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Via Electronic submission at www.regulations.gov

Roger Severino
Director, Office for Civil Rights
US Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Nondiscrimination in Health and Health Education Programs or Activities, Docket No.: HHS-OCR-2019-0007, RIN 0945-AA11

Dear Mr. Severino:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid, Office for Civil Rights, and Office of the Secretary proposed rule, *Nondiscrimination in Health and Health Education Programs or Activities,* 84 *FedReg* 27846 (June 14, 2019). The AAMC is a not-for-profit association representing all 154 accredited U.S. medical schools and 17 accredited Canadian medical schools, nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers, and more than 80 academic and scientific societies. Through these institutions and organizations, the AAMC represents more than 173,000 faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

Our members are key health care providers to their communities and are strongly committed to treating all patients and families with respect and providing the highest quality, most equitable care. The comments below reflect our concerns that the proposed changes to regulations that implement section 1557 of the Affordable Care Act (ACA; 42 USC §18816) will harm patients and their families; exacerbate existing inequities in health and health care in the communities served by our members; and may leave the providers who care for these patients without payment for that care.

In our October 2015 letter in response to the initial Notice of Proposed Rulemaking (RIN 0945-AA02), the AAMC voiced strong support for the HHS proposal to extend nondiscrimination protections to transgender populations and to strengthen protections for persons living with disability and those with limited English proficiency (LEP). Further, we encouraged HHS to explicitly include lesbian, gay and bisexual individuals in the definition of "sex" proffered in the rule. We voiced this support and encouragement based, in part, on the endemic inequities in health and health care experienced by those populations in the face of decreased health care access, implicit and explicit bias within the health care system, and pervasive stigma and discrimination.

Ultimately, implementation of the final rule was blocked in July 2017, and in the intervening two years not only have those inequities persisted, but for some groups – transgender women of color in

particular – the situation has worsened.[1] To ensure that regulations reflect the broad scope of section 1557 that "an individual shall not . . . be excluded from participation in, be denied the benefits of, or be subject to discrimination under, any health care program or activity that is administered by an Executive Agency or any entity established under this title . . ." **the AAMC urges HHS to withdraw the proposed changes to the Section 1557 regulations.**

More specific comments follow.

To clearly and consistently implement Section 1557 and ensure that the regulations reflect the clear meaning of the statute, the definitions of "on the basis of sex" and "covered entity" should not be changed.

Definitions are essential for the appropriate implementation of section 1557 requirements. Given the extensive comments that were received in response to the proposed definitions, including those of "on the basis of sex" and "covered entity" (see 81 FedReg 31376, May 19, 2019) it is clear that definitions are needed to ensure a consistent understanding of the application and enforcement of the regulation.

As HHS noted in the preamble to the final 2016 rule, "we sought comment on the best way of ensuring that this rule includes the most robust set of protections supported by the courts on an ongoing basis." (81 *FedReg* 31388). The AAMC was disappointed that the final rule did not add gender identity and gender expression to the definition of "on the basis of sex." While the proposed rule cites the Franciscan Alliance case to bolster this proposal, "every district court that has considered this issue [regarding that "on the basis of sex" includes discrimination based on "gender identity and "termination of pregnancy"] over the past two years has concluded that discrimination against transgender individuals is prohibited by Section 1557 itself (rather than the regulation)."[2]

The proposed revisions to Section 1557 regulations would limit the scope of the application of the rule to "entities with a health program or activity, any part of which receives Federal financial assistance from the Department" (p. 27877). It would also exclude short term limited duration insurance. The impact of these limitations on Section 1557 will mean that individuals will not have the protections afforded to them that were intended by Congress when it enacted the legislation.

The AAMC notes Section VIII of the proposed role provides a list of issues for which it is requesting comments, many of which focus on the <u>costs</u> of the current rule. However, there is no attempt by HHS to consider the <u>benefits</u> that will accrue to individuals who are protected by the rule. As was noted in the 2016 final rule:

> In enacting Section 1557 of the ACA, Congress recognized the benefits of equal access to health services and health insurance that all individuals should have, regardless of their race, color, national origin, age, or disability. Section 1557 brought together the rights to equal access that had been guaranteed under Title VI, the Age Act and Section 504. At the

[1] A National Epidemic: Fatal Anti-Transgender Violence in America in 2018 https://www.hrc.org/resources/a-national-epidemic-fatal-anti-transgender-violence-in-america-in-2018 Accessed 8/6/19.

[2] *HHS Proposes to Strip Gender identity, Language Access protections from ACA Anti-Discrimination Rule,* Katie Keith, Health Affairs Blog, 10.1377/hblog20190525.831858, May 25, 2019.

same time, Congress extended these protections and rights to individuals seeking access to health services and health insurance without discrimination on the basis of sex. (p. 31459)

In the final rule Table 7-Accounting Statement, noted as qualitative benefits, "potential health improvements and longevity extensions as a result of reduced barriers to medical care for transgender individuals." (p. 31465)

AAMC strongly opposes the removal of <u>any and all</u> discrimination prohibitions from the rule

While AAMC is glad to see that OCR proposes to maintain protections for persons living with disability, we oppose the roll back of protections for the LBGTQ population.

According to the Centers for Disease Control and Prevention (CDC), the LGBTQ community experiences significant inequities across a wide array of health and health care outcomes, including (but not limited to) tobacco use, depression, and HIV infection for gay and bisexual men; obesity, gynecological cancer, and heart disease for lesbian and bisexual women; and lack of insurance coverage, suicidality, and exposure to violence for transgender persons.

While multiple factors influence the development of these unjust and avoidable differences in health between the LGBTQ population and their heterosexual/cisgender counterparts, stigma, discrimination, and trans/homophobia in health care is a significant contributor.[3] AAMC's own research shows that members of the LGB community are more likely than heterosexuals to report they do not feel respected by their health care provider.[4]

There is no cost benefit to hospitals associated with permitting discrimination. There is no burden reduction related to sanctioning bias. The only outcomes of greenlighting systematic bigotry in health care will be to increase fear of discrimination, decrease health care access and use for the LGBTQ community, and widen already unconscionable health inequities.

HHS' stated mission is to "enhance and protect the health and well-being of all Americans". The AAMC encourages HHS to follow through on that promise and reject discrimination in health care.

There is no need to expand religious exemptions

HHS proposes that Section 1557 should incorporate abortion and religious exemptions contained in Title IX.

As we stated when we commented on the original 2008 Federal Health Care Conscience Rule, no individual or entity in this country has the option to pick and choose the laws to which he/she will adhere. Every health care provider and entity already has the obligation to comply with all applicable

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[3] Health and Care Utilization of Transgender and Gender Nonconforming Youth: A Population-Based Study. G. Nicole Rider, Barbara J. McMorris, Amy L. Gower, Eli Coleman, Marla E. Eisenberg Pediatrics Mar 2018, 141 (3) e20171683; DOI: 10.1542/peds.2017-1683.

[4] Dill, Michael J. 2014. "Sexual Orientation, Access to Care and Patient-Provider Communications." AAMC Health Workforce Research Conference. Washington, D.C.

federal laws. The Department has offered little evidence that this has not been the case. The Office of Civil Rights has received just forty-four complaints since it was designated with authority to enforce the Church, Coats-Snow, and Weldon Amendments. The paucity of complaints does not provide compelling evidence of a need for the expansion of OCR's authority, or the need for changes in the current regulations.

As the preamble to the proposed rule demonstrates, statutes and regulations already exist that broadly provide for religious exemptions. There is no need for additional exemptions.

Further, AAMC wishes to restate its concern that religious exemptions, particularly for family planning, will do harm to lower income Americans, racial and ethnic minorities, the LGBTQ community, and patients in rural areas.[5]

For rural- and frontier-dwelling Americans who reside in a health professional shortage area, access to certain services might functionally cease to exist as a result of religious exemptions: seeking care in distant locales might be too burdensome or expensive. This holds, too, for lower income Americans who lack the financial means to seek out care for procedures when their primary physicians decline to provide services.

Racial and ethnic minority women have reported experiencing race-based discrimination when receiving family planning care.[6] Religious exemptions may exacerbate this problem and the consequences that follow for women of color and their children.

For the LGBTQ communities, religious exemptions may further exacerbate health care access disparities. As noted above, LGBTQ Americans experience discrimination in health care settings, erecting a barrier to accessing health care services.[7] Religious exemptions codify what many within and beyond the LGBTQ communities view as state-sanctioned discrimination, and allow providers to refuse care or appropriate referrals solely based on their patients' sexual orientation or gender identity. This stands in stark opposition to OCR's stated goal to "protect fundamental rights of nondiscrimination."

The protections provided LEP populations by notice / tagline requirements outweigh any cost savings that might be achieved.

The 2016 final rule set forth specific requirements on how to communicate with individuals with limited English proficiency (LEP), including notice and tagline requirements to alert LEP individuals of the availability of free language assistance services. The AAMC strongly believes that the proposed recommendation to repeal the non-discrimination notice and tagline requirements would impede

[5] https://www.aamc.org/download/488276/data/aamccommentsonhhsproposedconsciencerightsrule.pdf
[6] Thorburn S, Bogart LM. "African American women and family planning services: perceptions of discrimination," *Women Health*. 2005;42(1):23–39.
[7] Cahill, S. "LGBT Experiences with Health Care," *Health Affairs* Vol. 36, No.4. 2017. Available from: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0277

access to critical language assistance services for millions of LEP individuals, contributing to and exacerbating existing racial and social inequities related to healthcare access and utilization.[8]

The Regulatory Impact Analysis in the final rule estimated that implementation of the notice requirements would impose $3.6 million in costs in the first year of compliance and zero costs in the four years following implementation. The final rule also estimated that the tagline requirements would incur the same cost as the notice requirement (a total of $7.2 million dollars). HHS contends that after independent analysis, the Department's original projection of the one-time notice and tagline costs "underestimated the actual costs associated with including nondiscrimination notices and taglines in significant communications and publications,"[9] and provides an alternative estimated burden of $147 million to $1.34 billion in annual costs and a cost savings projection of $3.16 billion over five years.[10] It is notable that HHS recognizes that "repealing the notice and taglines requirement 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. Even so, such an impact is expected to be negligible."[11]

The AAMC believes the Agency's cost estimations are inflated and at most add incremental burden given hospitals and healthcare facilities already print notice and tagline statements and therefore, these costs should not count toward the "recurring costs" (e.g., paper, postage) that HHS indicates the final rule failed to account for in its regulatory burden assessment. HHS' conclusions also lack sufficient evidence to justify the removal of the notice and tagline requirements, especially without proposing an alternative process that ensures meaningful access to LEP assistance.

We also strongly disagree with HHS' contention that the result of removing the notice and tagline requirements would have negligible impact on LEP populations. To illustrate the impact of these requirements, HHS relies primarily on data and anecdotal feedback from private health insurance companies.[12,13] We urge HHS to engage minority health professional organizations and advocacy groups to better understand the real human and societal costs of repealing the nondiscrimination and tagline requirements. Relying primarily on cost assessments and feedback from select covered entities/stakeholders to measure the impact of the notice and tagline requirements does not provide a complete and accurate perspective on the value of the current regulations.

The AAMC appreciates the opportunity to comment on ensuring nondiscrimination in health care, and we look forward to working with the HHS on this issue. Please contact me or my colleagues Philip M.

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[8] *Proposed Changes to the Health Care rights Law and Language Access*, Asian & Pacific Islander American Health Forum, "25 million individuals in the U.S. are LEP, meaning they speak little to no English" (June 2019). Available from: https://www.apiahf.org/resource/proposed-changes-to-the-health-care-rights-law-and-language-access/

[9] 84 Fed. Reg. 27858 (June 14, 2019).

[10] *Id*.

[11] 84 Fed. Reg. 27882 (June 14, 2019).

[12] 84 Fed. Reg. 27846 (June 14, 2019), Aetna Health Plan Representatives, *Member Reaction to 1557 Taglines* (April 13, 2017).

[13] 84 Fed. Reg. 27882 (June 14, 2019), "Reports from covered entities suggest, anecdotally, that utilization of translation services did not appreciably rise after the Final Rule's imposition of notice and taglines requirements." *Id*.

Alberti, PhD (palberti@aamc.org) or Ivy Baer, JD (ibaer@aamc.org) with questions about these comments.

Sincerely,

David J. Skorton, MD
President and CEO
Association of American Medical Colleges