Congress of the United States
House of Representatives
Washington, D.C. 20515

August 15, 2019

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health & Human Services
200 Independence Ave, SW
Washington, DC 20201

Dear Secretary Azar:

As Chairs of House Committees with legislative and oversight jurisdiction over the Patient Protection and Affordable Care Act (ACA), we write in strong opposition to the proposed rule *Nondiscrimination in Health and Health Education Programs or Activities*, which would roll back numerous civil rights protections under Section 1557 of the ACA.[1] This harmful proposal is a continuation of the destructive effort by the U.S. Department of Health and Human Services (HHS or Department) and the Trump Administration to undermine key provisions of federal law and weaken access to health care. We urge the Department to immediately withdraw this proposed rule.

Section 1557 of the ACA extended fundamental civil rights protections to patients in a range of health care settings

Section 1557 of the ACA strengthens patient protections against discrimination by ensuring that several core civil rights laws apply in health care settings. This historic reform ensures that all health programs and activities that receive federal financial assistance, federally-administered programs or activities, and all entities established under Title I of the ACA, may not engage in discriminatory activities. It specifically incorporates the full range of protections and enforcement mechanisms of Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973 to ensure that patients have full access to care without being excluded, denied benefits, or subject to discrimination on the basis of race, color, national origin, sex, age, or disability.[2]

Section 1557 took effect immediately upon the enactment of the ACA on March 23, 2010, and on May 18, 2016, the Department finalized implementing regulations. This final rule was strongly protective of patients and ensured the broad applicability of Section 1557 in the health care sector, while providing important clarifications regarding the law's scope and

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[1] Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846 (June 14, 2019).
[2] 42 U.S.C. § 18116(a)(1).

enforcement that have helped to facilitate compliance with its essential provisions.[3]

The proposed rule would narrow the scope and application of Section 1557, severely restricting the number of patients protected from discrimination under the law

The Department's proposal would narrow the application of Section 1557 by exempting a number of federally-administered programs and publicly-subsidized private entities intended by Congress to be covered under the law. The plain language of the ACA makes clear the broad applicability of the health care nondiscrimination protections, providing that the law applies to: "[1] any health program or activity, any part of which is receiving Federal financial assistance … [2] any program or activity that is administered by an executive agency… or [3] any entity established under [Title I of the ACA]."[4] The 2016 final rule interpreted this requirement in a manner more consistent with Congressional intent by ensuring that a broad range of federal programs and private entities that receive federal funding are covered by the law.

We are deeply troubled that HHS proposes to reverse its previous interpretation of the statute by limiting Section 1557's protections in a number of harmful ways. With respect to programs administered by the federal government, the proposed rule would provide that nondiscrimination protections apply only to those federal health programs that are established by Title I of the ACA, omitting a large number of important programs administered by HHS. This approach is inconsistent with the law's clearly stated requirement that "any program or activity that is administered by an executive agency" be subject to the nondiscrimination requirements.[5] The proposed rule also carves out large portions of the activities of health insurance companies, including many employer-sponsored plans, which under current rule are appropriately treated as health care programs and activities if any part of the company's business receives financial assistance from the federal government. These changes are inconsistent with Congressional intent, and collectively would have the impact of greatly reducing the number of covered entities under Section 1557, leaving many patients without fundamental civil rights protections in health care settings.

The proposed rule would sanction discrimination against LGBTQ people and jeopardize access to health care

The Department also proposes to roll back important civil rights protections in a manner that would undermine access to care for the LGBTQ community. The proposed rule could embolden health care providers to inappropriately deny care to patients because of their gender identity. Transgender people face many harmful barriers to care, with as many as 23 percent of transgender patients reporting they do not seek needed care as a result of mistreatment by providers because of their gender identity.[6] The proposal would also open the door for health insurance companies to categorically exclude coverage of medically necessary, gender-affirming

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[3] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31375 (May 18, 2016).
[4] *Supra* note 2.
[5] *Id.*
[6] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Center for American Progress (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care.

care to transgender patients, or to engage in discriminatory plan design that would make such care unaffordable. To justify this harmful change, HHS relies on a misguided federalism argument, calling for a limited federal role in enforcing civil rights protections. This argument fails to acknowledge the long history of discrimination by state and local governments throughout American history and is directly contradicted by more than a half century of legal precedent that establishes the crucial role of the federal government in enforcing civil rights laws.[7]

Furthermore, by eliminating the definition of discrimination on the basis of sex from the current rule, the proposal would weaken protections for LGBTQ people who are discriminated against as a result of sex stereotyping. In the 2016 final rule, the Department properly determined that discrimination on the basis of gender identity and discrimination based on stereotypical notions about gender constitute sex discrimination. This is a proper interpretation of Congressional intent in enacting the ACA and is consistent with case law dating back several decades holding that discrimination relating to an individual's sexual orientation or gender identity is discrimination on the basis of sex stereotyping.[8] However, with virtually no policy or legal justification for its decision, the Department now proposes to reverse this interpretation, placing potentially millions of LGBTQ people at risk of discrimination. In doing so, HHS is taking precisely the wrong approach from both a moral and legal standpoint, as case law supports an expansion – rather than a narrowing – of protections against discrimination based on sex stereotyping.[9]

The Department also proposes to eviscerate other protections for the LGBTQ community through a number of deeply harmful "conforming" amendments to ten regulations not directly related to Section 1557. These include removal of "sexual orientation" and "gender identity" from rules relating to: health insurance broker and agent marketing and enrollment assistance,[10] marketing and benefit design practices of health insurance issuers,[11] administration of Qualified Health Plans and direct enrollment of applicants,[12] nondiscrimination in Medicaid enrollment,[13] and nondiscrimination in Programs for All-inclusive Care of the Elderly (PACE) for frail Medicare beneficiaries.[14] These regulations were adopted under other statutory authorities separate from Section 1557. These are significant changes, yet the agency has offered little to justify their inclusion in this rulemaking and appears to have declined to perform a cost-benefit analysis as required under Executive Order 12866.[15]

The proposed rule would put in place discriminatory barriers that will make it harder for individuals with limited English proficiency to access health care

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[7] *See, e.g.*, Katzenbach v. McClung, 379 U.S. 294 (1964); Heart of Atlanta Motel, Inc. v. United States, 379 U.S. 241 (1964).
[8] *See, e.g.*, Price Waterhouse v. Hopskins, 490 U.S. 228 (1989); Smith v. City of Salem, Ohio, 378 F.3d. 566 (6th Cir. 2004).
[9] *See, e.g.*, Hively v. Ivy Tech Community College of Indiana, 853 F.3d 339 (7th Cir. 2017).
[10] 42 CFR §§ 155.120(c)(1)(ii) and 155.220(j)(2).
[11] 45 CFR § 147.104(e).
[12] 45 CFR §§ 156.200(e) and 156.1230(b)(3).
[13] 42 CFR §§ 438.3(d)(4), 438.206(c)(2), and 440.262.
[14] 42 CFR §§ 460.98(b)(3) and 460.112(a).
[15] William J. Clinton, Executive Order No. 12866, *Regulatory Planning and Review*, 58 Fed. Reg. 51735 (Oct. 4, 1993).

The Department's proposal would also jeopardize the health care of millions of patients whose primary language is not English or those with limited English proficiency (LEP). Although the proposed rule maintains the 2016 final rule's requirement that covered entities take "reasonable steps" to ensure access to care for LEP individuals, it substantially weakens the standard for compliance with this requirement. Specifically, the proposal no longer requires that a covered entity provide reasonable access to "each individual with LEP" but instead relies on a weaker requirement that "LEP individuals" as a general category be granted reasonable access. This vaguer wording may result in covered entities failing to meet the needs of many LEP patients through generalized, rather than particularized, steps to ensure reasonable access. Moreover, the Department proposes to further weaken these protections by abandoning the stronger test in effect under the current regulation to assess compliance by weighing the nature and importance of the health program and the communication, as well as other factors, and putting in place a weaker four-factor balancing test that is less protective of the rights of LEP patients. This would eliminate any consideration of whether the covered entity has in place a language access plan.

In addition, the proposed rule would eliminate the existing regulation's notice and tagline requirements, which require covered entities to notify patients of important information such as prohibitions on discrimination, the availability of language assistance, and the procedures for filing a complaint with the Office for Civil Rights. To facilitate access to this information by LEP individuals, these notices must provide taglines in the 15 languages other than English that are most commonly spoken in the covered entity's state. Disturbingly, HHS would entirely undo this protection, making it substantially more difficult for LEP individuals to receive health care and exercise their rights under the law. In justifying this harmful change, HHS brushes aside serious concerns that patients will lose access to care and instead points to a deeply flawed impact analysis that greatly exaggerates the perceived cost to covered entities of compliance. Together, these changes will allow covered entities to discriminate against LEP individuals, contrary to the intent of Section 1557.

The proposed rule would embolden providers to deny women access to health care

The Department also proposes several changes to current regulations that would have a direct negative impact on women's access to health care. By eliminating the clear definition of discrimination on the basis of sex in the 2016 final rule, which properly clarified that pregnancy, false pregnancy, and termination of pregnancy may not be used as ground for discrimination, HHS would embolden providers who wish to discriminate against women who seek medically necessary health care, including reproductive health care. Additionally, the Department proposes to impermissibly incorporate the Danforth Amendment from the Title IX law, contrary to the plain language of Section 1557, as yet another attack on abortion access. These changes are particularly harmful in light of the many other actions of the Trump Administration that weaken access to reproductive health care, including the rollback of contraceptive coverage

requirements,[16] attacks on the Title X family planning program,[17] and the recently finalized refusal of care rule.[18]

The proposal would also inappropriately incorporate religious exemptions from Title IX that could embolden health providers to ignore the prohibition on sex discrimination should the care be inconsistent with the religious beliefs of the organizations. Congress chose not to incorporate these exemptions into Section 1557, instead providing for only those exemptions stated in Title I of the ACA. As we have seen in numerous other contexts, overbroad religious exemptions too often serve as nothing more than an excuse to discriminate. The Department's proposal to incorporate Title IX religious exemptions would similarly open the door for providers who wish to deny women access to care under the guise of religious freedom. This could jeopardize access to care in rural and underserved communities in which women have no option other than a religiously-affiliated provider.

The proposed rule would sanction increased discrimination against people with disabilities

Several aspects of the proposed rule would have direct negative consequences on people with disabilities and chronic conditions. As discussed previously, deletion of key definitions provided in current regulations, limiting the scope of Section 1557's application to fewer covered entities, and weakening of crucial enforcement mechanisms would have broad implications for patients. The proposal would also eliminate current regulations that explicitly prohibit a number of discriminatory practices by health insurers in coverage, issuance of policies, benefit design and marketing, and other activities. We are deeply concerned that these and other changes could embolden discrimination against people with disabilities and chronic health conditions.

Shockingly, HHS also solicits feedback on additional changes that could directly target protections for individuals with disabilities. These include requirements that entities provide auxiliary aids and services to improve communication with people with disabilities, and architectural standards that ensure multistory structures provide elevators. However, the Department has provided little detail as to what policies are under consideration, nor has a rationale been provided for such changes. Should the Department finalize substantial modifications to existing regulations in this manner, its process will have failed to have been subject to public notice and comment as required under the Administrative Procedure Act.

The proposed rule would weaken enforcement and compliance under Section 1557

Finally, the proposed rule would weaken enforcement and compliance provisions established under the 2016 final rule. Specifically, through changes to §92.301 (newly designated §92.5) the Department proposes to roll back the enforcement of Section 1557 and

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[16] Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57536 (Nov. 15, 2018); Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57592 (Nov. 15, 2018).
[17] Compliance with Statutory Program Integrity Requirements, 84 Fed. Reg. 7714 (Mar. 4, 2019).
[18] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23170 (May 21, 2018).

restrict the remedies available to those subject to discrimination. This restriction is contrary to the clear language of the law, which provides that "enforcement mechanisms provided for and available under" civil rights laws are available to patients. Moreover, although courts have held that patients may bring claims for violations of Section 1557 based on the statutory text alone,[19] HHS's proposal would create additional confusion for patients by eliminating references to a private right of action in the regulations. Undermining the enforcement of civil rights laws in this manner would have a disproportionate impact on communities of color, who have seen important coverage gains thanks to the ACA but continue to face health disparities and discrimination in health care settings.[20]

Other harmful changes proposed by the Department would likely reduce compliance with the law, including eliminating the requirement that all covered entities with 15 or more employees designate a compliance coordinator and maintain a grievance procedure to address alleged discriminatory actions. In proposing this policy, HHS overemphasizes the costs to covered entities while ignoring the impact on individuals who have been subject to discrimination. This would place an unnecessary barrier to justice for patients who have been subject to discrimination in health care settings.

We are committed to ensuring the administration fully implements the requirements of this landmark law. Unfortunately, by rolling back the provisions of Section 1557 and opening the door to discrimination against patients in health care settings, the proposed rule is a harmful step in the wrong direction. We urge HHS to immediately withdraw this proposal in its entirety and join our efforts to strengthen – rather than weaken – access to health care and fundamental civil rights protections.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman
Committee on Education and Labor

FRANK PALLONE JR.
Chairman
Committee on Energy and Commerce

RICHARD E. NEAL
Chairman
Committee on Ways and Means

[19] *See, e.g.*, Rumble v. Fairview Health Services, No. 14-cv-2037 (D. Minn. Mar. 16, 2015).
[20] *See* Samantha Artiga, Kendal Orgera, and Anthony Damico, *Changes in Health Coverage by Race and Ethnicity since Implementation of the ACA, 2013-2017*, Kaiser Family Foundation (Feb. 13, 2019) https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-implementation-of-the-aca-2013-2017/.