AMERICAN CIVIL LIBERTIES UNION
Arkansas

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August 12, 2019

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, DC 20201

*Submitted electronically*

**Re: Comment on Proposed Rule Regarding Section 1557, Health Care Rights Law**

The Arkansas Civil Liberties Union Foundation, Inc. ("ACLU of Arkansas") submits these comments on the proposed rule published at 84 Fed. Reg. 27,846 (June 14, 2019), RIN 0945-AA11, with the title "Nondiscrimination in Health and Health Education Programs or Activities" (the "Proposed Rule").

The ACLU is a nationwide, non-partisan organization with more than 500,000 members; dedicated to protecting the individual liberties and freedoms guaranteed in the Constitution and laws of the United States. For the past 50 years, the ACLU of Arkansas has worked to protect the constitutional rights of all Arkansans, including combatting discrimination and advocating for expanding access to healthcare for all individuals.

The rule currently in place implementing Section 1557, titled "Nondiscrimination in Health Programs and Activities" (the "Current Rule"), was developed after years of review and consideration of comments from a variety of stakeholders. The Current Rule meets a critical need and fulfills Congress's intent to provide "equal access to health services and health insurance that all individuals should have, regardless of their race, color, national origin, age, or disability." 81 Fed. Reg. 31,459. Discrimination in the health care context leads to lasting harms to people's health and wellbeing, and the Department made detailed factual findings to that effect in support of the Current Rule: People subject to discrimination postpone or fail to obtain health services and are denied necessary care; such discrimination exacerbates health disparities in underserved communities.

The Proposed Rule, however, is yet another attempt by the Trump Administration and the Department of Health and Human Services (the "Department" or "HHS") to undermine access to health care for the most vulnerable individuals and communities, while emboldening discriminatory and dangerous denials of care. The Proposed Rule's explicit reductions in the scope of antidiscrimination protections, as well as the implicit invitation for health care providers to undermine access to care, completely disregard the potential harms to individuals trying to access health care and coverage. This approach is contrary to the statutory language of Section 1557, and is a reversal of the reasoned policy decisions of the Current Rule. Further, it



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will fail to accomplish its stated goal to *decrease* confusion, instead *increasing* the burdens and costs of compliance.

For these reasons, as well as the ones that follow, the ACLU of Arkansas recommends and requests that the Department decline to finalize the Proposed Rule in its entirety.

## I. THE PROPOSED RULE SHOULD NOT ROLL BACK AFFIRMATIVE ANTIDISCRIMINATION PROTECTIONS.

It is well known that Arkansas is ranked very low in terms of overall health; currently the health of Arkansans is ranked 48th out of 50 states. The Arkansas Department of Health stated in its state health assessment plan that with more than half a million Arkansans are already struggling to access healthcare due to the states' shortage of primary medical care, dental, and mental health workers. The Arkansas Department of Health repeatedly noted the need to improve access to testing and health care for underserved communities. Barriers to healthcare, including discrimination, must be removed if we want to improve the overall health of Arkansans.

Six Arkansas cities, including some of our most populated areas of the state, have passed laws granting anti-discrimination protections based on sexual orientation and gender identity. Arkansas' lawmakers and healthcare professionals have repeatedly condemned "medical conscience" bills because they have recognized the deadly results that could result from the healthcare industries refusal to provide healthcare through legal discrimination. During the March 9, 2017 Arkansas House of Representatives public health committee meeting, the State Surgeon General and healthcare professionals spoke firmly against a proposed Arkansas' healthcare conscience bill. House Bill 1628 ("The Healthcare Freedom of Conscience Act"), would have allowed healthcare providers, facilities, and insurers to refuse to provide or pay for healthcare on moral grounds. Arkansas State Surgeon General Greg Bledsoe urged the panel to reject the legislation, saying "I think it's misguided and it's the wrong direction for our state." Physician and House Representative, Stephen Magie, echoed the State Surgeon General's concerns stating "This goes against the grain of what being a physician is all about. We take care of patients, regardless of where they're from, what their background is, what they believe in, what they don't believe in." (*Arkansas House- Public Health, Welfare and Labor Committee hearing*. March 9, 2017. HB1628) It is clear from the actions of our State, that antidiscrimination protections are an important element of ensuring the health of Arkansans and increasing access to healthcare in Arkansas. The federal government should not roll back affirmative antidiscrimination protections that states, like Arkansas, have fought to protect.

### A. HHS Should Maintain the Existing Definition of Discrimination on the Basis of Sex and Protections Against Such Discrimination.

In promulgating the Current Rule, the Department recognized the importance of affirmative regulatory protections—specifically for all enumerated forms of sex discrimination. The Current Rule defines discrimination based on 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. 45 CFR 92.4. The Proposed Rule eliminates

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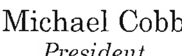

this key provision that clarifies what discrimination on the basis of sex encompasses, and removes explanatory examples of prohibited activity. The Proposed Rule also amends regulations—and incorporates an abortion exemption—that are unrelated to Section 1557. These changes are without justification and will directly harm patients seeking care.

1. *The proposed amendments abandon LGBT individuals and people seeking reproductive health care, who depend on HHS to protect their statutory rights.*

Section 1557 and the Current Rule are intended to protect people from the pervasive problem of sex-based discrimination in the health care context. Lesbian, gay, bisexual, and transgender ("LGBT") patients, as well as people who seek or have obtained reproductive health services, face discrimination based on sex in accessing health care. This discrimination can range from providers using harassing or abusive language to completely refusing necessary medical care. Sex-based exclusions from health care coverage can also make essential medical care unaffordable. For example, some transgender and non-binary individuals are subject to discriminatory categorical exclusions for health care related to gender transition that put necessary health care out of financial reach. By eliminating the definition of discrimination on the basis of sex, as well as stripping protections against discrimination based on gender identity and sexual orientation from other unrelated HHS regulations, the Proposed Rule will invite such discrimination against LGBT individuals and people seeking reproductive health care.

The Department fails to even consider the impact that the Proposed Rule would have on individuals who are protected under the Current Rule. Data on the Arkansas state population shows that this proposed rule will affect more than 13,400 residents who identify as transgender in our state. The Department must prioritize the impact that inviting discrimination against patients will have on public health, particularly the harms to transgender and non-binary individuals, as well as people who need or have obtained pregnancy-related health services, all of whom would no longer have explicit regulatory protections against sex discrimination if the Proposed Rule is finalized.

2. *The proposed amendments do not provide clarity, but only create more confusion.*

The Department contends that the Proposed Rule is needed to reduce confusion and to clarify the scope of Section 1557. But should the Department delete the definitional provisions, it would actually *cause* confusion and embolden health care and insurance providers to discriminate. The Department's proposal does nothing to clarify what constitutes prohibited sex discrimination under Section 1557, as eliminating the definition does not mean that discrimination on the presently enumerated bases is suddenly permitted. Instead, eliminating the definition invites discrimination and undermines uniformity among providers—to the detriment of covered entities and patients alike.

Because discrimination based on sex would still be prohibited, discrimination based gender identity would remain unlawful under Section 1557 as well. Courts have consistently held that Title IX's prohibition on sex discrimination protects individuals from discrimination based on

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gender nonconformity. *See EEOC v. R.G. &. G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 572 (6th Cir. 2018), *cert. granted in part*, 139 S. Ct. 1599 (2019); *Whitaker ex rel. Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1046–54 (7th Cir. 2017); *Glenn v. Brumby*, 663 F.3d 1312, 1316 (11th Cir. 2011); *Schwenk v. Hartford*, 204 F.3d 1187, 1201 (9th Cir. 2000); *Rosa v. Park W. Bank & Tr. Co.*, 214 F.3d 213, 215–16 (1st Cir. 2000). District courts across the country have also recognized that discrimination against transgender individuals because their gender identity diverges from their sex assigned at birth violates the plain text of Section 1557. *See Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 953 (D. Minn. 2018); *Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 951 (W.D. Wis. 2018); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1098–1100 (S.D. Cal. 2017). Given the extensive legal precedent, the Department cannot simply assert by regulation that covered entities will not be liable for gender identity discrimination claims where such discrimination is prohibited by the statutory text.

Further, while the preamble to the Proposed Rule spends an inordinate amount of time attempting to justify the elimination of gender identity as an identified form of sex discrimination, it does not explain why the other definitional provisions are eliminated as well. Removing the definition of sex discrimination cannot change the underlying legal precedent that the current definition was based on and that still prohibits discrimination on the enumerated bases, including discrimination based on sex stereotyping, pregnancy discrimination, and pregnancy-related conditions. For example, Arkansas, Ark. Code Ann. § 16-123-102 & 107 prohibit employment discrimination on the basis of gender, which is explicitly defined to include discrimination on the basis of pregnancy, childbirth, or related medical conditions.

To the extent there is variance among Arkansas state laws and federal courts as to what constitutes discrimination based on sex, the Current Rule provides crucial uniformity.

3. *HHS should not import an abortion exemption into its definition of sex discrimination.*

The Proposed Rule would unnecessarily incorporate the abortion exemption from Title IX into regulations implementing Section 1557. Incorporating the abortion exemption violates the text and purpose of Section 1557, which prohibits discrimination "on the *ground[s]* prohibited under" the referenced civil rights statutes, not the attendant exemptions contained in those statutes. 42 U.S.C. § 18116 (emphasis added). Abortion care is health care related to pregnancy, and targeting it for exclusion undermines and stigmatizes access to care that is a constitutionally protected right.

* * *

Taken as a whole, the Proposed Rule strips explicit regulatory protections for LGBT individuals and for people who require reproductive health care, indicating that the underlying purpose for the amendments is to target transgender and non-binary individuals, as well as other people who face sex-based discrimination in accessing health care and insurance coverage. That is neither consistent with the text of the statute, nor the appropriate mission of the Department.



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The Proposed Rule is also untimely, as the U.S. Supreme Court granted petitions for review in three cases addressing whether sex discrimination encompasses discrimination based on sexual orientation, gender identity, and discrimination against transgender individuals due to sex stereotyping under Title VII. *Altitude Exp., Inc. v. Zarda*, 139 S. Ct. 1599 (2019); *Bostock v. Clayton Cty., Ga.*, 139 S. Ct. 1599 (2019); *R.G. & G.R. Harris Funeral Homes, Inc. v. EEOC*, 139 S. Ct. 1599 (2019). Because Title IX generally adopts the standards for discrimination under Title VII, the Department will need to address the practical implications of any decision by the Court through a renewed comment process. Accordingly, the Department should abandon the Proposed Rule and instead leave in place the existing rule that discrimination based on gender identity is a form of sex discrimination, as is discrimination based on pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, and sex stereotyping.

### B. HHS Should Not Weaken Protections for People with Disabilities.

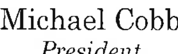
Historically, people with disabilities in the United States have been unable to access the health care they need because of discrimination by the health insurance industry. Prior to the ACA, people with disabilities were commonly denied or terminated from health coverage, faced annual and lifetime benefit limits, and could not find affordable coverage. Access to adequate health care at affordable rates is central to the ability of disabled people to participate fully in society.

The Department proposes to eliminate Section 92.207 of the Current Rule in its entirety, which would undermine the right of people with disabilities to challenge discriminatory benefit design. Under the Current Rule, for example, plans that cover bariatric surgery in adults but exclude such coverage for adults with particular developmental disabilities, place most or all drugs that treat a specific condition on the highest cost tiers, or exclude bone marrow transplants regardless of medical necessity, constitute disability discrimination in violation of Section 1577. The Department claims that the provision is redundant or may be confusing in relation to the Department's preexisting regulations. But the Current Rule is needed precisely because existing laws were insufficient to dismantle barriers to adequate health insurance for people with disabilities. The deletion thus contravenes Section 1557's plain language.

The application of antidiscrimination principles to health insurers and to benefit design is essential to the needs and rights of disabled people. The Proposed Rule does not apply those principles and should not be adopted.

### C. HHS should not weaken protections for individuals with Limited English Proficiency.

The Department should not eliminate the language access protections as described by the Proposed Rule. In Arkansas, 91,698 people have limited English proficiency ("LEP"), and they should all have meaningful access to health care and coverage. Language assistance is necessary to ensure that LEP persons are guaranteed such access, and is a critical protection



to combat discrimination on the basis of national origin, which encompasses discrimination on the basis of language.

The Proposed Rule would eliminate significant protections for LEP persons by removing the requirement that covered entities provide notices of legal rights and in-language taglines on significant publications. The taglines are cost-effective ways to maintain access for LEP individuals without translating entire documents. The Department ignores the impact on LEP individuals should this requirement be eliminated, relying solely on reports from health plans, with no public outreach to determine the impact of the taglines or to explore alternatives. Likewise, the Department should not eliminate references to language access plans, which are a useful tool for covered entities to fully plan how to meet the needs of LEP patients and consumers. Such plans also support covered entities' own compliance efforts, benefiting both LEP individuals and covered entities alike.

LEP individuals face unique risks and barriers to knowing and asserting their rights in the health care context. The 2019 Arkansas Racial and Ethnic Health Disparity Study found that forty-five percent of all Hispanic respondents reported needing an interpreter to help speak with doctors or other health providers. The proposed elimination of protections to aid communication with LEP individuals—both while they are accessing services and so that they know their rights—should be abandoned.

## II. THE DEPARTMENT SHOULD NOT LIMIT THE BROAD IMPACT OF SECTION 1557.

The Proposed Rule includes several provisions that would so limit Section 1557's application as to render its protections a nullity for the very people Congress sought to protect. The proposal inappropriately limits the statute's reach in several respects and, as such, the Department should decline to finalize the Proposed Rule, leaving in place the Current Rule.

### A. HHS Should Not Import a Religious Exemption into Section 1557.

The Proposed Rule wrongly would allow religiously affiliated healthcare providers to discriminate based on sex and to refuse access to necessary medical care, by importing Title IX's expansive religious exemptions into Section 1557. Religiously affiliated healthcare providers make up a significant percentage of the healthcare facilities in the United States. One in six patients is now treated in a Catholic facility each year, and religious hospitals are also increasingly the *only* health care option in many regions. More than 30% of Arkansas' 103 hospitals are controlled by religious organizations. In Arkansas, religious health care is provided by 20 Catholic hospitals, 10 Baptist hospitals, and 2 Methodist hospitals. The 32 religious hospitals account for 59.8% of the total staffed hospital beds in Arkansas (4,771 religious hospital beds out of 7,976 total hospital beds). The religious health care providers in Arkansas operate many different types of healthcare facilities in the state, including: Sole community hospitals, critical access hospitals, rural referral centers, Medicare dependent hospitals, Intermediate Care facilities, inpatient rehabilitation facilities, long-term care hospitals, urban medical-surgical hospitals, and psychiatric care facilities. Arkansas has 16 rural communities where religious organizations own and control the only healthcare provider in the region. The 16

rural hospitals are designated as critical access hospitals (CAH) and Rural Referral Centers (RRC) both provide acute hospital care to rural communities and are the only hospital within 35 miles for rural Arkansans to receive healthcare services. Of these rural religious hospitals, ten are CAH small acute care hospitals that handle low capacity, short term stays hospitals, that serve as the primary health care provider in the rural area, and six are RRC large acute care hospitals with more than 75 beds. The prevalence of religious healthcare providers in Arkansas impedes access to comprehensive healthcare for thousands of patients in underserved and rural communities. Religious discrimination and healthcare service restrictions put dangerous unnecessary hurdles in front of patients that are already struggling to access comprehensive health care.

The proposed religious exemption violates the text and purpose of Section 1557, as well as the constitutional commitment to the separation of church and state. The statute prohibits discrimination "on the *ground[s]* prohibited under" the referenced civil rights statutes, 42 U.S.C. § 18116 (emphasis added), but does not incorporate the attendant exemptions contained in those statutes—many of which are wholly inapposite to the health care context. The Department should not reverse course by incorporating the exemption, having initially rejected invitations to do so. Further, the First Amendment forbids government action favoring religion to the point of forcing third parties to bear the costs of those beliefs. *See Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 708–10 (1985). The Proposed Rule's exemption flies in the face of the careful balance courts have struck between civil rights and religious liberty, running afoul of the Establishment Clause.

Permitting a blanket religious exemption to Section 1557's nondiscrimination mandate threatens access to critical care for countless patients, especially transgender patients and patients seeking reproductive health services. The Proposed Rule altogether fails to consider the harmful consequences of importing a broad religious exemption into the health care context. In an ideal world, Americans would be able to pick their hospitals, however; this is not reality for most Arkansans. Due to the healthcare provider shortage and the rural geography of most of the state, religious health care providers are often the only provider available for patients in need of care.

### B. HHS Should Not Narrow the Scope of Covered Entities.

The Proposed Rule would further undercut Section 1557 by limiting the entities covered by the provision. Limiting the application of Section 1557's protections would sanction discriminatory denials of coverage by entities that are presently covered by Section 1557, causing confusion and serious harm to those unable to access care. Additionally, the Proposed Rule displays no awareness of the potential harm to individuals denied coverage of and access to health care due to the proposed limitations on Section 1557's application.

Excluding health insurance from Section 1557's nondiscrimination mandate as distinct from "health program or activity" is contrary to the text of the statute and the broader antidiscrimination purpose of the law. The false distinction is exacerbated by the Proposed Rule's new limitation on the application of Section 1557 in cases where the entity is not

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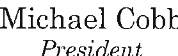

"principally engaged in the provision of health care." In such cases, under the proposal, Section 1557 would apply only to the specific operations of an entity that receive federal financial assistance—whereas Section 1557 covers *all* operations of entities principally engaged in health care that receive federal financial assistance. This distinction, too, is contrary to the text of the statute, which prohibits discrimination under "any health program or activity, *any part of which* is receiving Federal financial assistance." 42 U.S.C. § 18116 (emphasis added).

### C. HHS Should Maintain Existing Remedies Available for Section 1557 Claims.

The Current Rule adopts a uniform standard, applicable to all grounds covered by Section 1557, and incorporates enforcement mechanisms that exist under any of the civil rights laws referenced by Section 1557. This includes a private right of action for disparate-impact claims and the availability of compensatory damages for all claims under Section 1557. In removing these provisions, the proposed rule creates a scheme in which people are denied certain legal remedies because of the type of discrimination they experience. Such a change also privileges purported business interests in relieving regulatory burdens over the interests of the public and of individuals seeking health care. However, by removing the Current Rule, covered entities and protected individuals alike would be uncertain as to the law's requirements and protections, instead leaving them to look to four other separate civil rights laws and various agencies' implementing regulations for clues.

The Proposed Rule's silence regarding the availability of a private right of action is at worst contrary to the rights-expanding aims of the statute and, at best, purposeless. Parties asserting private rights of action pursuant to Section 1557 have significantly expanded access to health care and combatted discriminatory health care policies, and will continue to do so, regardless of regulatory language explicitly affirming that such a right exists.

The Department should also not eliminate the Current Rule's provision for disparate-impact claims, which promotes better compliance with Section 1557's nondiscrimination provisions. The disparate-impact mechanism encourages health care providers to identify disparities and to adopt solutions that make a crucial difference in eliminating those disparities for individuals and improving public health.

These enforcement mechanisms are particularly important for people of color. Addressing racial disparities in health care is a matter of life and death. Such disparities are found across a range of illnesses and health care services, even when accounting for socioeconomic factors. Disparities in health care also have historic roots. As in other sectors of society, segregated health care was once sanctioned by law, and government-sanctioned discrimination continues to have a systemic impact on access to quality health care. At the same time, research suggests that many racial and ethnic health disparities could be reduced or even eliminated if identified and addressed. A disparate-impact private right of action is a crucial enforcement mechanism to confront and redress discrimination.

The Department's proposal would instead make enforcement more difficult, and would increase confusion as to the scope of Section 1557's protections. The Department should accordingly



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continue to affirm existing enforcement mechanisms, including the private right of action for disparate-impact claims.

### D. The Department Should Not Eliminate Grievance Procedures and Notice Requirements.

The Proposed Rule would unnecessarily eliminate the specific grievance procedures established under Section 1557, which would leave covered entities and impacted individuals without cohesive, uniform procedures for investigating grievances. Further, the Department should not eliminate the explicit requirement that such procedures "incorporate appropriate due process standards," which provides that the procedures in place are sufficient to address claims of discrimination promptly and equitably. 45 CFR 92.7. Likewise, the Department should not eliminate the requirement that covered entities provide notice to the public that they do not discriminate, as the current procedure is crucial to ensure that individuals are aware of the safeguards in place and of the steps they can take to effectuate the protections under Section 1557. 45 CFR 92.8. The costs associated with the notice requirement are well worth the benefit of ensuring that protected individuals receive adequate notice of their rights.

## III. THE PROPOSED RULE VIOLATES SECTION 1554 OF THE ACA.

The Proposed Rule is additionally contrary to law because it violates another provision of the ACA: Section 1554. This provision limits the Department's rulemaking authority, prohibiting HHS from promulgating regulations that create any unreasonable barriers to the ability of individuals to obtain appropriate medical care, impede timely access to health care services, violate the ethical standards of health care professionals, or limit the availability of health care treatment for the full duration of a patient's medical needs—among other restrictions. 42 U.S.C. § 18114. For all the reasons outlined in this comment, the Proposed Rule represents a direct violation of Congress's command and should be entirely abandoned.

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For all these reasons, the Department should withdraw the Proposed Rule.

Sincerely,

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