

August 13, 2019

The Honorable Alex M. Azar, II
Secretary
U.S. Department of Health and Human Services
Herbert H. Humphrey Building, Room 509F
200 Independence Avenue, SW
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:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express our opposition to the Notice of Proposed Rulemaking (NPRM) entitled, “Nondiscrimination in Health and Health Education Programs or Activities,” published by the Office for Civil Rights (OCR) and the Centers for Medicare and Medicaid Services (CMS). Section 1557 of the Affordable Care Act (ACA) was intended to help protect people who experience significant barriers to accessing health care, including lesbian, gay, bisexual, transgender, and queer (LGBTQ) people, minorities, individuals whose primary language is not English, and those in need of reproductive health care and help provide those populations equal access to health care and health coverage. **This proposal, however, is contrary to the intent and the plain language of the law.** It will negatively affect patients by drastically limiting the scope of health plans to which the non-discrimination provisions apply, thereby eliminating coverage protections for certain individuals, such as transgender people, women, LGBTQ people, and individuals living with HIV. The NPRM also eliminates anti-discrimination protections based on gender identity and sex stereotypes, despite decades of case law recognizing such protections, including in the context of section 1557.

The NPRM comes on the heels of the Department of Health and Human Services’ (HHS) final regulations on more than 20 federal statutory provisions related to the ability of individuals and health care institutions to refuse to provide services to which they have religious or moral objections, as well as significant revisions by HHS to the Title X program, both of which empower individuals and institutions to refuse to provide or participate in medical treatment, services, information, and referrals. Meanwhile, **this proposal marks the rare occasion in which a federal agency seeks to remove civil rights protections.** It legitimizes unequal treatment of patients by not only providers, health care organizations, and insurers, but also by the government itself—and it will harm patients. HHS states that the NPRM is necessary to “address legal concerns” raised by the *Franciscan Alliance v. Burwell* litigation and simplify regulatory confusion, but it in fact creates confusion and enables discrimination. It deems certain classes of people less worthy of care, compassion, access, and good health than others. Such policy should not be permitted by the U.S. government, let alone proposed by it.

Respect for the diversity of patients is a fundamental value of the medical profession. There is no basis for the denial to any human being of equal rights or privileges because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin, or age. **Based on longstanding policy, the AMA strongly opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such policies.** AMA policy also supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

The AMA believes in the critical importance of ensuring health equity—optimal health for all—recognizing the importance and urgency of ensuring that all people and communities reach their full health potential. Unfortunately, at the provider and institutional levels, there is a growing body of evidence demonstrating that implicit and explicit biases negatively impact the quality of health care equity and patient safety and drive these inequities. Indeed, “racism is considered a fundamental cause of adverse health outcomes for racial/ethnic minorities and racial/ethnic inequities in health.”¹ Additionally, there is evidence that experiences of discrimination and racism have a “weathering”² physiological effect on the body (e.g., irregular heartbeat, anxiety, heartburn), which over time can be compounded and lead to long-term negative health outcomes.³ The Joint Center for Political and Economic Studies estimates that health inequalities and premature deaths cost the U.S. economy \$309.3 billion a year;⁴ the proposed elimination of most of the anti-discrimination protections in the 2016 implementing regulations (Current Rule) will likely increase this figure.

As advocates for our patients, we strongly support patients' access to comprehensive health care services. Physicians are expected to provide care in emergencies, respect basic civil liberties, and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient. We expect the same for the rest of the health care system and for the federal government's health care activities and programs. **In sum, the AMA strongly opposes the proposed elimination or rollback of critical protections guaranteed by section 1557 of the ACA and the Current Rule and, accordingly, we urge HHS to withdraw this proposal.**

Scope of Application

Section 1557 of the ACA prohibits discrimination by “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 [Title I of the ACA].”⁵ Accordingly, under the Current Rule, an insurer that offers a plan in the ACA Marketplace must ensure that all of its plans—not only those offered in the Marketplace—comply with section 1557. However, the proposed rule improperly attempts to narrow the application of section 1557's protections

¹ David R. Williams et al., *Racism and Health: Evidence and Needed Research*, Annu. Rev. Public Health (Jan. 2, 2019), available at <https://www.annualreviews.org/doi/pdf/10.1146/annurev-publhealth-040218-043750>.

² Arline T. Geronimus, ScD, et al., “Weathering” and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States, *Am J Public Health* (May 2006), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470581/>.

³ Healthy People 2020, citing Pascoe EA, Smart RL, *Perceived discrimination and health: a meta-analytic review*, *Psychol Bull.* 2009;135(4):531–54, available at <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/discrimination#5>.

⁴ Thomas A. LaVeist, et al., *The Economic Burden Of Health Inequalities in the United States*, Joint Ctr. for Pol. and Econ. Stud., available at <https://jointcenter.org/sites/default/files/Economic%20Burden%20of%20Health%20Inequalities%20Fact%20Sheet.pdf>.

⁵ 42 U.S.C. § 18116(a).

to only the portion of a health care program or activity that receives federal financial assistance. As such, insurers offering plans in the Marketplace will only need to ensure that Marketplace plans comply with section 1557—not all of their plans. **The statute is clear that it applies to health programs or activities, any part of which receives federal financial assistance.** If Congress had intended that only the product receiving such assistance was bound by the nondiscrimination provisions, it could have easily stated as much in very simple terms.

Additionally, the NPRM restricts the scope of application to health plans that are “principally engaged in the business of providing health care” as opposed to those primarily engaged in providing health insurance. As stated in the preamble, these criteria would thus exclude short term limited duration insurance (STLDI) plans from needing to comply with section 1557 as such plans are neither (1) principally engaged in the business of health care, nor (2) receiving federal financial assistance with respect to STLDI plans specifically. Notably, such plans are widely-regarded as discriminatory on the basis of sex, age, and disability. For example, a 2018 study found that no short term plans covered maternity care.⁶ Other data demonstrates that short term health plans charge women higher premiums than men.⁷ Free of a requirement to comply with non-discrimination laws, STLDI plans will be emboldened to deny coverage for any number of conditions and services, including those that affect only women (e.g., uterine cancer or abortion) or transgender populations (e.g., gender dysphoria or transition-related services).

HHS also appears to be narrowing the scope of the regulations to only HHS-administered health programs and activities that fall under Title I of the ACA. This is a drastic and improper shift that will have a wide-ranging impact, as health programs and activities such as those administered by the Health Resource Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), Substance Abuse and Mental Health Services Administration (SAMHSA), CMS, and the Indian Health Service (IHS) would no longer be covered by section 1557. We are unsure why HHS is proposing this change as section 1557’s statutory text clearly states that it applies to “any program or activity that is administered by an Executive Agency.”

Each of these proposals are contrary to what section 1557’s statutory text states and are a clear attempt to reduce the number of health insurance plans, health programs, and health activities covered by the regulations. This policy is not only illogical and confusing, but also creates a standard that discrimination is acceptable for some beneficiaries but not others. **HHS should not finalize the proposed change in scope and should instead retain the Current Rule’s application of section 1557, which accurately reflects the language and intent of the underlying statute.**⁸

Protections on the Basis of Sex

The NPRM eliminates the regulatory definition of sex-based discrimination. If finalized, this will impact protections not only for LGBTQ individuals, but also for women who are pregnant, have miscarried, who have had complications with childbirth, or who have terminated a pregnancy. Loss of protections for these classes of individuals will lead to barriers to care, lack of health insurance coverage, and higher

⁶ Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Foundation (Apr. 23, 2018), available at <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.

⁷ Sarah Lueck, *Key Flaws of Short-Term Health Plans Pose Risks to Consumers*, Ctr. on Budget & Pol’y Priorities (Sept. 20, 2018), available at <https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers>.

⁸ 45 CFR §92.2(a).

costs (either in premiums or cost-sharing rates) for those services that are covered. It also simply chips away at people's dignity.

The AMA strongly believes that discrimination on the basis of sex includes discrimination on the basis of gender identity and sexual orientation. The courts and federal agencies agree. Since 2012, OCR has interpreted section 1557 of the ACA's sex discrimination prohibition to extend to claims of discrimination based on gender identity or sex stereotypes and accepted such complaints for investigation. Numerous federal agencies, including the U.S. Department of Justice, U.S. Department of Labor, U.S. Department of Education, and the U.S. Department of Housing and Urban Development, have previously interpreted sex discrimination to include discrimination on the basis of gender identity. The NPRM disregards these interpretations—reversing OCR's own long-standing policy—and disregards the Supreme Court's holding in *Price Waterhouse v. Hopkins* (1989), which states that discrimination based on stereotypical notions of appropriate behavior, appearance, or mannerisms for each gender constitutes sex discrimination.⁹ Lower courts, including in the context of section 1557, have also recognized that sex discrimination includes discrimination based on gender identity.¹⁰

Section 1557's protections against sex discrimination are necessary. Transgender, nonbinary, and gender nonconforming people already experience high rates of discrimination and harassment in health care. According to the 2015 U.S. Transgender Survey, 33 percent had at least one negative experience in a health care setting relating to their gender identity in the past year, and 23 percent did not seek health care when they needed it due to fear of being disrespected or mistreated as a transgender person.¹¹ These rates tend to be higher for non-white respondents and individuals with disabilities.¹² Following an early 2017 Freedom of Information Act (FOIA) request to HHS for complaints of discrimination under section 1557, the Center for American Progress (CAP) found that the most common complaints involved individuals being denied care or insurance coverage because of their gender identity or transgender status.¹³ Examples include a transgender woman being denied a mammogram, a transgender man being refused a screening for a urinary tract infection, an insurer not covering reproductive health care because of an individual's gender identity, and an insurer not covering genetic testing for breast cancer for a transgender man despite the testing being recommended by the complainant's physician.¹⁴ CAP notes that existing enforcement of section 1557 is "working well to resolve very real issues of discrimination, and that the fears raised by the *Franciscan Alliance [v. Burwell]* lawsuit are not well-founded."¹⁵ Incidentally,

⁹ 490 U.S. 228 (1989).

¹⁰ See, e.g., *Rumble v. Fairview Heath Servs.*, Civ. No. 14-cv-2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (Section 1557) (order denying motion to dismiss); *Barnes v. City of Cincinnati*, 401 F.3d 729, 737 (6th Cir.), cert. denied, 546 U.S. 1003 (2005) (Title VII); *Smith v. City of Salem, Ohio*, 378 F.3d 566, 575 (6th Cir. 2004) (Title VII); *Schroer v. Billington*, 577 F.Supp.2d 293, 304 (D.D.C. 2008) (Title VII).

¹¹ S.E. James, et al., Nat'l Ctr. for Transgender Equality, *Report Of The 2015 U.S. Transgender Survey* (2016), available at <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>.

¹² S.E. James, et al., Nat'l Ctr. for Transgender Equality, *Report Of The 2015 U.S. Transgender Survey* (2016), available at <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>.

¹³ Sharita Gruberg and Frank J. Bewkes, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial*, Center for American Progress (March 7, 2018), available at <https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/>.

¹⁴ Sharita Gruberg and Frank J. Bewkes, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial*, Center for American Progress (March 7, 2018), available at <https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/>.

¹⁵ Sharita Gruberg and Frank J. Bewkes, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial*, Center for American Progress (March 7, 2018), available at <https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/>.

none of the complaints involved HHS ordering a health care professional to perform a service against his or her medical judgement.

Additionally, the AMA does not condone discrimination based on whether a woman has had an abortion. While the NPRM notes that Title IX prohibits discrimination based on pregnancy, including termination of pregnancy, it fails to clarify whether HHS will enforce those protections. HHS should clearly state, for example, that it is illegal for a pharmacist to refuse medication for someone who is miscarrying, or for an insurer to refuse coverage to a woman who has had an abortion. **Given HHS' recent regulations finalizing the ability of individuals and health care institutions to refuse to provide services to which they morally object, as well as the significant revisions to the Title X program, protections against discrimination on the basis of pregnancy (including termination thereof) are critical.** We anticipate that many women will experience barriers when they seek reproductive health services or attempt to obtain insurance coverage for reproductive health care.

Furthermore, the NPRM attempts to incorporate Title IX's religious exemption, which could permit health care entities controlled by a religious organization to discriminate if the entity claims that compliance with sex discrimination protections would conflict with its religious beliefs. If finalized, this could impact a broad range of health care services, including access to birth control, sterilization, certain fertility treatments, abortion, gender-affirming care, and end of life care. For example, religiously-affiliated pharmacies could refuse to prescribe contraception to someone because they are not married or refuse to provide infertility treatment to a same-sex or transgender couple.

Finally, HHS is proposing to eliminate prohibitions on discrimination based on gender identity and sexual orientation in 10 regulations outside of section 1557, including those concerning qualified health plan issuers, agents, and brokers that assist with Marketplace applications and enrollment; marketing or benefit design practices of health insurance issuers under the ACA; organizations operating Programs for All-inclusive Care of the Elderly (PACE) programs and participants receiving PACE services under Medicare; Medicaid beneficiary enrollment; and promotion and delivery of access and services. The regulations for these programs are not connected to section 1557 and many have been in effect for years; changing them now would not only create significant confusion, but also have wide-ranging consequences for millions of individuals. Furthermore, this NPRM is not the appropriate mechanism to revise such regulations. HHS should not finalize this proposal.

Language Access

The AMA supports access to quality care for all individuals and encourages physicians to make their offices accessible to patients with disabilities and limited English proficiency (LEP). Moreover, the AMA strongly believes that clear, direct communication and understanding is the bedrock of the patient-physician relationship and is very important in ensuring the provision of quality medical care to all patients. However, we believe that the financial burden of medical interpretive services and translation should not fall entirely on physician practices. Rather, as with interpreters or other auxiliary aids or services for individuals with hearing impairments, language interpretive services should be a covered benefit for all health plans, which are in a much better position to pass on the costs of these federally mandated services as a business expense.

Relatedly, AMA members have reported to the AMA that individuals with LEP often bring trusted adults with them to an appointment to facilitate communication. The Current Rule states that a physician may

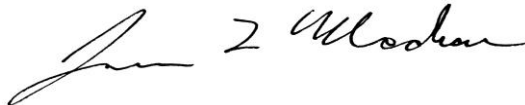
rely on an adult accompanying an individual with LEP to interpret or facilitate communication only if reliance on that adult for such assistance is “appropriate under the circumstances.” This standard remains unclear to physicians, causing them to take on the additional burden and expense of interpreters out of an abundance of caution when it may not be always necessary to do so. For example, when a physician sees an adult male patient presenting with flu-like symptoms, who is accompanied by his adult brother, and the patient requests that his brother translate, a physician may find this request appropriate under the circumstances. Conversely, if a female patient presenting with a broken arm is accompanied by her husband, the physician may have concerns about domestic abuse. In this case, it may be inappropriate to rely on the husband to provide accurate interpretation services. The AMA urges HHS to clarify the circumstances in which a physician may rely on an adult accompanying a patient to interpret or facilitate communication. We would welcome the opportunity to assist the agency with guidance.

Conclusion

This NPRM is at odds with section 1557’s clear mandate. Undoing the protections of the Current Rule will cause confusion about what the law requires and who is protected by it and, in doing so, will limit access to critically needed care and services for millions of individuals. The proposed rule disproportionately harms people seeking reproductive health care (including abortion), LGBTQ individuals, individuals with LEP (including immigrants), those living with disabilities, and people of color. For the reasons detailed above, **HHS should not finalize the proposed rule, but rather should redirect their efforts toward advancing health care access and equity for all. The AMA remains ready to assist with such efforts.**

Thank you again for the opportunity to submit comments on the proposed rule. Should you have any questions or wish to discuss these issues, please contact Laura Hoffman, Assistant Director of Federal Affairs, at laura.hoffman@ama-assn.org or 202-789-7414.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with a large initial "J" and "M".

James L. Madara, MD