Nondiscrimination in Health Programs and Activities: Sample Comments
November 9, 2015

Jocelyn Samuels, Director
Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

Re: Comments on Proposed Nondiscrimination in Health Programs and Activities
45 CFR Part 92, RIN 0945-AA02

Dear Ms. Samuels,

These comments address the proposed regulations implementing Section 1557 of the Affordable Care Act (ACA). [Brief introduction of person/organization submitting comments, with explanation of interest in nondiscrimination in health programs and activities]

As the Department of Health and Human Services (HHS) noted in the proposed regulations, individuals who experience discrimination in health care often postpone or do not seek needed care, resulting in adverse effects on their health status. We appreciate the dedication of HHS to develop the first-ever comprehensive regulations to clarify discrimination protections in health programs and activities.

The proposed regulations go a long way to implement the promise of Section 1557. We commend HHS for its commitment to ending discrimination in all federally funded, supported and conducted health programs and activities. We strongly support the proposed regulations’ prohibition of discrimination on the basis of race, color, national origin (including immigration status and language), sex (including sex stereotyping and gender identity), disability, and age.

To truly reduce health disparities and improve health equity, however, we urge HHS to make several improvements to the proposal in the final regulations. Our four key regulatory recommendations, as described further below, are:

1) Include Medicare Part B providers as covered entities;
2) Set bright line population thresholds to trigger requirements to translate vital documents;
3) Ensure the prohibition of sex discrimination is sufficiently broad to encompass all sexual orientation and gender identity discrimination; and
4) Strengthen enforcement and compliance by setting clear and specific standards.

Thank you for the opportunity to comment.

Sincerely,

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Title
I) Include Medicare Part B providers as covered entities.

We oppose the proposed exclusion of Part B providers from the protections of the 1557 statute. All Medicare providers, without exception, should be subject to this regulation. The continuation of the Part B exclusion is based on a fictional notion that enrolled Medicare Part B providers are merely receiving payments passed on by Medicare B beneficiaries. This is not how Medicare Part B operates today and it is inappropriate to incorporate this fiction into the 1557 regulations.

The history of the Part B exclusion started at a discriminatory moment in health care policy history. When the Part B exclusion was first adopted it was inconsistent with the powerful role Medicare played in desegregating health care entities and bringing civil rights into the health care system. In a groundbreaking and forward thinking regulation, it is wrong to carry over this anachronistic exclusion, the justification of which was strained at the outset and today is without support.

Further, excluding Part B providers will limit HHS’ ability to transform and improve health care delivery for Medicare beneficiaries. All Medicare providers, without exception, should be subject to Section 1557 requirements. Because including Part B providers will constitute a change in HHS policy, we ask that, to provide clarity, the regulation specifically identify Part B providers as covered entities.

II) Set bright line population thresholds to trigger requirements to translate vital documents.

1) Strongly recommend numerical and percentage thresholds, oppose a multi-factor test (45 CFR § 92.201)

We are concerned that the proposed regulation does not set any specific criteria for determining when written documents should be subject to translation requirements. If Section 1557 is going to live up to its promise of making a genuine difference in health care, the translation requirements need to be clear, simple and enforceable. Relying exclusively on the proposed multi-factor analysis will fail to fulfill two core components of successful language access requirements: 1) ease of understanding for covered entities, and 2) ease of understanding for agency enforcement.

We urge HHS to apply a bright line numerical and percentage threshold test. Decades of Medicare and Medicaid experience demonstrate that a test weighing factors without concrete markers does not work. For the ease of the agency and covered entities, and to ensure effective communication to all consumers, we urge HHS adopt the lower 5% or 1,000 individuals in a service area threshold for the translation of vital documents, websites, outreach and education materials. We emphasize the importance of having a threshold that is based on both percentage and numerical information. In Medicare Part C and D, percentage thresholds alone have failed in extending language access to large numbers of limited English proficient (LEP) individuals in large states and led to anomalous results.

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1 80 Fed. Reg. at 54174 (Sep. 8, 2015).
2) **Recommend Clarifying Vital Documents for Translation Purposes** *(45 CFR § 92.8 (7)(f)(1)(i))*

We ask HHS to include in the text of the regulation a definition of “vital document,” mirroring the definition in current HHS guidance. The definition should state that vital documents include but are not limited to:

- Consent and complaint forms.
- Intake forms with the potential for important consequences.
- Written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, actions affecting parental custody or child support, and other hearings.
- Notices advising LEP persons of free language assistance.
- Written tests that do not assess English language competency, but test competency for a particular license, job, or skill for which knowing English is not required.
- Applications to participate in a recipient’s program or activity or to receive recipient benefits or services.

Providing this level of specificity will assist both in compliance and enforcement.

3) **Translate notices into local threshold languages, not just the top 15 nationally** *(45 CFR § 92.8)*

We support the proposal to make a sample notice available in the top 15 languages spoken by individuals with limited English proficiency nationally, as well as creating the translated taglines in the same languages.

We also ask for a commitment by HHS to undertake translations of both notices and taglines into the languages beyond the top 15 nationally. We ask that HHS add translations of languages that, at the local and state level, would emerge among the top 15. This commitment would encompass more than the top 15 languages nationally, with thresholds grounded in local data and geographically tailored to the communities that covered entities serve. Such translations would allow all LEP communities, regardless of their overall size nationally, meaningful awareness of the rights afforded to them under Section 1557.

4) **Test all notices and taglines with beneficiaries before finalizing.** *(45 CFR § 92.302)*

We recommend HHS engage in beneficiary testing of the sample notice language and make changes to the sample notices based on testing results. The current Sample Notice (Appendix A to Part 92) reads as boilerplate and is far too confusing for an individual, particularly an individual who is low literacy or LEP, to understand the technical terms and complex policy jargon. We also recommend the notice include a heading that explains the notice’s purpose in plain language. For example, “We’re here to help. Tell us if you need language assistance or assistance with a disability.”

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III) Ensure the prohibition of sex discrimination is sufficiently broad to encompass all sexual orientation and gender identity discrimination.

1) Support prohibiting discrimination on the basis of gender identity (45 CFR § 92.4)

We strongly support the proposal that discrimination “on the basis of sex” includes discrimination on the basis of gender identity. This protection is long overdue and vital for eliminating health disparities among older adults. Multiple studies underscore the discrimination LGBT older adults face from health care and service providers.\(^5\) In a survey of over 4,000 LGBT individuals, 70% of transgender and gender non-conforming adults reported they experienced at least one of the following types of discrimination in health care: being refused needed care, health professionals refusing to touch them or using excessive precautions, health professionals using harsh or abusive language, being blamed for their health status, or health care professionals being physically rough or abusive.\(^6\)

The inclusion of gender identity in the protection against discrimination “on the basis of sex” is an important protection for older adults.

2) Strongly urge HHS to include sexual orientation in “on the basis of sex” of definition (45 CFR § 92.4)

We are concerned that the protections on the basis of sex discrimination do not currently include discrimination on the basis of sexual orientation. LGBT older adults face significant ignorance and discrimination in health and long-term care settings.

We urge HHS to specifically include sexual orientation in the definition. HHS’ internal policy bans discrimination in health programs on the basis of sexual orientation. A national survey of LGBT older adults in long-term care settings\(^7\) validates the importance of explicit nondiscrimination protections. According to the study, in long-term care settings, only 22% of respondents felt they could be open with staff about their sexual orientation and/or gender identity and 89% of respondents feared staff would discriminate against an LGBT elder who was out of the closet.

Without an explicit prohibition on discrimination on the basis of sexual orientation, LGBT older adults will continue to face discrimination, isolation, and fear as health and long term care providers will not be required to adhere to a regulatory discrimination prohibition.

3) Strongly oppose any limitation to the rule’s protections on the basis of religious refusal (45 CFR § 92.2)

We strongly oppose adding any exemption that would permit discrimination based on religious views. There is no religious concern that warrants permitting health care entities who receive federal funds to

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\(^6\) Lambda Legal, When Health Care Isn’t Caring, at 5.

discriminate against patients, residents, caregivers and other participants of the health care delivery system. As noted in the rule, a fundamental purpose of the ACA is to ensure that vital health care services are broadly available to individuals throughout the country without discrimination. HHS cannot meet this goal by allowing exemptions based on religious refusal and we urge the agency to reject any proposal to include additional limitations to the application of Section 1557’s protections.

IV) **Strengthen enforcement and compliance by setting clear and specific standards.**

1) **Support the proposed clarification that Section 1557 permits a private right of action** (45 CFR § 92.302)

We appreciate that the proposed regulation explicitly clarifies that Section 1557 allows an individual or entity to file suit in federal district court when a violation of the section or the regulations has occurred. This right is essential to ensuring these nondiscrimination provisions are adequately enforced.

2) **Recommend adding additional specificity to the private right of action** (45 CFR § 92.302)

HHS should add specific guidance to the private enforcement right. This is a timely opportunity for the agency to assist the courts in setting the applicable standard to employ when adjudicating discrimination claims.

The statute incorporates existing civil rights laws to indicate the grounds upon which discrimination is prohibited. While the proposed regulation clarifies the *procedural* provisions with respect to enforcement, this is not enough to reflect the statute. The proposed rules must clarify the *substantive* legal standards courts are to use when adjudicating claims based on violations of Section 1557. Different civil rights laws incorporated into Section 1557 carry different legal standards and burdens of proof. In the absence of such guidance, courts have already begun reaching inconsistent decisions regarding the appropriate standard to apply. Compare *Rumble v. Fairview Health Services*, 2015 WL 1197415 (D. Minn. 2015) (holding that one standard and burden of proof applies to cases under Sec. 1557) to *Southeastern Pennsylvania Transportation Authority v. Gilead Sciences, Inc.*, 2015 WL 1963588 (E.D. Penn. 2015) (holding that the protected class determines the appropriate legal standard and burden under 1557).

We find the reasoning in *Rumble* persuasive. Rumble, 2015 WL 1197415, *11: “Here, looking at Section 1557 and the Affordable Care Act as a whole, it appears that Congress intended to create a new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff’s protected class status. Reading Section 1557 otherwise would lead to an illogical result, as different enforcement mechanisms and standards would apply to a Section 1557 plaintiff depending on whether the plaintiff’s claim is based on her race, sex, age, or disability.” The proposed rules should clarify the substantive legal standard courts should use when adjudicating a claim under Section 1557.

Finally, consistent with Congressional intent that Section 1557 would bring a new level of commitment to nondiscrimination in healthcare, further guidance should clarify that the statute provides protected beneficiaries with a claim to redress practices that have a discriminatory, disparate impact. Further, as the statutory language of Section 1557 authorized the Secretary of HHS to promulgate regulations, we recommend the proposed rule apply to **all** federally funded, supported and conducted activities and not just those of HHS.