

Section 1557: Strengthening Civil Rights Protections in Health Care

ISSUE BRIEF • JANUARY 2017

Written by

Georgia Burke

Directing Attorney, Justice in Aging

Denny Chan

Staff Attorney, Justice in Aging

Introduction

Section 1557 of the Affordable Care Act (ACA)¹—although only a single paragraph in that legislation—is a powerful tool for improving civil rights in every corner of the American health care system. It is particularly appropriate for combating discrimination and addressing health disparities for individuals enrolled in the Medicare or Medicaid programs.

Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in federal health programs and activities.² In May, 2016, the Office of Civil Rights (OCR) of the Department of Health and Human Services (HHS) issued regulations that provide guidance about the responsibilities of entities covered by the requirements of Section 1557.³

This issue brief provides an overview of Section 1557, looks at specific areas of discrimination, and describes enforcement options. Throughout, the brief focuses on how Section 1557's protections apply to programs and providers serving older adults who are Medicare and/or Medicaid beneficiaries.

Table of Contents

Introduction.....	1
The Basics.....	2
Discrimination Based on Sex	4
Discrimination Based on National Origin	6
Discrimination Based on Race and Age	9
Discrimination Based on Disability	9
How is Section 1557 Enforced?..	10
Fixing the Medicare Part B Provider Exclusion.....	12
Conclusion.....	12

1 42 U.S.C. § 18116.

2 45 C.F.R. § 92.1.

3 81 Fed. Reg. 31376 (May 18, 2016).

As with the rest of the ACA, significant uncertainty exists about possible legislative or regulatory changes to Section 1557 and about agency enforcement priorities in coming years.⁴ Further, a recent nationwide preliminary injunction issued by a Federal District Court in Texas prohibits the HHS Office of Civil Rights from enforcing those portions of the Section 1557 implementing regulations that specifically address discrimination based on transgender status and termination of pregnancy.⁵ The regulations issued by HHS, however, remain on the books, and many entities have already taken significant steps toward compliance. Immediately after the issuance of the injunction, HHS announced that enforcement will continue on all other aspects of the law not covered by the injunction.⁶

This brief has two goals. First, it provides practical guidance to advocates about how Section 1557 protections apply to Medicare and Medicaid beneficiaries.

Second, it gives policy makers an understanding of the concrete ways that Section 1557 protections can address health disparities. Stark health disparities exist across race, gender, and poverty lines, and older adults are no exception. For example, a larger share of Black and Hispanic Medicare beneficiaries report fair or poor health status than white beneficiaries.⁷ Similarly, Black and Hispanic adults age 65 and older are almost twice as likely as white older adults to develop diabetes.⁸ Section 1557 is an important part of the arsenal to combat health disparities such as these, and improve health care delivery.

The Basics

What discrimination is prohibited?

Section 1557 prohibits discrimination against protected classes by incorporating existing protections under civil rights laws and applying them directly to the health care context. Specifically, Section 1557 applies:

- Title VI of the Civil Rights Act of 1964 (barring discrimination on the basis of race, color, and national origin, including discrimination based on language ability for limited English proficient individuals⁹);
- Title IX of the Education Amendments of 1972 (barring discrimination based on sex);
- The Age Discrimination Act of 1975 (barring discrimination based on age); and
- Section 504 of the Rehabilitation Act of 1973 (barring discrimination based on disability).

Section 1557 states that no one shall be “excluded from participation in, be denied benefits of, or be subjected to discrimination under, any health program or activity,” on the basis of membership in one of these protected classes.¹⁰ The commentary to the regulations explains that Section 1557 may be used

4 While Section 1557 is unlikely to be included in an ACA repeal bill that goes through the budget reconciliation process due to Congressional budgetary rules, the HHS may develop different interpretations or have different enforcement priorities regarding Section 1557 in the coming months.

5 *Franciscan Alliance, Inc. v. Burwell*, Civil Action No. 7:16-cv-00108-O (N.D. Tex.), Preliminary Injunction (Dec. 31, 2016), available at <http://premiumtaxcredits.wikispaces.com/file/view/Franciscan%20Alliance%20PI%20order.pdf/602930830/Franciscan%20Alliance%20PI%20order.pdf>.

6 HHS Office of Civil Rights, Notice of Preliminary Injunction Against Enforcement of Section 1557 Rule Provisions on Gender Identity and Termination of Pregnancy (Jan. 3, 2017).

7 Kaiser Family Foundation, *Profile of Medicare Beneficiaries by Race and Ethnicity*, March 9, 2016, available at: <http://kff.org/medicare/report/profile-of-medicare-beneficiaries-by-race-and-ethnicity-a-chartpack/>.

8 Centers for Disease Control and Prevention, *The State of Aging and Health in America*, 2013, Figure 2, available at: <http://www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf>.

9 *Lau v. Nichols*, 414 U.S. 563 (1974).

10 42 U.S.C. § 18116.

to combat intersectional discrimination, i.e. discrimination that affects people who belong to multiple protected classes, e.g. an older woman of color who is discriminated against on the basis of age, sex, and race.¹¹

Who is subject to Section 1557's prohibition?

The anti-discrimination mandate of Section 1557 applies to all health programs and activities, any part of which receives Federal financial assistance.¹² It also applies to all federal agencies established under Title 42 of the U.S. Code, including HHS and the Social Security Administration (SSA).

In addition, for purposes of Section 1557, a health program or activity is defined as the provision or administration of health-related services, health-related insurance coverage, or other health-related coverage, and the provision of assistance to individuals in obtaining health services or coverage. Many health providers—assuming they receive Federal financial assistance—who interact with older adults would likely be subject to Section 1557, including pharmacies, skilled nursing facilities, durable medical equipment vendors, non-emergency medical transportation (NEMT) companies, behavioral health providers, and many more.

Many of the programs and activities that interface with low-income seniors are covered entities under Section 1557, including:

- HHS, including the Centers for Medicare and Medicaid Services (CMS), and the Medicare-Medicaid Coordination Office (MMCO);
- Health programs and activities administered by HHS;
- Federal marketplaces and state-based marketplaces;
- Medicare Advantage Plans, Medicare Part D Plans, and Dual Eligible Demonstration Plans; and
- State Medicaid programs, and State Medicaid Managed Care Plans.

The final regulations to Section 1557 make clear that HHS has retained the “carve out” for Medicare Part B providers, meaning that physicians receiving *only* Medicare Part B payments are not covered under Section 1557. For a more extensive discussion on the Part B exclusion and advocacy opportunities, please refer to the enforcement section.

A Special Note about Contractors

The rule clarifies the distinction between covered entities that receive federal funds and contractors that deliver services on behalf of those covered entities. Contractors, if they receive no other federal financial assistance from other sources, do not have direct liability under Section 1557. The covered entity, however, is liable if its contractor fails to comply with Section 1557 requirements.¹³ Importantly, the final rule prohibits covered entities from contracting away their Section 1557 non-discrimination obligations.

¹¹ 81 Fed. Reg. at 31405.

¹² Federal financial assistance is defined as any grant, loan, credit, subsidy or contract, or any other arrangement by which the Federal government provides or otherwise makes available assistance in the form of funds; services of Federal personnel; or real or personal property or any interest in or use of such property, including tax credits and other subsidies under Title I of the Affordable Care Act. 45 C.F.R. § 92.4.

¹³ 81 Fed. Reg. at 31383-84.

Example: Smiling Day Adult Day Health Center is contracted with the State Medicaid Managed Care plan to provide adult day services to low-income older adults. Smiling Day, if it does not receive other Federal financial assistance, is not directly liable under Section 1557 by virtue of the contract with the Medicaid plan; however, the plan is still responsible for ensuring that its contractors, including Smiling Day, comply with its nondiscrimination obligations. If Smiling Day engages in discriminatory conduct toward a protected class, then the managed care plan will be liable.

Discrimination Based on Sex

Section 1557 newly applies Title IX protections, designed originally around sex discrimination in education, to health care settings. The HHS regulations also break new ground by specifically addressing issues of gender identity, both in the regulations themselves and in the accompanying commentary. The December 31, 2016 federal preliminary injunction arises out of a case challenging the application of Title IX to gender identity.¹⁴ The injunction, which continues until that case is heard and an opinion issued, prohibits HHS from enforcing the regulations that prohibit discrimination based on gender identity or termination of pregnancy. However, the injunction only applies to HHS and those particular provisions. It does not prohibit private enforcement of Section 1557 regulations, or the underlying protections against discrimination based on Title VI of the Civil Rights Act.

Defining discrimination “on the basis of sex”

In discussing discrimination on the basis of sex, HHS emphasized that such discrimination encompasses:

- Discrimination based on pregnancy, false pregnancy, termination of pregnancy or recovery therefrom, childbirth or related medical conditions.¹⁵
- Discrimination based on gender identity, which includes gender expression. Gender identity is defined as an individual’s “internal sense of gender, which may be different from an individual’s sex assigned at birth and which may be male, female, neither, or a combination of male and female.”¹⁶
- Discrimination based on sex stereotyping.¹⁷
- Intersectional discrimination. For example, discrimination that is based on both an individual’s gender and also on language or national origin.¹⁸

HHS, based on its review of court decisions, declined to explicitly include discrimination based on sexual preference as a basis for a 1557 violation. The agency noted, however, that discrimination based on sex or gender stereotyping in many cases overlaps with sexual orientation discrimination.¹⁹

Discriminatory behaviors

The commentary provides guidance on some behaviors that would constitute sex discrimination.

¹⁴ *Franciscan Alliance*, supra note 5.

¹⁵ 45 C.F.R. § 92.4.

¹⁶ 45 C.F.R. § 92.4.

¹⁷ 45 C.F.R. § 92.4.

¹⁸ 81 Fed. Reg. at 31405.

¹⁹ 81 Fed. Reg. at 31389-90.

- Covered entities must treat individuals consistent with their gender identity.²⁰ A persistent and intentional refusal to use a transgender individual’s preferred name and pronoun and insistence on using those corresponding to the individual’s sex assigned at birth constitute illegal sex discrimination if such conduct is sufficiently serious to create a hostile environment.²¹ This is the portion of the regulation that the December 31, 2016 injunction addresses.²²
- Using derogatory language because an individual is unmarried, sexually active, or pregnant if the conduct creates a hostile environment.²³

Health Providers Must Respect an Individual’s Gender Identity

Mr. Ramsey, a transgender man and a Medicare beneficiary, is recovering from a badly broken hip in a skilled nursing facility near his home. Though Mr. Ramsey has made his gender identity clear, the staff insists on treating him as a woman. They address him using an earlier name that is still found on some of his medical files and frequently make derogatory comments about how he acts and dresses. Mr. Ramsey has complained to the management, but problems continue.

The staff’s actions are creating a hostile environment, violating Mr. Ramsey’s rights to protection from discrimination on the basis of sex. Mr. Ramsey has multiple ways to enforce these rights, including a private right of action.

Discriminatory coverage

For LGBT Medicare and Medicaid beneficiaries, perhaps the most important part of the 1557 regulations and commentary is the discussion of coverage for transgender health services.

The regulations provide that a covered entity may not deny or limit services ordinarily available to one sex to a transgender individual whose gender is recorded differently.²⁴ Further, an insurer may not impose additional cost sharing or other limitations or restrictions due to the fact that sex assigned at birth and gender identity are different. For example, a Medicare Advantage plan may not deny coverage of a medically appropriate pelvic examination to a transgender man solely because his gender identification is male. Plans may flag certain procedures or prescription drugs based on their appropriateness for one sex but may not do so in a way that would require a transgender person to repeatedly appeal a denial.²⁵

Most significantly, covered entities also may not limit or deny coverage for specific health services related to gender transition if such denial results in discrimination.²⁶ For example, if an insurer—such as a state Medicaid program—covers medically necessary hysterectomies, but does not cover hysterectomies when medically necessary to treat gender dysphoria, HHS will carefully scrutinize the policy to determine if it is discriminatory.

²⁰ 45 C.F.R. § 92.206.

²¹ 81 Fed. Reg. at 31406.

²² *Franciscan Alliance*, supra note 5.

²³ *Id.*

²⁴ 45 C.F.R. § 92.206.

²⁵ 81 Fed. Reg. at 31436.

²⁶ 45 C.F.R. § 92.207(b)(5).

Medicare and Medicaid—Big Changes in Coverage of Transition Services

Starting in 2013, the Medicare program began covering transition surgeries, with determination of medical necessity on a case-by-case basis. There have been access problems as CMS and Medicare Advantage plans develop appropriate protocols, but some beneficiaries are getting needed services. Currently the majority of state Medicaid programs do not cover transition surgeries and other transition treatments.^A

Section 1557 has the potential to promote expansion in Medicaid coverage of transgender health either through voluntary changes by the states or by actions to enforce the statute and regulations. Such actions do not require federal government enforcement, as they can be brought by individuals.

A The National Center for Transgender Equality maintains a map showing which states provide coverage, available at: <http://www.transequality.org/issues/resources/map-state-health-insurance-rules>. Many have absolute bars to coverage of any transition services.

Discrimination Based on National Origin

The Section 1557 regulations are particularly extensive on national origin discrimination, with a detailed discussion of translation and interpretation standards for serving individuals with limited English proficiency (LEP).

Defining national origin discrimination

The regulations define “national origin” broadly: “The term ‘national origin’ includes, but is not limited to, an individual’s, or his or her ancestor’s, place of origin (such as a country), or physical, cultural, or linguistic characteristics of a national origin group.”²⁷

It is established law that national origin discrimination encompasses denial of language access.²⁸ Further, discrimination based on national origin, like discrimination against other protected classes, also includes such practices as giving preferential treatment based on national origin, slurs and other actions that create a hostile environment.

Providing language access for limited-English proficient (LEP) individuals

The regulations require that “[a] covered entity shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs or activities.”²⁹ Because the regulations cover a wide range of entities, HHS decided that bright line tests for what constitutes “meaningful access” would be inappropriate. Instead the regulations give “substantial weight” to “the nature and importance of the health program or activity and the particular communication at issue” to the LEP individual. Other relevant factors may be taken into account, but the only other factor specifically mentioned in the regulations is whether the covered entity has an appropriate language access plan in place.³⁰

²⁷ 45 C.F.R. § 92.4.

²⁸ *Lau*, supra note 9.

²⁹ 45 C.F.R. § 92.201(a).

³⁰ 45 C.F.R. § 92.201(b).

Interpreters

Interpreter services must be provided “when oral interpretation is a reasonable step to provide meaningful access for that individual.”³¹ Interpreter service must be offered without charge, must be timely, and must be provided by either “qualified” bilingual staff or a “qualified” interpreter. It is not permitted to use a staff member who is less than fully proficient in both English and the relevant non-English language. The staff member also must have a demonstrated proficiency in necessary specialized vocabulary, terminology, and phraseology.³² Qualified interpreters, in addition to meeting these requirements, also must adhere to generally accepted interpreter principles including client confidentiality.³³ Interpreter services may be offered either in person or remotely (language lines, video interpretation), but if video or audio is used, transmission must be clear, without lags, blurring, or audio interference.

Covered entities may not require individuals to provide their own interpreters. An accompanying adult friend or family member may be used only in emergencies or when the LEP individual specifically requests it and the accompanying adult agrees, and then only when reliance on the accompanying adult is “appropriate.”³⁴ Accompanying minor children may never be used as interpreters except in an emergency.³⁵

Example: Mrs. Lopez is worried about the sudden onset of almost constant pain in her stomach. She calls the office of Dr. Smith, her primary care doctor and an in-network provider in ABC Medicare Advantage plan, requesting an urgent appointment. The doctor’s office usually uses a bilingual nurse to interpret when Mrs. Lopez comes in for an appointment but the nurse is on vacation and won’t be back for two weeks. Mrs. Lopez is told that she will either have to wait until the nurse returns or bring her own interpreter.

Dr. Smith’s office violated Section 1557 because it did not offer Mrs. Lopez timely, free interpreter service. The office treated her differently from other patients because of her language access needs. Further, the office should not have suggested—much less required—that Mrs. Lopez bring her own interpreter.

Translations

The regulations set out no bright line for when translations are required, preferring instead a “contextualized approach.”³⁶ In commentary, however, HHS specifically addresses translation issues for long and complex documents. The agency notes that a written translation may be necessary “so the individual can refer back to or study it at a later time.”³⁷ But the agency opines that in some other cases, an oral summary of the document by a qualified interpreter might be sufficient to provide meaningful access. Length and complexity of a document are not the only factors to be considered when deciding what type of language assistance is appropriate. Other factors include: the prevalence of the language in the area served, the frequency with which the entity encounters the language, whether the entity has explored the individual’s communication preferences, and the cost of the assistance.³⁸

31 45 C.F.R. § 92.201(d)(1).

32 45 C.F.R. § 92.4.

33 45 C.F.R. § 92.4.

34 45 C.F.R. § 902.201(e)(2).

35 45 C.F.R. § 902.201(e)(3).

36 81 Fed. Reg. at 31420.

37 81 Fed. Reg. at 31416.

38 *Id.*

Example: Mr. Ng, a frail 89 year old with many chronic conditions, has difficulty staying safely at home without assistance. He understands only a little spoken English, but reads Vietnamese. After an assessment, his state Medicaid agency denied Mr. Ng’s request for daily home aides, saying he only qualified for one hour of assistance three days a week. The four-page denial letter, which included the basis for the state’s decision and directions on how to appeal, was written in English, though Mr. Ng could ask for an interpreter to summarize its content.

Ms. Jones, Mr. Ng’s legal aid lawyer, argues that this is insufficient language assistance. Instead, the state should have translated this complex document into Vietnamese. The case-by-case approach of the rule, however, means that the guidance is not clear cut.

Notices of rights and taglines

Covered entities must include notices of individual rights and multi-language taglines with every “significant” document or communication. In its commentary, HHS stressed that the definition of “significant” is broad. Significant documents include documents intended for the public such as outreach, education, and marketing materials; written notices requiring a response from an individual; as well as written notices to an individual such as those pertaining to rights or benefits.³⁹

The notices and taglines also must be posted in a conspicuous location on the entity’s website and on the wall of public areas operated by the entity.⁴⁰ HHS created a model notice but entities are permitted to modify the model and/or to combine the statement with others that may be required under different regulations.⁴¹

The taglines tell consumers about the availability of free language services and must appear in the top 15 languages spoken in the state where the entity operates.⁴² National entities can use the top 15 languages nationally. Though entities have the option of using their own wording, HHS created a model tagline and translated it into 64 languages. The model says: **ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call [1-xxx-xxx-xxxx] (TTY 1-xxx-xxx-xxxx).**

For small size mailings, an abbreviated non-discrimination notice can be used and it is permitted to limit taglines to only two languages.⁴³

Example: Ms. Chen speaks Mandarin Chinese, one of the top 15 languages in her state and in the United States. She is a dual eligible receiving both Medicare and Medicaid benefits. All notices about her benefits that she receives from her Medicare Part D plan, from Medicare and from her state Medicaid program should include an insert with taglines, including a Mandarin tagline, reminding her that interpreters are available to help her understand the document sent to her. Taglines also should be posted at her pharmacy, at the hospital and at the clinics, labs, and provider offices that she visits.⁴⁴

³⁹ 81 Fed. Reg. at 31402.

⁴⁰ 45 C.F.R. § 92.8.

⁴¹ 45 C.F.R. Appendix A to Part 92.

⁴² 45 C.F.R. § 92.8(d)(1).

⁴³ 45 C.F.R. § 92.8(d)(2).

⁴⁴ Although OCR asserts that Part B providers who receive no other federal funding are not covered by Section 1557, OCR also estimates that almost all practicing physicians in the United States are reached by Section 1557. 81 Fed. Reg. at 31446.

Discrimination Based on Race and Age

The regulations say nothing specific about discrimination based on race, relying instead on existing guidance and court rulings on the topic.⁴⁵ Race discrimination, however, is very much a part of Section 1557 protections.

Statistics can be a powerful tool to support a claim of race discrimination. If, for example, statistics show that a transportation provider routinely is late more often and misses appointments for black consumers compared to white consumers, those numbers could offer powerful evidence of race discrimination actionable under Section 1557.

Moreover, because Section 1557 incorporates laws addressing discrimination against a number of protected classes, the statute offers opportunities to address intersectional discrimination, that is, discrimination on the basis of race and national origin or discrimination on the basis of race and sex.

As with race discrimination, the regulations say little with respect to age discrimination. They do, however, specifically incorporate the exemption in the Age Act for any age distinctions in programs that are part of a federal, state or local statute or ordinance adopted by a legislative body.⁴⁶ Thus, for example, the age restrictions for Medicare eligibility are exempt from coverage by Section 1557, as are age limitations for state Medicaid programs pursuant to state or federal law. In contrast, age limitations imposed solely by regulatory agencies, without accompanying statutory authority, would be subject to scrutiny under the regulations.

Arbitrary Cut-Offs or Medically Justified?

There is potential for age discrimination in many different areas. Age cut-off for transplants or for gender reassignment surgery; a failure to provide the same coverage for psychiatric services to older adults as to younger adults; or home care assessments that disproportionately exclude older adults by ignoring IADL needs are just a few examples. Medical justifications, if offered, can be scrutinized, looking at whether they are solid or a pretext for discrimination.

Discrimination Based on Disability

The regulations on disability-based discrimination require that covered entities take appropriate steps to ensure that communications with individuals with disabilities are as effective as communications with others in health programs and activities. Entities also must provide appropriate auxiliary aids and services for persons with impaired sensory, manual or speaking skills.⁴⁷ The requirement to provide auxiliary aids and services applies to all covered entities, regardless of size or number of employees.⁴⁸ The regulations also require that buildings meet certain accessibility requirements if construction or modification is commenced on or after July 18, 2016.⁴⁹ Further, the regulations require that covered entities make reasonable modifications to policies, practices and procedures when necessary to avoid discrimination on the basis of disability. HHS adopts the standards of the Americans with Disability Act to determine reasonableness.⁵⁰

⁴⁵ 81 Fed. Reg. at 31387.

⁴⁶ 45 C.F.R. § 92.2(b)(1). See also the HHS discussion available at <http://www.hhs.gov/civil-rights/for-individuals/age-discrimination/index.html>.

⁴⁷ 45 C.F.R. § 92.202.

⁴⁸ 81 Fed. Reg. at 31407.

⁴⁹ 45 C.F.R. § 92.203.

⁵⁰ 45 C.F.R. § 92.205.

Electronic communications must also be accessible, although there is a financial hardship exception.⁵¹

Perhaps as important as the regulations themselves is the commentary in which HHS takes the position that Section 1557 encompasses a ban on the unnecessary segregation of individuals with disabilities, and thus is another statutory basis for *Olmstead* claims.⁵²

How is Section 1557 Enforced?

Enforcement mechanisms

Individuals and their advocates have multiple ways of enforcing the non-discrimination provisions of Section 1557.

- **Complain to the entity involved, using established grievance procedures.** If the individual is a member of a managed care plan and either the plan or its contractors engaged in the prohibited conduct, file a complaint with the plan itself. All covered entities are responsible for adopting appropriate grievance procedures for dealing with Section 1557 complaints.⁵³
- **File an administrative complaint with the Office of Civil Rights at HHS.**⁵⁴ If OCR finds a covered entity is noncompliant, HHS can issue a corrective action plan (CAP) that allows the covered entity to work toward compliance. Further noncompliance can result in loss of Federal financial assistance, and/or a referral to the U.S. Department of Justice with a recommendation to bring enforcement proceedings against the entity.
- **File an enforcement action in federal district court against the covered entity for failing to comply with Section 1557's mandate.** Individuals need not raise their discrimination claims through the administrative complaint process prior to filing a lawsuit, except for age discrimination claims.⁵⁵ Compensatory damages are available under Section 1557 in either appropriate administrative and judicial actions brought under the rule.⁵⁶ Judicial enforcement actions can be brought under a private right of action and a disparate impact theory of discrimination, even where this avenue might not have been available in the corresponding civil rights statute.⁵⁷ For example, courts have held a private right of action does not exist in the Title VI context to enforce language access claims based on a disparate impact theory of discrimination;⁵⁸ such a bar does not exist when raising a language access claim under Section 1557.

There is no requirement to exhaust internal grievance processes before filing an OCR complaint and no requirement to file with OCR before going directly to federal court.

⁵¹ 45 C.F.R. § 92.204.

⁵² *Olmstead v. L.C.*, 527 U.S. 581 (1999). In *Olmstead* and subsequent cases, courts have found that Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 require provision of services to individuals with disabilities in the most integrated setting appropriate to their needs. For more discussion of the importance of *Olmstead* to the aging community, see Justice in Aging's issue brief, ADA at 25, Aging Advocates Celebrate Partnership and Programs, available at http://justiceinaging.org/wp-content/uploads/2015/06/ADA-at-25_Aging-Advocates-Celebrate-Partnership-and-Progress.pdf.

⁵³ 45 C.F.R. § 92.7.

⁵⁴ For more information on the administrative complaint process or to file one with OCR, see <http://www.hhs.gov/civil-rights/filing-a-complaint/index.html>.

⁵⁵ 81 Fed. Reg. at 31394, 31441.

⁵⁶ 45 C.F.R. § 92.301.

⁵⁷ 81 Fed. Reg. at 31439-40.

⁵⁸ *Alexander v. Sandoval*, 532 U.S. 275 (2001).

Examples of Cases and Administrative Enforcement Actions Brought Under Section 1557

A number of cases and OCR enforcement actions have already been brought under Section 1557. A few notable examples, many of which are still pending:

- *Rumble v. Fairview Health Services*, 2015 WL 1197415 (D. Minn. 2015): Plaintiff Jake Rumble brought a lawsuit under Section 1557 and state law against a hospital and emergency physician group alleging that he received worse care as a transgender man. *Rumble* is noteworthy because it interprets Section 1557 as creating “a new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of the plaintiff’s protected class status.”⁵⁹ The federal regulations reference this language from *Rumble* when specifying that a private right of action exists under Section 1557.⁶⁰
- *Franciscan Alliance, Inc. v. Burwell*, is a pending case challenging Section 1557 regulations. Eight states and three private healthcare providers sued HHS, alleging that its rule interpreting Section 1557 to include gender identity and termination of pregnancy violated the Religious Freedom Restoration Act and the Administrative Procedure Act, among others.⁶¹ The plaintiffs took specific issue with the rule defining the gender identity spectrum as including an array of possible gender identities beyond male and female. A federal district court in Texas granted plaintiffs’ motion for preliminary injunction, enjoining HHS from enforcing Section 1557’s prohibition of discrimination on the basis of gender identity and termination of pregnancy, until a decision on the merits is made.⁶² Note that the injunction only applies to gender identity and termination of pregnancy, not other protected classes covered under Section 1557. Furthermore, as the injunction applies only to HHS, private plaintiffs can still challenge discrimination on these bases in federal court.
- The Mexican American Legal Defense and Education Fund (MALDEF), along with other civil rights and health consumer organizations, filed an administrative complaint challenging California’s low Medicaid reimbursement rates under Section 1557 and other civil rights statutes.⁶³ Since Latino Californians, when compared to other groups, are over-represented among Medi-Cal enrollees, the state’s low reimbursement rates and long wait times to access services are alleged to discriminate against Latino Medi-Cal beneficiaries on the basis of race and ethnicity.
- The National Health Law Program (NHeLP) and The AIDS Institute filed an administrative complaint alleging that qualified health plans in Florida had placed all HIV/AIDS medications, including generics, on the highest cost-sharing tier, discouraging people with HIV and AIDS from enrolling in their health plans.⁶⁴ This, they claimed, violated Section 1557 and other statutes because the plans were discriminating on the basis of disability.
- In *Robinson v. Dignity Health*, 4:16-CV-03035, filed June 6, 2016, plaintiff Josef Robinson filed

⁵⁹ *Rumble v. Fairview Health Services*, 2015 WL 1197415, at *11 (D. Minn. Mar. 16 2015).

⁶⁰ 81 Fed. Reg. at 31439-40.

⁶¹ *Franciscan Alliance*, supra note 5.

⁶² *Id.*

⁶³ See administrative complaint, filed December 15, 2015, available at: http://www.sciu-uhw.org/wp-content/blogs.dir/166/files/2015/12/CivilRightsComplaint_Text_12.15.15.pdf.

⁶⁴ See complaint, filed May 29, 2014, available at: <http://www.healthlaw.org/component/jfssubmit/showAttachment?tmpl=raw&cid=00Pd000000B9TMYE3>.

a lawsuit in federal district court challenging Dignity Health, a large health plan system, on the grounds that its employee health benefit plan explicitly and categorically excluded care for gender dysphoria, thus discriminating against Robinson and other transgender employees on the basis of sex.⁶⁵ In December 2016, the federal district court granted defendants' motion to stay the action pending the resolution by the United States Supreme Court of *Gloucester County School Board v. GG*, No. 16-273, to see whether the Court's decision would decide the issue of whether Title IX's ban on sex discrimination includes discrimination on the basis of gender identity.⁶⁶

Fixing the Medicare Part B Provider Exclusion

As indicated previously, HHS excludes Medicare Part B providers who receive no other form of Federal financial assistance from the requirements of Section 1557. HHS indicates that because almost all physicians or other outpatient providers who receive Part B payments also receive payments from other HHS programs, very few in practice are excluded from the anti-discrimination mandate.⁶⁷ **In light of the HHS assertion, advocates should assume that all Medicare providers serving their clients are subject to Section 1557 requirements.**

Nevertheless, the ongoing exclusion of Medicare Part B providers from explicit coverage under this important civil rights mandate should end. Justice in Aging and many advocates believe that that HHS interpretation is legally incorrect. HHS itself appears to have left open the possibility of changes but said that the rule "is not the appropriate vehicle to modify the Department's position."⁶⁸ To ensure adequate protections for Medicare beneficiaries, we ask advocates to contact Justice in Aging if they are aware of low-income seniors who have experienced discrimination from their Part B physician.

Conclusion

Section 1557 and its accompanying regulations, as they are applied to the Medicare and Medicaid programs, have the potential to make both programs more accessible to the most vulnerable populations and can be an important tool to address health disparities. Even though HHS priorities may shift in coming months, Section 1557 offers important tools through the private right of action. Understanding Section 1557 and its potential will allow advocates to more effectively combat discrimination in health care and promote health equity.

⁶⁵ *Robinson v. Dignity Health*, 4:16-CV-03035, filed June 6, 2016. Complaint available at: <https://www.aclu.org/legal-document/robinson-v-dignity-health-complaint>.

⁶⁶ See order, filed December 6, 2016, available at: <https://casetext.com/case/robinson-v-dignity-health>.

⁶⁷ 81 Fed. Reg. at 31445-46.

⁶⁸ 81 Fed. Reg. at 31383.