JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

August 13, 2019

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Ave. SW, Washington, DC 20201

Submitted via www.regulations.gov

Re: Nondiscrimination in Health and Health Education Programs and Activities (Section 1557 NPRM), RIN 0945-AA11

Justice in Aging writes to comment on the notice of proposed rulemaking (NPRM) on Section 1557 of the Patient Protection and Affordable Care Act (ACA) issued by the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS). Because of the harmful effects of these proposed changes on low-income older adults, we urge HHS to withdraw this NPRM in its entirety.

The Health Care Rights Law (Section 1557 of the ACA) prohibits discrimination in health care on the basis of race, color, national origin, sex, age, and disability.[1] We strongly oppose the NPRM provisions which seek to either eliminate or limit legal protections for Limited English Proficient (LEP) individuals, LGBTQ persons, persons with disabilities and chronic conditions, and persons needing reproductive health services, as well as individuals whose identities intersect across multiple protected classes.

Justice in Aging uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicaid and Medicare, with a focus on long-term services and supports and the particular needs of those dually eligible for Medicare and Medicaid coverage. Our advocacy focuses on populations of older adults who have historically faced discrimination, including older women, LGBTQ older adults, seniors of color, and LEP seniors. Therefore, ensuring that programs and services are delivered without discrimination based on race, ethnicity, language ability, disability, gender identity, sexual orientation or age is at the heart of our work. We advocate for culturally competent, person-centered care in programs like Medicare and Medicaid to meet the diverse needs of low-income seniors across the country. Every day, we work with a network of advocates and professionals serving low-income seniors who benefit from the non-discrimination protections of Section 1557, so the implementing regulations for the statute are critically important to us, the advocates we support, and ultimately low-income older adults.

Our comments begin with a discussion of the NPRM's language access provisions and provisions that would eliminate or weaken protections contained in the 2016 Nondiscrimination in Health Programs and Activities Final Rule (2016 Final Rule) as they apply to LEP older adults. We then discuss the NPRM's harmful effects on LGBTQ older adults and older adults with disabilities. We also comment on how the proposed rule would limit and weaken the ability of all older adults to fight discrimination in healthcare. The proposed changes eliminate some of the most important and unique protections underlying Section

[1] 42 U.S.C. 18116.

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1557, which was the first and only federal law to incorporate existing civil rights statutes and apply them directly to health programs and activities receiving federal financial assistance. Again, because of the importance of the 2016 Final Rule's protections and the proposed rule's harms to low-income older adults, we urge HHS to withdraw this NPRM in its entirety and retain the 2016 Final Rule. If HHS does finalize any of the proposed revisions, we strongly oppose the proposed incorporation of any changes into regulations implementing the underlying civil rights laws, such as Title VI, Title IX, and Section 504.

I. The Proposed Rule Would Greatly Harm Older Adults Who Are Limited English Proficient

We strongly oppose the proposal to eliminate Section 1557's nondiscrimination notice, taglines – short statements in multiple languages alerting individuals to the availability of language assistance services – and language access plan provisions. As a threshold matter, we are troubled that HHS largely conflates its discussion of taglines with Section 1557's notice requirement. We believe that while both requirements are critical to LEP older adults and others, they have different purposes. We discuss the tagline requirement and the language access plan provisions in this section and then address the proposed elimination of the notice requirement in section IV(a) below.

The taglines and language access plan provisions are key to ensuring the country's more than 10 million seniors over age 60 and other individuals who are LEP can access care and services, receive important healthcare information in a language they understand, and are informed of their rights and how to enforce them.

(a) Low-Income Older Adults Require Robust Language Access Protections

It is especially critical that older adults have robust language access resources and protections from discrimination. Due to their age, physical limitations, and other factors, it is unrealistic to expect many LEP seniors to attain full English proficiency.

Four million Medicare beneficiaries—older adults and people with disabilities—are limited English proficient, and 12% of Medicare beneficiaries living in the community report that English is not their primary language. Reports from the Office of Minority Health estimate that almost 2 million Medicare beneficiaries speak languages other than English or Spanish, including over 200,000 beneficiaries who speak Chinese, over 150,000 who speak Vietnamese, and over 140,000 who speak Tagalog. [2] They live in every part of the country, including California (where 22% of all Medicare beneficiaries are LEP), Hawaii (19%), New York (16%), Texas (13%), New Jersey (12%), Florida (12%), Massachusetts (11%), and more.[3] In all, 1.8 million LEP seniors and people with disabilities are also low-income and rely on the tagline requirements in the 2016 Final Rule to get the information they need across both Medicaid and Medicare.[4]

[2] CMS Office of Minority Health, Understanding Communication and Language Needs of Medicare Beneficiaries, Apr. 2017, available at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf.
[3] *Id*.
[4] Proctor, K., Wilson-Frederick, S. M., & Haffer, S. C., 2018. The Limited English Proficient Population: Describing Medicare, Medicaid, and Dual Beneficiaries. Health Equity, 2(1), 82-89, available at https://www.liebertpub.com/doi/full/10.1089/heq.2017.0036.

In our experience, the language access requirements in Section 1557's implementing rule are critical to LEP older adults getting access to the healthcare they need to stay engaged and healthy, and live with dignity in the community. For an older adult with limited resources, not getting needed care in a language one understands could pose serious and adverse health risks. Most people's health care needs increase and become more complicated as they age, and LEP older adults are no different. Health care information is complex and can only be communicated effectively in an individual's primary language. Furthermore, older adults may be less inclined to ask for language assistance, out of a fear of inconveniencing others, even if the language assistance is necessary for them to truly understand their health care. In this context, affirmative reminders of one's rights through taglines are critical and help to counter the stigma of asking for help. If LEP older adults do not understand a statement they receive and are not told how to get help in their primary language, they may not ask for an interpreter. As a result, they may fail to follow up as necessary or may not appeal a wrongful denial of coverage because they are not adequately informed of their appeal rights. Especially for older adults with limited income and high health care needs, the consequences of an erroneous bill or forgoing care can be catastrophic.

(b) The NPRM Fails to Adequately Account for the Importance of Language Access Protections to LEP Consumers Or to Consider Any Alternatives

In proposing to eliminate the tagline requirements, HHS describes them as not justified by need, overly burdensome, and inconsistent or duplicative with other legal requirements. The agency's reasoning is flawed and not persuasive. The NRPM focuses solely on the burdens that taglines impose on providers and other covered entities and takes, at face value, those entities' accounts of beneficiary need and impact. Congress passed Section 1557, a key civil rights law included within the Affordable Care Act, as a way to protect individuals from discrimination in healthcare. In the NPRM, HHS seems to imply that it must weigh any alleged burdens imposed by taglines against the benefits provided to LEP individuals. First, we note that such a balancing is not required in either Section 1557's statutory language or any other authority. Second, HHS must better consider the benefits provided to affected individuals. HHS rationalizes the elimination by citing data that over three-quarters of the U.S. population 18 years of age and older speak only English at home and concluding that they are not well served by taglines or notices, but in doing so, fails to recognize the fact that a quarter of the U.S. population does not speak English at home is itself a powerful argument for use of taglines. Civil rights laws are meant to protect minorities, and while particular protections may not benefit the majority, their value should not be diminished based on that fact. Though taglines may be directly beneficial primarily for LEP populations, low-income seniors are disproportionately LEP. In 2018, over half of all older adults applying for Supplemental Security Income (SSI) asked to be interviewed in a language other than English.[5] We encourage HHS to not jettison established legal requirements, which have been in place for years helping LEP older adults and others access healthcare, without a searching inquiry into the benefits they provide consumers. HHS's inquiry to date has been inadequate. HHS has not considered the utility of the taglines from any perspective other than covered entities.

The failure to provide adequate language access has a real, well-documented cost to consumers, and policies promoting language access are widely recognized as leading to better care. For example, a study examining individuals receiving palliative care for cancer found that without professional interpreter

[5] Social Security Administration (SSA) Quarterly Data for Spoken Language Preferences, Supplemental Security Income (SSI) Aged Initial Claims, available at https://www.ssa.gov/open/data/LEP-Quarterly-Spoken-Language-SSI-Aged-Applicants.html.

services, individuals did not properly understand their diagnoses and prognoses, experienced more pain and anxiety, and experienced worse quality in their end-of-life care.[6] Another study found poorer health outcomes for LEP Asian American Pacific Islander (AAPI) and Latino older adults and recommended written instructions in native languages as a priority.[7] The proposed changes to eliminate the tagline requirement runs counter to even HHS's own recommendations. The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) through HHS's Office of Minority Health recommends "inform[ing] all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing."[8]

Justifying the proposed elimination of taglines from Section 1557's implementing rule based on the financial burdens on covered entities is misguided because long-term healthcare spending actually decreases when LEP individuals have appropriate language access. For instance, one report found that consistent and convenient access to professional interpreter services in the acute hospital setting was associated with decreased 30-day readmission rates for LEP patients who were 50 years and older.[9] The same report acknowledged the modest costs of professional interpretation but emphasized the estimated hospital expenditure savings due to the decreased readmission rates.

In proposing to eliminate the tagline requirements entirely, the NPRM fails to strike the proper balance and makes a policy decision favoring the interests of covered entities, inadequately considering the interests of those whom the underlying statute was designed to protect. HHS uses reports and evidence provided by those covered entities who arguably are best situated to handle the costs imposed by such requirements – large health insurance companies and provider groups—and does not cite to any reports from smaller covered entities who presumably might have less resources to implement the rule's language access requirements.[10] HHS's proposed changes to the rule go beyond the purported basis for their NPRM. In order to meet the goal of lessening the burdens to covered entities, HHS could propose other reasonable requirements that would better balance the language access interests of beneficiaries and the administrative realities on covered entities. For example, it could have addressed the definition of "significant communications" in response to claims that covered entities did not know what constituted significant communications that triggered the inclusion of taglines, or it could have considered reducing the number of required taglines from 15 to a smaller number. Not only did HHS not propose any alternative to the current tagline requirements, the NPRM does not examine any alternatives or explain why the only option proposed is total elimination.

We also note that in proposing the elimination of the tagline requirements to covered entities, HHS failed to adequately account for the intangible costs of LEP older adults and others of not knowing what their rights are and how to access language assistance services. These costs, while difficult to estimate and enumerate, must be considered because the statute's ultimate aim is to eliminate health disparities and protect against discrimination. The costs of not knowing how to access language assistance services is the cost of eliminating the tagline – and related notice – requirements. We believe such a proposal, if finalized, will only further exacerbate health inequities among LEP older adults.

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[6] https://www.ncbi.nlm.nih.gov/pubmed/26549596

[7] Kim, et. al. Vulnerability of Older Latino and Asian Immigrants with Limited English Proficiency. Journal of the American Geriatrics Society. Vol. 59, No. 7, July 2011.

[8] https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5309198/

[10] 84 Federal Register 27858, 27859.

For these reasons, we believe the NPRM fails to account for the importance of taglines to LEP older adults, and the elimination of the tagline requirement should be withdrawn.

(c) Section 1557's Tagline Requirements Are Not Duplicative of nor in Conflict with Existing Requirements and Guidance

HHS erroneously states that some of the tagline requirements are unnecessary because they are duplicative of existing requirements.[11] The rules governing Medicare Advantage (MA) and Part D (PDP) plans are one example. While it is true that 42 C.F.R. 422.2268 and 423.2268[12] set forth requirements that plans must translate vital materials if a 5% threshold in the plan's service area is met, that requirement pertains only to *translation* and only when the *population threshold* is triggered; it does not include a tagline requirement. In addition to Section 1557, the only Medicare-specific authority requiring taglines existed in the Medicare Marketing and Communications Guidance (MCMG). However, in guidance issued in August 2019 to MA and PDP plans about the MCMG, CMS eliminated the tagline requirement from Appendix 2, described as "Non-English Translations disclaimer," effective for plan year 2020.[13] Simply put, the tagline requirements in the 2016 Final Rule are not duplicative of or in conflict with rules governing MA and PDP documents and communications.

We note that although the MCMG guidance no longer requires taglines beginning plan year 2020, covered entities, including MA and PDP plans, are still subject to the requirements of the 2016 Final Rule and as such must include taglines in all significant communications. This obligation continues until a new NPRM that eliminates the tagline requirements is in effect. In the interim, we encourage HHS to remind MA PDP plans and other covered entities of their obligations under the 2016 Final Rule, including the tagline requirement.

The tagline requirement also is not duplicative or in conflict with rules governing forms for Medicare Savings Programs and Medicaid. Rules governing applications for Medicare Savings Programs like the Qualified Medicare Beneficiary Program and the Specified Low-Income Medicare Beneficiary Program do not include a tagline requirement on those applications, instead only providing a model application that has been translated into ten languages in addition to English. While states must treat a completed model application as a start, it can require additional information from the applicant.[14] HHS correctly notes that Medicaid beneficiaries are required to be notified of the availability of language services through taglines.[15] But again 1557 is not duplicative, but rather adds specificity in how Medicaid beneficiaries are to be notified and in what languages taglines should be made available. Because of these reasons, HHS is incorrect in its assertion that taglines are duplicative of or in conflict with other Medicare or Medicaid rules.

(d) Language Access Plans Can Better Connect Individuals with Language Access Services and Help Covered Entities Fully Comply with Non-Discrimination Mandates

[11] 84 F.R. 27859.
[12] Note that HHS cited dated regulations in the NPRM as 422.2264(e) and 423.2264(e) have been re-codified in 422.2268(a)(7) and 423.2268(a)(7) respectively.
[13] CMS, Changes to Contract Year 2019 Medicare Communications and Marketing Guidelines, Aug. 6, 2019.
[14] 42 U.S.C. 1396(p)(5)(A).
[15] 42 C.F.R. 435.905(b)(3).

Language access plans are documents that spell out how an entity will provide services to individuals who are non-English speaking or LEP. They are tailored to individual entities but may have common components, like needs assessments, notices, training for staff, evaluations, and more. From CMS's own materials, language access plans are described as helping ensure that an organization provides high-quality and appropriate language services and that its staff are aware of what to do when an LEP individual needs assistance.[16] In this way, language access plans are similar to racial impact assessments or statements that have been largely recognized to assist decision makers in crafting policies that explicitly address inequities and help reduce racial disparities.[17]

In proposing to eliminate the language access plan provisions, HHS notes that the HHS LEP Guidance allowed for recipients of federal financial assistance not to develop a plan if they served very few LEP individuals or had limited resources. HHS appears to find an inconsistency between the 2016 Final Rule and others discussed above, but this is a phantom problem. In fact, in issuing the 2016 Final Rule, HHS indicated that a language access plan was not required but could be useful in determining whether a covered entity was in compliance with Section 1557.[18] Language access plans for LEP individuals were a key component of Executive Order 13166, which required all federal agencies, including HHS, to create LEP plans for how they would provide services for LEP persons to ensure meaningful access.[19] HHS arbitrarily eliminates the 2016 Final Rule's provisions for language access plans without addressing how covered entities are different from agencies who are required to have plans in place. The 2016 Final Rule strikes the right balance in recognizing how effective language access plans can be in promoting compliance while allowing covered entities discretion by not requiring them. Such a balance should be retained.

Because of the profound harmful effects on low-income older adults, we oppose the NPRM's elimination of the taglines requirement and the language access plan provisions in the Section 1557 implementing rule.

II. The Proposed Rule Would Greatly Harm LGBTQ Older Adults

We strongly oppose the proposed rule's elimination of the definitions of sex, gender identity, and references to sex stereotyping. The current regulations make clear that the law's prohibition on discrimination on the basis of sex includes discrimination on the basis of gender identity and sex stereotyping.[20] The rules' protections for transgender older adults include requiring covered entities to treat individuals consistent with their gender identity and prohibiting health plans from denying medically necessary care, such as a prostate exam for a trans woman or a hysterectomy for a trans man.[21]

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[16] CMS Office of Minority Health, Guide to Developing a Language Access Plan, https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan.pdf.
[17] Mauer, Marc. Racial Impact Statements as a Means of Reducing Unwarranted Sentencing Disparities, 5 Ohio St. J. Crim. L. 19 (2007-2008). Race Forward, Racial Equity Impact Assessment, 2009, available at https://www.raceforward.org/sites/default/files/RacialJusticeImpactAssessment_v5.pdf.
[18] 42 C.F.R. 85.12 and 84.22(f).
[19] E.O. 13166, "Improving Access to Services for Persons with Limited English Proficiency," Aug. 11, 2000.
[20] 45 C.F.R. 92.4.
[21] 45 C.F.R. 92.206.

Because Section 1557 is the first to apply Title IX sex discrimination protections to healthcare, how the rule implements the sex discrimination prohibition is paramount. By proposing to eliminate these definitions and provisions providing explicit protections for transgender older adults and other transgender individuals, HHS not only reverses existing regulations but also runs counter to nearly two decades of caselaw that say federal sex discrimination laws protect transgender people.[22]

There is significant evidence that discrimination in health care contributes to health disparities among LGBTQ older adults. For example, they may be denied care or provided inadequate care. Only 16% of surveyed hospitals report having any LGBTQ comprehensive training for their providers,[23] and in one survey, an overwhelming 78% of LGBTQ older adults living in nursing homes, assisted living facilities, and long-term care facilities said "no" or "not sure" in response to the question of whether they felt comfortable being open about their sexual orientation or gender identity to facility staff.[24] Many older adults report having to go back "in the closet" because of stigma and fear when transitioning to a long-term care facility or other institutional setting.[25] These fears and stigmas contribute to overall feelings of dissatisfaction and health disparities that LGBTQ seniors experience, and the rule's protections are necessary because covered entities like hospitals and other providers routinely fall short of culturally competent care for this population.

In addition to this discrimination, LGBTQ older adults experience disproportionate rates of poverty compared to their cis-gendered, heterosexual peers. For example, 21% of LGBTQ adults living alone reported incomes of less than $12,000 a year, compared to 17% of non-LGBTQ adults.[26] Due to intersectional discrimination, women, people of color, and transgender individuals are particularly hard hit. Lesbian couples over 65 have poverty rates twice that of heterosexual married couples over 65, and Latina lesbian couples have poverty rates three times as high as non-Hispanic lesbian couples.[27] The rollback of the gender identity protections will potentially exacerbate senior poverty among LGBTQ older adults and increase health disparities, contrary to one of statute's desired outcomes.

The practical impact cannot be overstated. The proposed changes would sanction discrimination, such as, health insurance companies denying treatment to a transgender older adult because a service they sought did not match their gender identity. It would also allow staff at a Medicaid adult day health center to mis-gender older adults by using improper pronouns and calling them by another name. By eliminating the protections in the existing rule against sex discrimination, seniors will have little recourse when faced with discrimination based on their LGBTQ identity.

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[22] National Center for Transgender Equality, "Federal Case Law on Transgender People and Discrimination," available at https://transequality.org/federal-case-law-on-transgender-people-and-discrimination.
[23] Justice in Aging, LGBT Older Adults in Long-Term Care Facilities: Stories from the Field, updated June 2015, available at https://www.justiceinaging.org/wp-content/uploads/2015/06/Stories-from-the-Field.pdf.
[24] American Journal of Public Health, (Apr. 16, 2015), available at http://ajph.aphapublications.org/doi/10.2105/AJPH.2014.302448.
[25] Anna Gorman, "LGBTQ seniors face discrimination in long-term care," Kaiser Health News, Oct. 18, 2016, available at https://www.pbs.org/newshour/nation/lgbtq-seniors-face-discrimination-long-term-care.
[26] Center for American Progress, Map, et al, Paying an Unfair Price: The Financial Penalty for Being Gay in America, (Sept. 2014; Updated Nov. 2014), available at http://www.lgbtmap.org/file/paying-an-unfair-price-full-report.pdf.
[27] The Williams Institute, Poverty in the Lesbian, Gay, and Bisexual Community, (Mar. 2009), available at http://williamsinstitute.law. ucla.edu/wp-content/uploads/Albelda-Badgett-Schneebaum-Gates-LGB-Poverty-Report-March-2009.pdf.

The NPRM makes a point of discussing the impact of one federal district court's issuance of a preliminary injunction, enjoining HHS from enforcing the sex and pregnancy-related discrimination protections in the rule.[28] The NPRM does not explain why the *Franciscan Alliance* decision alone is adequate grounds for eliminating the gender identity protections in the current rule. The NPRM mentions attempting to avoid future litigation over HHS's Section 1557 regulations as one rationale, but issuing new regulations that are a dramatic departure from existing rules is likely to confuse covered entities and increase potential litigation.[29] We oppose any proposed changes that would curtail the rights of LGBTQ older adults to obtain protection from discrimination on the basis of their sex or gender identity.

Finally, we oppose HHS's attempt to use this rulemaking process to change other, long-standing rules that prohibit discrimination on the basis of gender identity and sexual orientation.[30] These other rules are outside the scope of this proposed rulemaking and furthermore not promulgated by OCR, so they cannot be properly considered at this time.[31] These other rules are critically important for low-income older adults as they prohibit, for example, the Program of All Inclusive Care for the Elderly (PACE) and Medicaid managed care organizations from denying enrollment to LGBTQ older adults on the basis of their gender identity or sexual orientation. It is inappropriate for HHS (OCR) to change these other, long-standing rules without any discussion. Furthermore, HHS has characterized them as "conforming amendments" without offering any legal, policy, or cost-benefit analysis about them and their impacts on various HHS programs.

III. The Proposed Rule Would Harm Older Adults with Disabilities & Chronic Conditions

We oppose HHS's proposal to eliminate provisions in the 2016 Final Rule that prohibit health insurers from using discriminatory benefit design and marketing. Eliminating these provisions will have a harmful effect on older adults with disabilities and chronic conditions. The 2016 Final Rule prohibits health insurance companies from discriminating through marketing practices and benefit design. These protections are especially important for people with disabilities and chronic conditions. However, as discussed below, the proposed rule seeks to exempt most health insurance plans from Section 1557's nondiscrimination protections and also would eliminate the regulation prohibiting discriminatory benefit design and marketing, a protection that exists in the current rule. Together, these changes could lead to health insurers excluding benefits or designing their prescription drug formularies in a way that limits access to medically necessary care for those living with disabilities and other chronic conditions.

Furthermore, nearly half of adults 65 and older have a disability, and nearly eight million Medicare beneficiaries have hearing impairments or deafness, and four million have visual impairments, blindness, or low-vision. HHS's NPRM has other far-reaching consequences for all these older adults with disabilities. For example, the NPRM's removal of the notice requirement informing individuals with disabilities about their rights to auxiliary aids and interpreter services – discussed in greater detail below in section IV(a) – suffers from the same deficiencies as we discussed above with respect to the removal of the tagline requirement for LEP older adults and others.

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[28] See 84 F.R. 27864, discussing *Franciscan Alliance v. Burwell*, et. al, 227 F. Supp. 3d (N.D. Tex. Aug. 23, 2016).
[29] 84 F.R. 27870.
[30] 84 F.R. 27871.
[31] For example, the PACE regulations in question at 42 C.F.R. 460.98(b)(3), 460.11(a) were not promulgated by OCR, and neither were the Medicaid managed care regulations at 42 C.F.R. 438.3(d)(4), 438.206(c)(2), and 440.262.

The proposed rule also changes the definition of auxiliary aids and services, deleting "acquisition or modification of equipment and devices, and other similar services and actions" from the list of examples. Such a proposed change could stoke confusion because it seems to imply that the list is exhaustive. Furthermore, Justice in Aging is opposed to the NPRM's proposal to exempt covered entities with 15 or fewer employees from the requirement to provide effective communication.[32] We concur with HHS's conclusion in 2016 that a standard requirement, regardless of number of employees, would promote "uniformity and consistent administration of law."[33] Any carve-out for smaller covered entities could potentially result in older adults with disabilities, especially those who live in rural communities or other areas where provider networks are already stretched thin, stranded without a provider who is able to communicate with them.

IV. The Proposed Rule Would Harm Older Adults' Meaningful Access to Care and Nondiscrimination Protections

In addition to eliminating protections for LEP older adults, LGBTQ seniors, and seniors with disabilities, the NPRM significantly reduces the scope of entities covered under Section 1557 and the types of discrimination that the regulations can be used to remedy. Further, the NPRM attempts to eliminate a private right of action under the statute. The combined effect of these proposed changes frustrates the purpose of Section 1557 as the premier federal health care rights law and would make it dramatically more difficult for low-income older adults to challenge discrimination.

(a) The Proposed Rule Would Make It Much More Difficult for Older Adults to Know about Their Non-Discrimination Rights

The proposed rule eliminates the requirement that covered entities provide notice of non-discrimination rights. Above, we noted how the elimination of this notice has a particularly detrimental effect on older adults with disabilities because the notice requires specific information about the way they can access auxiliary aids and related services. We also note that many of our concerns regarding the elimination of taglines on significant communications that we raised in I applies with equal force to the elimination of the notice requirement, and therefore we incorporate them here. HHS argues that as a result of the notice, consumers call OCR about plan issues rather than discrimination, but this suggests that the notice could be edited for clarity, not scrapped altogether.[34] We also note that those calls may also demonstrate the language access needs of LEP individuals and their desire for more direction on how to receive it. Additionally, we emphasize that the notice from the 2016 rule benefits *all individuals*, including low-income seniors who are not LEP or do not have disabilities, because it apprises every one of their right to access health care free from discrimination. Specifically, it includes pertinent information about how individuals can file a grievance with a covered entity and how they can file a complaint with OCR.[35]

Because HHS conflates the elimination of the notice requirement with its discussion of taglines, we note here that any claim that the notice requirement in Section 1557 is duplicative of or in conflict with

[32] 84 F.R. 27866.
[33] 81 F.R. 31407.
[34] 84 F.R. 27859, 27860.
[35] Appendix A, "Sample Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Sample Nondiscrimination Statement."

existing rules is even more unpersuasive. The notice requirement in the 2016 Final Rule informs all individuals of their legal rights. Without such notice, older adults of all backgrounds and identities will be less likely to know what to do if they experience discrimination, including filing grievances and complaints. Such a specific notice requirement is not currently mandated by any other authority in health programs and activities receiving federal financial assistance.

(b) The Proposed Rule Grossly Narrows the Scope of Entities Covered under Section 1557

In proposed sections 92.1-92.3, HHS narrows the scope of entities that would be required to comply with Section 1557's mandate. Under current rules, Section 1557 applies to all health programs and activities administered by HHS as well as other federal departments and the entirety of those entities, any part of which receives federal financial assistance. The NPRM would limit application of Section 1557 to only federal health programs and activities administered by an agency established under Title I of the ACA and only to the portion of the covered entity receiving federal financial assistance.

HHS engages in a gross misreading of both Section 1557's plain statutory language and the existing rule to achieve a result that applies Section 1557 solely to programs and activities administered under Title I of the ACA.[36] In doing so, it appears that HHS is attempting to carve out federal agencies, including HHS itself, from the statute's non-discrimination requirements. This interpretation would potentially mean that many of the programs and activities that are tasked with delivering care to low-income older adults, like the Centers for Medicare and Medicaid Services (CMS), would no longer have to comply with Section 1557. This approach flies in the face of Section 1557's statutory language, which explicitly states:

"An individual shall not…be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, *or* under any program or activity that is administered by an *Executive Agency* or any entity established under [Title I]."[37] (emphasis added)

By limiting the statute's application to only programs under Title I, the NPRM engages in a contrived exercise of statutory interpretation that is not supported by the statute's plain language. The NPRM provides little rationale on why such an interpretation is either appropriate or necessary. Congress could not have intended to limit the statute to covered entities under Title I when executive agencies are expressly included in the statute's language. Furthermore, HHS fails to provide any justification in the NPRM for why health programs or activities created under the Affordable Care Act should be subject to a different non-discrimination standard than the agency tasked with administering those programs and activities.

The NPRM goes even further, proposing that only those programs or activities of a covered entity receiving federal financial assistance are to be subject to the non-discrimination protections of Section 1557 and not the entire entity itself, and attempts to limit what counts as federal financial assistance.[38] HHS provides no sufficient rationale for this decision, only indicating that the business of providing

[36] 84 F.R. 27862.
[37] 42 U.S.C. 18116(a).
[38] 84 F.R. 27850 ("Therefore, the Department is now proposing to clarify that health insurance programs administered by entities not principally engaged in providing health care will only be covered by the Rule to the extent those programs (as opposed to those entities) received Federal financial assistance from the Department."); 27860 ("'Federal financial assistance' includes credits, subsidies, or contracts of insurance.").

healthcare is substantially different from the business of providing health insurance coverage. The proposed changes could potentially exempt most health insurance companies' plans, products, and operations from meeting the statute's non-discrimination protections. For example, employer-sponsored insurance and short-term limited duration insurance would no longer be subject to Section 1557. In our experience, particularly given the degree to which managed care companies now routinely provide care for individuals dually eligible for Medicare and Medicaid, the distinction between health care and health insurance is increasingly muddied. Consider, for example, a health insurance company that organizes an enrollment fair in the local community to connect individuals with services and explain their different enrollment options, and one of the vendors is offering free health screenings. Also consider care coordinators who offer some guidance and advice with respect to navigating and accessing healthcare benefits but are employed by the health insurance company. Dual eligibles, due to the fractured nature of health care delivery between Medicare and Medicaid, are widely believed to benefit from the assignment of care coordinators, so HHS's potential exemption of health insurance companies is particularly concerning for this population.

The proposal also creates an environment where programs and activities run by the same company could have different non-discrimination requirements, depending, for example, on whether the specific program or activity receives federal financial assistance. When two separate programs are both run by the same entity, it does not make sense to allow one to discriminate while prohibiting the other simply because the latter is the only recipient of federal financial assistance. This type of granular interpretation, which contradicts the NPRM's purported rationale of creating consistency, is simply not administrable and would ultimately harm consumers.

(c) The Proposed Rule Attempts to Eliminate a Private Right of Action for Discrimination Claims

We oppose the proposed changes in proposed section 92.5 that seeks to severely limit the remedies available to individuals under Section 1557. Section 1557 expressly provides individuals access to any and all of the "enforcement mechanisms provided for and available under" the cited civil rights statutes, regardless of the type of discrimination. The current regulations already have clarified that, for example, victims of disparate impact discrimination under Title VI - incorporated into Section 1557 - have a private right of action to challenge that discrimination in federal district court. We strongly oppose the proposed rule's elimination of provisions recognizing a private right of action for disparate impact discrimination claims.

In proposing such changes, the NPRM focuses to a significant extent on one or two federal district courts opinions that have found that Congress's express incorporation of enforcement mechanisms manifests an intent to import those standards and burdens of proof into a Section 1557 claim, depending on the protected class at issue.[39] In the same discussion, the NPRM glaringly omits any significant discussion of *Rumble v. Fairview Health Servs.*, 2015 WL 1197415, in which a federal district court, faced essentially with the same question as in *Gilead*, decides that Section 1557 created a single standard, regardless of a plaintiff's protected class, therefore allowing disparate impact claims to be heard under the statute. The lack of consideration in the NPRM of *Rumble* is concerning as it appears that HHS is cherry-picking legal justifications to support its proposed changes and failing to adequately consider counter-authorities. The *Rumble* court reached a conclusion at odds with the NPRM: if Section 1557 is read as simply reiterating existing civil rights protections in healthcare programs and activities receiving federal

[39] 84 F.R. 27850, citing *Southeastern Pennsylvania v. Gilead*, 102 F. Supp. 3d 725, 738 (N.D. Ill. 2015).

financial assistance, it does not actually effectuate Congress's intent in passing an additional non-discrimination protection in the Affordable Care Act. If federal civil rights laws already applied to covered entities under the incorporated statutes, Section 1557's mandate becomes superfluous.[40] Rather, HHS should read Section 1557 in such a way as to best effectuate a new non-discrimination provision in healthcare.[41] We also note that both *Rumble* and *Gilead* – despite erroneous dates cited in the NPRM – were decided prior to the issuance of the 2016 Final Rule. Thus, the 2016 rule should be fairly interpreted as having ultimately settled the question of whether such claims under Section 1557 are permissible.[42]

The effects of the proposed change are significant in barring access to courts for many of the country's low-income older adults. For example, if LEP older adults or seniors of color experience discrimination on the basis of their race or ability to speak English, they would be foreclosed from bringing their Section 1557 – and Title VI – disparate impact claims to federal court based on the NPRM's interpretation that only the Title VI underlying enforcement mechanisms prevail and that *Alexander v. Sandoval* has essentially barred a private right of action for disparate impact claims.[43] While those older adults could still file an administrative complaint with OCR, the ability of the office to respond is limited by constrained resources, and even fewer older adults would be made aware of their rights should HHS finalize its proposal to eliminate the notice of non-discrimination requirement as discussed in IV(a). This leaves those older adults with very few avenues of relief. For all these reasons, we oppose the proposed changes regarding enforcement and remedies in the NPRM.

(d) The Proposed Rule Silently Eliminates Claims of Intersectional and Associational Discrimination under Section 1557

The 2016 Final Rule and its preamble expressly allow for claims of intersectional discrimination and associational discrimination as cognizable under the statute.[44] Both are critical to the rights of older adults to receive health care services free from discrimination, yet the NPRM is entirely silent on whether associational and intersectional forms of discrimination are still prohibited should the proposed changes take effect. The silent elimination of cognizing intersectional and associational discrimination is particularly problematic because HHS does not provide any justification for the change from the 2016 Final Rule in the NPRM. We oppose any changes, express or implied, that would limit an older adult's ability to seek relief based on claims of either intersectional or associational discrimination.

Intersectional discrimination occurs when individuals experience discrimination that is particular to the intersection of multiple protected classes or identities. For example, a black woman can be

[40] The notable exception is that sex discrimination under Title IX applied only to the education context.
[41] This approach is in line with canons of statutory interpretation, including the rule against surplusage – that courts should give effect to every clause and word of a statute so that it is not rendered superfluous, void, or significant – as well as the rule of purposive construction – to interpret statutes so as best to carry out their statutory purposes. *See Duncan v. Walker*, 533 U.S. 167, 174 (2001); *Young v. UPS*, 135 S. Ct. 1338, 1352 (2015); Antonin Scalia & Bryan A. Garner, Reading Law: The Interpretation of Legal Texts (2012); William N. Eskridge, Jr., Phillip P. Frickey, Elizabeth Garrett, & James J. Brudney, *Cases and Materials on Legislation and Regulation: Statutes and the Creation of Public Policy*, 2014.
[42] 45 C.F.R. 92.301, 81 F.R. 31440 ("We note as well that both the proposed and final rule specify that a private right of action is available under Section 1557").
[43] *Alexander v. Sandoval*, 532 U.S. 275 (2001).
[44] 81 F.R. 31405, 42 C.F.R. 92.209 (non-discrimination on the basis of association).

discriminated against because she is both black and a woman. Intersectional discrimination occurs among low-income older adults, many of whom hold multiple identities and can experience discrimination at those intersections, like age and gender, race, ethnicity, and disability. The results of intersectional discrimination on disparate health outcomes are well-established. For example, one study that compared functional limitations across intersections of race and gender found that all demographic groups exhibited worse functional imitation trajectories than white men, and specifically that Black and Latino women had the highest disability levels.[45] At the intersection of age and race, it is also well-researched that Black older adults have shorter life expectancies, live a greater proportion of their lives with a disability, and have higher rates of many leading causes of death, like cancer and heart disease, compared to white older adults.[46] For Section 1557 to make important differences in curbing health disparities, it must recognize intersectional discrimination claims.

Similarly, protecting someone's right to be free from associational discrimination is important to older adults. Protection from associational discrimination allows older adults to support others who are in a protected class and to seek redress if they are discriminated against in providing support or receiving healthcare themselves. For example, the 2016 rule makes clear that nursing facilities are prohibited from denying admission to a white older adult whose spouse is black, or that managed care companies cannot exclude a doctor from their network who primarily serves LEP individuals. The right, codified in the current rule at 42 C.F.R. 92.209, has been removed in the proposed rule, and the silence of the NPRM on whether Section 1557 protects against associational discrimination is concerning, allowing the inference that it may be foreclosed. We oppose any attempt to remove or otherwise limit 42 C.F.R. 92.209.

Conclusion

Thank you for the opportunity to comment on the nondiscrimination NPRM. The NPRM would result in harm to many populations of older adults, including LEP seniors, LGBTQ older adults, and seniors with disabilities. The NPRM would exacerbate existing health disparities for these communities. It would also frustrate the ability of all older adults to challenge discrimination they face by reducing the scope of remedies offered under the statute. Because of these harms, we strongly urge HHS to withdraw this NPRM in its entirety. Again, should HHS finalize any of the proposed revisions, we strongly oppose incorporating any changes into regulations implementing the underlying civil rights laws, such as Title VI, Title IX, and Section 504. For questions about our comments, please contact Denny Chan at dchan@justiceinaging.org.

Sincerely,

Jennifer Goldberg
Deputy Director

[45] David Warner and Tyson Brown, Understanding How Race/Ethnicity and Gender Define Age-Trajectories of Disability: An Intersectional Approach, Soc Sci Med, Apr. 2012.
[46] Kenneth Ferraro, Blakelee Kemp, and Monica Williams, Diverse Aging and Health Inequality by Race and Ethnicity, Innovation in Aging, Mar. 2017.