protection and Affordable Care Act (ACA § 1557), codified at 45 CFR part 92 (the 1557 Regulations). MassHealth opposes the Proposed Rule and respectfully requests that it be withdrawn.

MassHealth provides comprehensive, affordable health insurance coverage to approximately 1.8 million residents of the Commonwealth, including 40% of all Massachusetts children and 60% of all residents with disabilities. MassHealth's mission is to improve the health outcomes of our diverse members, their families and communities by providing access to integrated health care services that sustainably promote health, well-being, independence and quality of life.

[1] https://www.govinfo.gov/content/pkg/FR-2019-06-14/pdf/2019-11512.pdf

MassHealth strongly opposes the Proposed Rule because it exposes vulnerable populations to potential discrimination, erodes access to language assistance for individuals with limited English proficiency (LEP), and limits the ability of individuals to seek assistance when they have experienced discrimination.

Such revisions are likely to result in both increased barriers to care for some of our most vulnerable members, and ultimately higher health care costs if such individuals are discouraged from seeking primary and preventive care services. Further, these changes are likely to create considerable confusion among state agencies, Medicaid managed care programs (as well as integrated care programs such as PACE), and other entities who have already taken substantial steps to ensure their programs comply with the current regulations.

Proposed Changes could Lead to Discrimination in Vulnerable Communities, including against the LGBTQ Community

HHS proposes to eliminate the definitions set forth at section 45 CFR 92.4, which include, among other important clarifying definitions, additional detail on what constitutes discrimination on the basis of sex. MassHealth is strongly opposed to the removal of these definitions. If finalized, HHS' proposed changes would eliminate the current regulation's prohibition of discrimination on the basis of gender identity and sex stereotyping, which will likely lead to increased barriers to care for members of LGBTQ communities.

LGBTQ individuals and others with diverse sexual orientations and gender identities experience significant health challenges and higher rates of illness when compared to other groups,[2] making access to equitable treatment and care for these populations especially important. For instance, LGBTQ individuals are at increased risk for adverse health outcomes, including[3] increased risk for suicide, HIV and other sexually transmitted diseases (STDs), and are less likely to seek care for behavioral health services, cancer, depression, and smoking. Higher rates of chronic diseases such as lifetime asthma, arthritis, and obesity are of major concern especially among lesbians and bisexual women.[4] Beyond adverse health outcomes for individuals, increased barriers to care for LGBTQ communities can also lead to negative public health outcomes including higher rates of HIV and STDs, and other serious consequences.[5]

At the same time, LGBTQ individuals can also face discrimination when trying to access needed care. For example, among transgender individuals who had visited a doctor or health care provider's office in the past year, 29% reported that a doctor or other health care provider refused to see them because of their gender identity.[6] Further, LGBTQ individuals also experience discrimination in accessing housing and are at increased risk for homelessness, which has also been shown to lead to poor health outcomes. These health disparities are often compounded for LGBTQ individuals of

[2] https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health?topicid=25
[3] www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3490559/pdf/AJPH.2011.300379.pdf
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3490559/pdf/AJPH.2011.300379.pdf
[6] https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/

color, and/or LGBTQ individuals living with disabilities.[7] The results from a study reported in the *American Journal of Public Health* suggest that disparities in chronic health conditions, health risk behaviors, and poor physical and mental health among LGBTQ adults may contribute to the heightened prevalence of disability. Higher mental distress prevalence among all of the groups and higher poor physical health among gay men and bisexual women and men are also significant indicators of disability.[8]

The proposed changes to this rule would allow providers and plans to discriminate against individuals on the basis of sex, including gender identity and sexual orientation, by denying or limiting health care coverage for LGBTQ individuals, and/or requiring higher cost sharing amounts for their care. Such actions could range from excluding coverage or denying care for medically necessary, gender-affirming care to transgender individuals, to refusing to serve LGBTQ individuals altogether, even for routine preventive care such as primary care visits or flu shots.

Adverse health outcomes for this population are also likely to lead to higher costs for MassHealth, other state Medicaid programs and Medicare, particularly if groups of members facing discrimination are unable to access, or are discouraged from accessing, primary or preventive health services, and must ultimately resort to more expensive urgent or emergency care.

The Proposed Rule's Religious and Abortion Exemptions for Providers Could Harm Public Health

The Proposed Rule would allow health care providers and other covered entities to invoke blanket abortion and religious objection exemptions from the regulation's general prohibition on sex discrimination. These exemptions could allow providers to create barriers for individuals, particularly women who may be stigmatized for their medical history, seeking medically necessary care, potentially jeopardizing their health. The Proposed Rule could result in situations where members seeking health care services (including abortion or other health care services) are denied, delayed, or discouraged from seeking necessary care, placing them at risk of serious or life-threatening results in emergencies and other circumstances, especially when the individual's choice of health care provider is limited. For example, the Proposed Rule allows health care staff and providers to refuse women reproductive care, such as an emergency abortion to protect the life or health of the mother. Furthermore, an individual's choice of health care provider may be limited, especially in rural areas, to hospitals or other provider sites that are run by religious institutions.

In the event that HHS elects to finalize those exemptions, it should adopt additional safeguards to protect members seeking necessary services. Specifically, MassHealth urges HHS to require covered providers declining to provide services because of religious or moral objections to inform the patient about alternative means for accessing health care services which they are entitled to receive under federal Medicaid law.

[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3490559/pdf/AJPH.2011.300379.pdf
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3490559/

Access to Language Assistance Improves Health and Lowers Costs

The 1557 Regulations required covered entities to provide language assistance services, multi-language "taglines," and nondiscrimination notices to ensure meaningful access for *each* limited English proficiency (LEP) individual. The Proposed Rule requires "reasonable steps to provide meaningful access" to LEP individuals, in general and not to each specific individual, as required by the current rule. The Proposed Rule would relax the current requirement to provide meaningful access to each individual by adopting a four-part balancing test which would allow covered entities to potentially deny language assistance services to an LEP member who needs them when a covered entity decides the costs of doing so outweigh the benefits. MassHealth recommends that HHS should continue to require providers and plans to provide meaningful access to such interpretation and translation services for each LEP individual.

Additionally, HHS' Proposed Rule would also repeal the current rule's requirement that covered entities develop, post, and/or provide prescribed notices and taglines. Because such notices and taglines facilitate communication for LEP individuals within the health care system, MassHealth recommends that HHS should also continue to require their use.

Relaxing the current standards could limit access to necessary care, jeopardize patient safety and incur higher costs. LEP patients who do not receive professional interpretation at admission and discharge have longer lengths of stay and higher readmission rates compared to patients who receive professional interpretation services. [9] Studies show that LEP patients experience high rates of medical errors with worse clinical outcomes than English-proficient patients and receive lower quality of care by other metrics.[10] Patient safety can be impacted by poor patient comprehension of their medical condition, treatment plan, discharge instructions, complications, and follow-up; inaccurate and incomplete medical history; ineffective or improper use of medications or serious medication errors; improper preparation for tests and procedures; and poor or inadequate informed consent.

In fact, research has shown this issue extends beyond the patient's ability to communicate with their doctors. In a recent survey of 15,800 physicians about the topic of bias, 32% of physicians (both male and female) admitted they held specific bias towards patients for whom there was a language difference.[11] Despite evidence and professional standards that call for interpreter services, health care providers often try to "get by" with their own limited language skills or with ad hoc interpreters such as accompanying family members. Easing access to language services has been shown to improve patient care.[12]

While there may be potential cost savings to Medicaid agencies associated with changes to translated member communications as a result of the relaxed requirements in the Proposed Rule, HHS should balance these potential savings against the potentially increased costs incurred when members are unable to communicate with, or understand information provided by, their providers,

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3445680/
[10] AMA J Ethics. 2017;19(3):263-271. doi: 10.1001/journalofethics.2017.19.3.medu1-1703.
[11] https://connectwithpartners.org/2016/09/07/tackling-lep-issues-at-mgh
[12] https://www.ncbi.nlm.nih.gov/books/NBK43719/

health plans, or insurers. This is especially true if individuals are unable to access primary/preventive care services and ultimately require urgent or emergency care.

Grievance Process Helps Vulnerable Members

The 1557 Regulations required larger covered entities, including state Medicaid agencies, to develop a grievance procedure and designate a compliance coordinator to investigate grievances alleging violation of the 1557 Regulations. The Proposed Rule would eliminate these requirements.

MassHealth urges HHS to retain the requirements that larger covered entities (1) designate a responsible employee to coordinate efforts to comply with the 1557 Regulations and (2) adopt grievance procedures that guide the resolution of such grievances. Investigations conducted by Section 1557 Compliance Coordinators may prompt corrective measures for individuals who experience discrimination within entities such as hospitals, managed care plans and doctors' offices, including dual eligible members (who are especially vulnerable by virtue of being low income, elderly and/or disabled).

HHS Request for Comments: Access and Accommodation Standards for Persons with Disabilities

HHS seeks comment on whether to maintain current access standards for persons with disabilities, although the agency has not proposed changes to those standards at this time. MassHealth strongly urges HHS to maintain existing standards to ensure access to care and reasonable accommodations for persons with disabilities. A significant portion of MassHealth members have disabilities, and the existing access and accommodations requirements are critical to ensuring that these members are able to apply for and maintain MassHealth coverage to properly access the benefits and services they need to maintain health and independence. This includes the provision of auxiliary aids and services to ensure effective communication, requiring compliance with ADA construction and architectural standards, and providing reasonable modification in policies, practices and procedures to prevent discrimination. Further, Massachusetts has worked closely with CMS, its members, and other stakeholders on the State Demonstration to Integrate Care for Dual Eligible Individuals (known as One Care), which is explicitly designed to improve care and reduce costs for dual eligible individuals ages 21 to 64 who are living with disabilities. As with the other proposed changes to this rule, removing these protections for individuals with disabilities could lead to increased barriers to care and reduced access to benefits and services, resulting in poorer health outcomes and increased costs for dual eligible populations. These impacts could jeopardize the potential of innovative initiatives, like One Care, which are expressly designed to improve the lives and health care experiences of these communities but which depend on the ability of members to access critical benefits and services to be successful.

Conclusion

The proposed revisions to the 1557 Regulations would negatively impact the lives of the diverse communities that make up the Commonwealth and would perpetuate inequality among some of MassHealth's most vulnerable groups of members. The proposed revisions are also in direct conflict with MassHealth's goals promoting health equity and reducing health disparities.

For these reasons, and the reasons detailed above, MassHealth respectfully requests that HHS withdraw the Proposed Rule and revert to the 1557 Regulations. Massachusetts appreciates the opportunity to comment on this Proposed Rule and looks forward to continuing to work with the Administration to strengthen and improve the Medicaid program and public health. Thank you for consideration of these comments.

Sincerely,

Daniel Tsai
Assistant Secretary for MassHealth and Medicaid Director

cc: Marylou Sudders, Secretary, Executive Office of Health and Human Services

CONNECT for HEALTH COLORADO®
4600 South Ulster Street | Suite 300
Denver, CO 80237

August 13, 2019

BY ELECTRONIC DELIVERY

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Section 1557 NPRM
RIN 0945 – AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, D.C. 20201

Re: Nondiscrimination in Health and Health Education Programs or Activities

Dear Director Severino:

The staff of Connect for Health Colorado, the state-based health insurance marketplace (SBM) for Colorado, greatly appreciates the opportunity provided by the Office for Civil Rights (OCR) to comment on the proposed "Nondiscrimination in Health and Health Education Programs or Activities." As the mission of Connect for Health Colorado is to improve access, affordability, and choice for all Coloradans, we are committed to nondiscrimination in our work and in equal access to care for vulnerable populations.

Regarding the proposed removal of notice and tagline requirements, Connect for Health Colorado appreciates OCR's interest in reducing notice length and improving careful reading and complete understanding of notices by the public. We are concerned about the environmental impact of lengthy notices, and about consumer confusion with overly complex information. As a result, we have been involved in myriad efforts on improving readability and concision in our notices.

While we feel that efforts to shorten and improve notices are laudable, we are concerned that this proposed rule's approach is unsupported by the evidence in Colorado and results in regulatory uncertainty.

The OCR proposal cites information on the percentages of applicants who are proficient in English and shows that the majority of those requesting language

assistance sought Spanish language support. The aim of these regulations is to provide meaningful access for individuals from all national origins. As such, we would caution against the use of these percentages to disadvantage non- English or Spanish speaking applicants or enrollees.

Connect for Health Colorado has experienced an increase in use of language line services over time in a wide range of languages. We routinely utilize a language line to communicate with customers in Vietnamese, Karen, Mandarin, Tigrinya, Amharic, Cantonese, Korean, Arabic, Mongolian, French, Sorani, Nepali, Burmese, Albanian, Tamil, Somali, Russian, Thai, Bosnian, and Spanish, (among others) and have done so since our inception. Language line services provide Coloradans from diverse backgrounds with access to information about their coverage, and the ability to ask questions and improve health literacy. Without tagline requirements, these communities may not know that translation services are available, and may under-utilize programs that they are eligible for, resulting in increased health disparity and higher costs in accessing emergency care. We are concerned about regulatory changes that would limit or undermine access for these communities and are committed to nondiscrimination in our provision of support to all Coloradans.

We are also concerned by the regulatory uncertainty that this proposed rule would cause if finalized. Existing tagline and notice requirements provide a clear structure for how to comply. In their absence, regulated entities would have to apply a multi-factor test to their efforts, and in many cases would default to the same taglines and notice language being provided in their current form, but now would contend with uncertainty as to whether or not their approach continues to meet requirements. Moreover, the removal of necessary definitions further hinders the ability of regulated entities to understand the confines of the law. This increased uncertainty and confusion ultimately results in increased time and funds spent on regulatory compliance.

In the interest of continuing to improve access, affordability, and choice for all Coloradans, Connect for Health Colorado opposes these proposed changes and respectfully requests that OCR reconsider them. We support regulatory changes that provide consumers with clear and concise information, and that provide solutions on how to convey complex information. However, we are concerned that these proposed changes would limit or undermine access for Coloradans of all walks of life.

Sincerely,

Connect for Health Colorado Staff