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National Advocates for Asian
American, Native Hawaiian &
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Mr. Roger Severino
Director, Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave. SW, Washington, DC 20201

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

Dear Mr. Severino:

The Asian & Pacific Islander American Health Forum (APIAHF) appreciates the opportunity to provide comments to the Office for Civil Rights (OCR) on the notice of proposed rulemaking (NPRM) to Nondiscrimination in Health and Health Education Program and Activities under Section 1557 of the Affordable Care Act (ACA). APIAHF is the nation's leading health justice organization working to advance the health and well-being of over 23 million Asian Americans, Native Hawaiians, and Pacific Islanders (AA and NHPI) across the U.S. and territories. APIAHF works to improve access to and the quality of care for communities who are predominantly immigrant and many of whom are limited English proficient (LEP). Over 60 percent of Asian Americans and Pacific Islanders are foreign-born and one third are LEP.¹ For 32 years APIAHF has advanced the health and well-being of these communities and other immigrant communities of color, working with over 150 partners in 28 states.

It is for these reasons that APIAHF opposes the proposed changes to Section 1557 in the proposed rule that would limit application of the law to certain covered entities, eliminate protections for LGBTQ+ persons and persons needing reproductive health care, and roll back and eliminate certain language access protections. The NPRM runs counter to the explicit text of Section 1557 and its underlying purpose. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, and disability. As an organization that works to improve the health and wellbeing of minority and marginalized populations, we have direct experience advocating for the rights of persons protected by Section 1557 and an understanding of why the protections are required. Further, the protections of Section 1557 are not merely stand-alone, they address the intersection of the multiple protected classes covered. As such, an attack on the civil rights of one group in the NPRM is an attack on the civil rights of all. The focus of these comments will be on the fact that APIAHF opposes eliminating protections as proposed in the NPRM and urges the Department of Health and Human Services (HHS) to withdraw and not finalize this rule.

¹ Asian American Center for Advancing Justice, *A Community of Contrasts: Asian Americans in the United States: 2011*, Executive Summary (2011), https://www.advancingjustice-la.org/sites/default/files/ENTERED_Community_of_Contrasts_2011.pdf.

Overall, HHS has failed to justify the proposed rule and seeks to impermissibly depart from the statutory text of Section 1557 and the 2016 Final Rule, which was finalized after considerable public comment, including a request for information and one notice of proposed rulemaking. By replacing most of the 2016 Final Rule with unclear regulations, the proposed rule, if finalized, would create confusion and could open the door to illegal discrimination.

I. Proposed Subpart A General Provisions

Proposed § 92.1 Purpose

In contrast to the 2016 Final Rule, the NPRM seeks to narrow the scope of 1557 by removing the terms “any part of which” is receiving federal financial assistance for “any health program or activity.” This runs counter to the Title VI context where, pursuant to HHS 2003 Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (HHS 2003 LEP Guidance), “coverage extends to a recipient’s entire program or activity, i.e., to all parts of a recipient’s operations. This is true even if only one part of the recipient receives the federal assistance.”¹ We therefore oppose this change.

Proposed § 92.2 Nondiscrimination Requirements and Proposed § 92.3 Scope of Application

Similar to the text proposed in 92.1 and 92.3, the NPRM seeks to narrow the scope of Section 1557 by redefining Federal financial assistance. The Final Rule states that Federal financial assistance includes assistance that HHS “does not have primary responsibility for administering,” but merely “plays a role” in providing or administering. This change runs counter to the text and purpose of 1557, which applies to “any health program or activity, any part of which is receiving Federal financial assistance or under any program or activity that is administered by an Executive Agency.”

Overall, we strongly oppose the proposed changes which would substantially reduce the scope of covered entities subject to Section 1557 as compared to the 2016 Final Rule. Specifically, the NPRM would remove application of Section 1557 to any health program or activity administered by the Department other than those established by Title I of ACA and removes reference to programs or activities administered by other executive agencies. This runs counter to the explicit statutory text of Section 1557, which states that an individual may not be subjected to discrimination “under any health program or activity, any part of which is receiving Federal financial assistance or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the ACA.”² By law, all of HHS’s activities must be covered by the nondiscrimination protections.

Further, the NPRM would redefine “health program or activity” in a way that would limit application of Section 1557 for entities that are not “principally engaged in the business of providing health care.” This is in contrast to the 2016 Final Rule, which provided that “for an

¹ 68 FR 47315.

² 42 U.S.C. 18116.

entity principally engaged in providing or administering health services or health insurance coverage or other health coverage, all of its operations are considered part of the health program or activity, except as specifically set forth otherwise in this part.” As such, the NPRM would substantially limit Section 1557, and it would largely no longer apply to health insurance plans outside those offered on the Exchanges or managed through Medicare and Medicaid by redefining “health program or activity” to exclude the provision of health insurance.

Further, if this change were nevertheless implemented, it would have significant consequences, particularly for consumers who purchase short-term limited duration insurance (“STDLI”). If implemented, the proposed rule would generally not apply to STDLI plans because insurers are no longer considered health care entities, and these specific plans do not receive federal financial assistance. Exempting STDLI plans from Section 1557’s protections is not consistent with Congress’s intent to provide broad protection against discrimination in health care and would cause significant distortion to the health care marketplaces. APIAHF previously expressed concerns about these plans when HHS accepted public comments in 2018, and exempting them from nondiscrimination protections serves to exacerbate the potential harm to consumers.

We oppose eliminating the current regulation defining Federal financial assistance because HHS’ selective interpretation that Federal financial assistance applies narrowly under Section 1557 is incorrect.

Moreover, if the NPRM were implemented, it would lead to a situation whereby recipients of federal funds would be subject to Section 1557, but the programs themselves, and the agencies administering them, would be exempt. For example, under HHS’s new interpretation, state Medicaid programs would be subject to Section 1557 as recipients of federal funding, but the Centers for Medicare & Medicaid Services, which administers these programs, would be exempt. Such an interpretation is not only inconsistent with the plain meaning of Section 1557, but it is also inconsistent with Section 504 of the Rehabilitation Act and therefore likely to cause significant confusion. HHS and all its components, including CMS, HRSA, CDC, and SAMHSA, are subject to Section 504’s prohibition on discrimination.³

We strongly urge HHS to retain the current regulations addressing the applicability of Section 1557 and not finalize the proposed 45 C.F.R. § 92.3.

Proposed § 92.4 Assurances

We support retaining the assurances provisions contained under the current 92.5, including the requirement for covered entities to submit an assurance of compliance.

Proposed § 92.5 Enforcement

We oppose the proposed changes to § 92.301 as newly designated § 92.5. OCR incorrectly limits the remedies available under Section 1557, in part by referencing the regulations implementing the cited statutes. One of the goals of Section 1557 was to build and expand on prior civil rights laws such that individuals seeking to enforce their rights would have access to the full range of

³ 29 U.S.C. § 794; 45 C.F.R. Part 85.

available civil rights remedies and not be limited to only the remedies provided to a particular protected group under prior civil rights laws. This is why 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 proposed language is not a valid interpretation of Section 1557. While the statute expressly sets out the grounds for discrimination by reference to the cited civil rights statutes, it does not set forth separate remedies, legal standards, and burdens of proof applicable to each prohibited basis of discrimination based on the statutes from which each was incorporated.⁴ To the contrary, Congress specified that “[t]he enforcement mechanisms provided for and available under such title VI, title IX, section 504, *or* such Age Discrimination Act shall apply for purposes of violations of this subsection.”⁵ The use of the disjunctive “or” indicates that any of the enforcement mechanisms applicable under any of the incorporated statutes are available to every claim of discrimination under Section 1557, regardless of the particular type of discrimination triggering the claim. Applying standard rules of construction, all the enforcement mechanisms provided for and available under each of the referenced statutes in Section 1557 are available to every claim of discrimination under Section 1557.

It is also necessary to read Section 1557 as establishing a single standard for addressing health care discrimination to avoid “patently absurd consequences.”⁶ HHS’s reading of Section 1557 in this proposed section “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.”⁷ Moreover, courts would be left without guidance on how to address intersectional claims—should a person who alleges discrimination on the basis of both race and age be subject to the standards and enforcement mechanisms under a title IX analysis or the Age Discrimination Act? Section 1557 recognizes the reality that discrimination “may occur not solely because of the person’s race or not solely because of the person’s sexual orientation or gender identity, [disability status, or national origin], but because of the combination.”⁸ Thus, the law aimed to make it easier for people to file complaints of intersectional discrimination in one place. The proposed rule will only make it harder for people to file complaints. Congress explicitly adopted one provision to prohibit all discrimination in health care. It strains the imagination to read that one provision would require agencies and courts to apply a hodgepodge of standards and enforcement mechanisms.

Further, the proposed changes to the regulation do not comport with congressional intent. Congress did not intend that the enforcement mechanisms and standards available under Section 1557 be tethered to the nature of the claim. Rather, in enacting Section 1557, Congress sought to

⁴ See Sarah G. Steege, *Finding A Cure in the Courts: A Private Right of Action for Disparate Impact in Health Care*, 16 MICH. J. RACE & L. 439, 462 (2011) (“[T]here is no indication in § 1557 that each listed statute’s enforcement mechanisms apply only to its own protected classes.”).

⁵ 42 U.S.C. § 18116(a) (emphasis added).

⁶ *United States v. Brown*, 333 U.S. 18, 27 (1948).

⁷ See *Rumble*, 2015 WL 1197415, at *11.

⁸ Brief for National LGBTQ Task Force as Amici Curiae Supporting Respondents, *Masterpiece Cakeshop v. Col. C.R. Comm’n*, 137 S.Ct. 2290 (2017), <http://www.thetaskforce.org/wp-content/uploads/2017/10/16-111-bsac-LGBTQ-Task-Force.pdf>.

“create a new right and remedy in a new context without altering existing laws.”⁹ Congress has repeatedly expressed that it intends civil rights laws to be broadly interpreted in order to effectuate their remedial purposes.¹⁰ By narrowly limiting the legal standards and burdens of proof that apply to those who have experienced health care discrimination, HHS’s interpretation in the proposed rule would ignore Congress’s intent to provide broad remedies to address discrimination. HHS should not finalize the proposed language in § 92.5.

Proposed § 92.6 Relationship to Other Laws

HHS proposes to re-designate and combine current § 92.2 and § 92.3 into a new § 92.6, titled “Relationship to Other Laws.” These changes are unnecessary, and the proposed revisions conflict with the statutory language and congressional intent.

HHS proposes to substantially amend current § 92.2 and re-designate the amended language as § 92.6(b). We oppose this change. Nothing in the legislative history or language of the regulation itself permits exceptions to Section 1557’s prohibition on discrimination. Moreover, existing statutes that allow individuals and entities to refuse to provide certain services are more than sufficient to accommodate any religious objections. HHS’s attempt to import some of these statutes into Section 1557 by regulation goes too far. The proposed new language is inconsistent with the statutory text of Section 1557, conflicts with the purpose of the ACA, and will cause confusion among entities.

Neither statutory nor legislative history supports adding exemptions to Section 1557, and the only exceptions to Section 1557’s broad nondiscrimination mandate are specifically and explicitly contained in Title I of the ACA, including §§ 1553 and 1303.¹¹ Because the exemptions contained in those two provisions are already explicit, there is no need to incorporate them into this regulation.

In addition, while Title VI, Title VII, Title IX, the Age Discrimination Act, and Section 504 of the Rehabilitation Act are referenced in Section 1557, the plain language of the statute does not incorporate any exemptions contained in those statutes. Thus, this regulation goes too far in attempting to import exemptions from these statutes into Section 1557.

HHS considered in its 2016 Final Rule a blanket religious exemption, and determined such an exemption is not needed. In its assessment, HHS concluded that application of Section 1557 would not be required of federally funded programs and entities if doing so would violate existing religious freedom and conscience protections.

The proposed regulation may affect overall access to care for women and others. Because the proposed regulation incorporates Title IX’s religious exemption, a religious provider could say

⁹ *Rumble v. Fairview Health Servs.*, No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at *11 n.6 (D. Minn. Mar. 16, 2015).

¹⁰ See *Kang v. U. Lim Am., Inc.*, 296 F.3d 810, 816 (9th Cir. 2002); see also H. Rep. No. 102–40(I), at 88, U.S. Code Cong. & Admin. News at 626 (stating that “remedial statutes, such as civil rights law[s], are to be broadly construed”).

¹¹ See 42 U.S.C. § 18116(a).

that they do not have to comply with sex discrimination protections. Allowing a religious exemption to Section 1557's protection against sex discrimination could have far-reaching consequences. Incorporating Title IX's religious exemption could create new instances in which health care providers and entities could allow their beliefs to determine patient care and open the door to discrimination. If implemented, this could allow religiously-affiliated hospitals and other health care entities to discriminate against people seeking reproductive health services and LGBTQ+ people. Providers, hospitals, or clinics could also be permitted to refuse to provide health services to a woman who is not married.

We oppose the inclusion of Title IX exemptions since they do not apply to health care situations and settings.

Finally, HHS lacks the authority to mandate that any requirements of Section 1557 that "violate, depart from, or contradict definitions, exemptions, affirmative rights, or protections" from the laws listed above that pre-date the ACA will not be imposed.

II. Proposed Subpart B Specific Application to Health Programs or Activities

Proposed § 92.101 Meaningful Access for Individuals with Limited English Proficiency

a) Obligations

The proposed 92.101 inappropriately switches the emphasis from "each individual with limited English proficiency" as provided in the 2016 Final Rule to the covered entity's program or activities. In Section 1557, Congress declared "an individual shall not" be subject to discrimination. Section 1557 regulations cannot offer less protection than the statute that authorizes such regulations. Therefore, the correct emphasis must be on each *individual* and not programs. As such, this NPRM would weaken meaningful access, runs counter to Congressional intent and the administrative record supporting the 2016 Final Rule, and we oppose it.

b) Specific Applications

We are concerned about the implications of OCR's proposed re-designation of this section from "Evaluation compliance" in the 2016 Final Rule to "Enforcement discretion," signaling a lack of enforcement by OCR as required by its jurisdiction.

We appreciate the Department's historical emphasis on ensuring meaningful access for LEP individuals as required by Title IV and regulations and consistent with over four decades of U.S. Supreme Court precedent and enforcement by HHS and the U.S. Department of Justice (DOJ). As language access advocates, we have strongly supported Title VI and 2003 HHS LEP Guidance and have provided significant input on how to interpret the 4-factor test to ensure its application results in meaningful access for LEP persons required by Title VI and its regulations. We oppose, however, the codification of the 4-factor test in the Section 1557 regulation for the following reasons.

First, it is already OCR's interpretation that the 2-factor test in the 2016 Final Rule is consistent with Title VI, the only statute in Section 1557 that prohibits national origin discrimination

against LEP individuals.¹² Section 1557 provides that an individual shall not, on the grounds prohibited under Title VI of the Civil Rights Act of 1964 and the other statutes referenced, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity...” The protections in Section 1557 and its regulations cannot be anything less than those already guaranteed by Title VI.

In formulating the 2016 Final Rule, OCR stated “for the most part, because this regulation is consistent with existing standards” and the “final rule, except in the area of sex discrimination, applies pre-existing requirements in Federal civil rights laws to various entities, the great majority of which have been covered by these requirements for years.”¹³ As such, the language access standards finalized in the 2016 Final Rule are well within existing authorities. This interpretation negates the claims made by OCR in the current NPRM that it seeks to align Section 1557 with Title VI, as they are already in alignment.

Second, in providing the 2-factor test based upon, informed by and consistent with Title VI, OCR was providing a method of articulating how it would engage in its enforcement review in the health activities and programs context, a specific application of Title VI and newly created by Section 1557. The 2-factor test incorporates the principles in HHS LEP Guidance and allows OCR to better explain how the factors will be considered in the specific 1557 health activities and programs context, giving substantial weight to the nature and importance of the particular communication at issue.

In putting forth the proposed 2-factor test in the 2015 NPRM and adopting a similar final version in the 2016 Final Rule, OCR considered and reflected on decades of experience applying the 2003 LEP Guidance 4-factor test. For example, OCR identified that some entities mistakenly believed that OCR would *only* consider the factors identified and no others, despite the test being fact-dependent. In addition, advocates noted that there was concern that some entities were using the 4-factor test to relieve themselves of their obligations, going against HHS’s goal of voluntary enforcement. This is why OCR finalized the requirement that the Director “evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue to the individual with limited English proficiency, and requires the Director to take into account all other relevant factors, including whether the entity has developed and implemented an effective language access plan.”¹⁴ If OCR adopts the 4-factor test in the Section 1557 regulation, covered entities may interpret the change, as feared by advocates originally, as a signal that only those factors will be taken into account when the list is not meant to be exhaustive.

This interpretation is consistent with OCR’s statements in the 2015 NPRM that:

Proposed § 92.201, which effectuates Section 1557’s prohibition of national origin discrimination as it affects individuals with limited English proficiency,

¹² See 45 CFR part 92 “...the proposed rule adopted recipients’ existing obligations under Title VI to take reasonable steps to provide meaningful access to individuals with limited English proficiency and codified the standards consistent with long-standing principles from the HHS LEP Guidance regarding the provision of oral interpretation and written translation services.”

¹³ 45 CFR part 92.

¹⁴ 45 CFR part 92.

does not pose any new burden on covered entities. With regard to recipients of Federal financial assistance, the proposed rule adopts recipients' existing obligations under Title VI to take reasonable steps to provide meaningful access to individuals with limited English proficiency and codifies standards consistent with long-standing principles from the HHS LEP Guidance regarding the provision of oral interpretation and written translation services. Because the proposed rule does not impose duties beyond recipients' legal obligations under Title VI, the proposed rule imposes no new burden. Although Title VI does not apply to the Department, Executive Order 13166... has applied to HHS for nearly 15 years... Title VI applies to Title I entities that receive Federal financial assistance, including State-based Marketplaces.¹⁵

Thus, by OCR's own interpretation, entities have been on notice about legal obligations under Title VI for decades; while Title VI did not apply to the Department, Executive Order 13166 has since 2000; and creation of new Title I entities would be covered by Title VI as receiving federal financial assistance. In evaluating comments to the 2015 NPRM and published in the 2016 Final Rule, OCR noted that it "declined to modify the general obligation in 92.201(a) because it reflects familiar and longstanding requirements applicable under Title VI." **That is, it is already the interpretation of OCR that Section 1557 is in alignment with Title VI.** Further, OCR noted in the Final Rule that the factors provided in 92.201(b)(1) "places covered entities on notice about the way in which we will evaluate the Title VI standard within the context of health programs and activities." As such, the current standard is the application of Title VI specifically to the health programs and activities covered by Section 1557.

As noted earlier, we support maintaining all existing provisions in the 2016 Final Rule and agree with the Department to specifically retain § 92.201(c) through (e) and (g) from the current rule.

With respect to the Department's question about the possibility of amending the Department's Title VI regulation, we do not believe this is necessary given the decades the Department and DOJ have interpreted Title VI and *Lau v. Nichols*.

Comments on § 92.101(b)(3)(iii)

We oppose the removal of technical and training requirements for the use of video remote interpreting services for spoken language interpretation. The type of interpretation during a medical visit should depend on the encounter as telephonic communication may be appropriate for scheduling but not for interpretations for trauma, mental health, or death. Non-verbal cues in the medical setting or prescription writing cannot be done via telephone. Further, even with the higher cost in equipment and training, Video remote interpretation has saved costs from in person interpreting as there are no minimums, travel time, or cancellation risks. Keeping the current standard allows providers to determine which technology is appropriate and when an entity uses video, as long as it is high quality and without lagging.

¹⁵ Nondiscrimination in Health Programs and Activities, Notice of Proposed Rulemaking, 45 CFR Part 92, September 8, 2015.

The Proposed Rule Impermissibly Attempts to Eliminate Prohibitions on Discrimination in Insurance Plan Benefit Design and Marketing

Before the ACA, people with serious and/or chronic health conditions were often denied health insurance coverage or paid high prices for substandard plans with coverage exclusions, leaving many people unable to afford the health care they needed. Under the ACA, insurers can no longer charge higher premiums or deny coverage for people with pre-existing conditions. These protections have been lifesaving for many people and particularly communities of color.

Under the 2016 Final Rule, covered entities are prohibited from designing benefits that discourage enrollment by persons with significant health needs. For example, insurers are prohibited from placing all or most prescription drugs used to treat a specific condition, such as HIV prescriptions, on a plan's most expensive tier.¹⁶ Additionally, covered entities are prohibited from using discriminatory marketing practices, such as those “designed to encourage or discourage particular individuals from enrolling in certain health plans.”¹⁷ The proposed rule improperly attempts to eliminate these prohibitions.

The proposed rule will disproportionately impact LGBTQ+ people and people of color who live with disabilities and/or chronic conditions. Due to systemic barriers to health care and the stress of stigma and discrimination, people of color and LGBTQ+ people, and especially gay, bisexual, and queer men of color and transgender women of color, are at a higher risk of developing chronic conditions and have a higher prevalence of disabilities.

III. Current Section 1557 Regulation Provisions Proposed for Repeal or Reconsideration

Overall, we strongly disagree that the nondiscrimination notice, taglines, and language-access plan language in the 2016 Final Rule were not justified by need, were overly burdensome and created inconsistent requirements. In focusing most significantly on the costs and burdens to covered entities and devoting minimal discussion and analysis to the costs to LEP individuals and the organizations that serve them, OCR is not acting consistent with the balancing principles identified by it in 2003 HHS LEP Guidance. That guidance stated: “First we must ensure that federally assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English... Nevertheless, well-substantiated claims of lack of resources to translate all vital documents into dozens of languages do not necessarily relieve the recipient of the obligation to translate those documents into at least several of the more frequently-encountered languages...”

OCR cites two HHS Office of the Inspector General (OIG) reports from 2009 and 2010 to substantiate its claim of voluntary compliance with HHS's LEP 2003 Guidance. OCR further uses the same report to justify claims by Medicare providers and plans about the cost of language services. While cost is a consideration for the type of language services to be provided, as referenced in 2003 HHS LEP Guidance, it is necessarily intertwined with the resources available

¹⁶ MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), <https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/>.

¹⁷ *Id.*

to an entity. Cost is not dispositive, but merely a factor to be considered. In contrast, OCR presents cost as the main factor to settle the issue of compliance. Further, OCR provides no other justification for the high rate of voluntary action other than citing an OIG report pertaining to Medicare that is over 10 years old. Since that time, there are now 25 million people in the U.S. who are LEP, and Section 1557 was newly created by the ACA and applies to entities not in existence at the time of the OIG report. Further, compliance with Title VI and civil rights laws is not voluntary, but required as a condition of receiving Federal financial assistance.

a) Nondiscrimination Notice

We strongly oppose the repeal of the requirement that covered entities provide a notice of nondiscrimination. Currently, all covered entities are required to post a “notice of nondiscrimination” on their websites and in conspicuous locations and in “significant publications and communications.” The notice broadly describes who is protected by Section 1557 (all protected classes) and informs the public of their rights. The notice requirement is consistent with the long history of civil rights regulations requiring posting of notice of rights, including implementing regulations of Title VI, Section 504, Title IX and the Age Discrimination Act that all require that recipients of federal financial assistance notify recipients that they do not discriminate. The 2016 Final Rule created a new obligation to post a 1557 notice of nondiscrimination given the new application of 1557 to health care and sex discrimination. In an effort to harmonize existing notice requirements, OCR developed a sample notice that meets the other statutory requirements under Title VI, Section 504, Title IX and the Age Discrimination Act, thereby lessening the burden on covered entities subject to multiple civil rights laws. At the same time, OCR established flexibility in allowing covered entities to adopt their own notice, at their preference, to best meet their needs. This flexibility should be sufficient in allowing entities to meet their civil rights obligations on their own terms, without compromising their responsibility to ensure individuals are aware of their rights.

Now, OCR is proposing to completely repeal the requirement to post notice, without properly evaluating the implication of this repeal and without proposing any alternative method in which notice is to be provided. While OCR reiterates the important obligations it is under with respect to Title VI numerous times in the NPRM and desire to harmonize Section 1557 to it, repealing the nondiscrimination notice runs entirely counter to HHS LEP Guidance. HHS has previously stated that “Awareness of rights or services is an important part of ‘meaningful access.’ Lack of awareness that a particular program, right or service exists may effectively deny LEP individuals meaningful access.”¹⁸ Similarly, as stated in the 2016 Final Rule:

The posting of a notice of certain important information and the posting of taglines in the top 15 languages spoken by individuals with limited English proficiency nationally are necessary to ensure that individuals are aware of their protections under the law, and are grounded in OCR’s experience that failures of communication based on the absence of auxiliary aids and services and language assistance services raise particularly significant compliance concerns under Section 1557, as well as Section 504 and Title VI.¹⁹

¹⁸ 2003 HHS LEP Guidance 68 FR 47311.

¹⁹ 45 CFR part 92.

Further, a review of voluntary enforcement actions under Title VI taken by OCR over the past 10 years provides evidence that in many cases, voluntary enforcement included the posting of a notice of nondiscrimination.

OCR incorrectly asserts that the nondiscrimination notice is redundant of existing civil rights notices under other statutes. Rather, the notice recognizes the fact that individuals may face multiple forms of discrimination and in fact eliminates duplication by consolidating the underlying statutes' notice requirements into one.²⁰

OCR has provided no explanation for how individuals will know of their rights and how elimination of notices will not deny LEP individuals, LGBTQ+ persons, women, and persons with disabilities meaningful access. Without the notice, members of the public will have limited means of knowing they have the right to file a complaint and how to file such a complaint.

APIAHF has received numerous stories from community-based organizations working to meet the needs of LEP individuals and communities demonstrating not only the lack of knowledge about their civil rights protections, including those guaranteed by Section 1557, but about their rights to Federally-supported health care programs and activities in general. In general, our partners, who generally work with immigrant communities, tell us that notices play an important role in helping establish an understanding among their clients about the U.S. civil rights regime. For example, the following is a story from a community based organization in Mississippi that illustrates the need to educate individuals about their ability to access in-language services.

Mr. Tran has lived in Biloxi, MS with his wife and three children for the past 15 years, working as a deckhand on a shrimping boat. His wife works part time at a local seafood processing center. Neither qualified for employer-sponsored coverage and they were not able to afford coverage on the open market based on their low income. During the past open enrollment period, Mr. Tran came to Boat People SOS Gulf Coast (BPSOS), a community-based organization employing navigators to get people enrolled in coverage. At the time, Mr. Tran had been uninsured for about 6 years. With the help of BPSOS' bilingual navigators, Mr. Tran learned he could enroll in coverage and his children qualified for CHIP. Because he is limited English proficient and speaks Vietnamese, Mr. Tran was completely unaware of his health care rights and options prior to getting help from BPSOS navigators and outreach staff. Now Mr. Tran is able to visit a doctor and have a plan he can afford.²¹

b) Taglines

We strongly oppose the repeal of the tagline requirement as, combined with the elimination of nondiscrimination notice, doing so threatens the civil rights of LEP persons. Currently, covered entities, such as health insurance plans, must also include in-language taglines in the top 15 languages spoken by individuals with LEP in the state or relevant states the entity operates.

²⁰ To reduce the burden on covered entities, OCR developed a model nondiscrimination notice that treats compliance with § 92.8 as satisfying the notice requirements under the regulations implementing Title VI, Section 504, Title IX, and the Age Act.

²¹ Story as collected by BPSOS, a partner of the Asian & Pacific Islander American Health Forum.

The inclusion of taglines is well-supported by long-standing federal and state regulations, guidance, and practice.²² In addition, a number of states have independent tagline requirements to support language access, including California, Colorado, the District of Columbia, Maryland, Nebraska, and Washington.²³ The use of taglines is a cost-effective approach to ensuring that covered entities are not overly burdened while maintaining access for LEP individuals. Thus, taglines are already a compromise to balance costs and benefits on covered entities and to LEP individuals.

According to OCR, “[t]aglines have a high utility as a gateway to language assistance services: They are written in non-English languages that individuals with limited English proficiency can understand, inform those individuals how to access language assistance services, and encourage those individuals to identify themselves and the languages in which they communicate. The Department’s LEP Guidance describes the practice of tagging non-English statements in publications and informational materials.”²⁴

In the absence of fully translated documents, taglines are necessary “to ensure that individuals are aware of their protections under the law, and are grounded in OCR’s experience that failures of communication based on the absence of auxiliary aids and services and language assistance services raise particularly significant compliance concerns under Section 1557, as well as Section 504 and Title VI.”²⁵

As such, we oppose the proposal to eliminate taglines, as doing so raises serious concerns that OCR is failing to enforce Section 1557 with respect to LEP persons and other protected classes. For example, as provided by APIAHF’s partner in Hawaii:

We Are Oceania (WAO), established in 2015 and located in Honolulu, Hawaii, is a community-based organization that serves more than 6000 people per year, or an average of 240 per month. Five out of their seven staff serve on the healthcare team. In addition to English, their bilingual staff speak 3 dialects of Chuukese, Marshallese, Pohnpeian, and Kosraean. WAO established a partnership with an FQHC so that their Certified Application Counselors can do ACA enrollments as well as health literacy training on site, co-locating health education with health care access. Part of WAO’s work is to conduct community outreach around open enrollment dates, eligibility, etc., both in and around Honolulu, but also on Maui, Hawaii and the Big Island.

²² See Title VI Coordination Regulations, 29 C.F.R. § 42.405(d)(1), Marketplace and QHP issuer requirements, 45 C.F.R. § 155.205(c)(2)(iii), Medicaid Managed care plans, 42 C.F.R. § 438.10(d)(3), DOL WIOA Nondiscrimination requirements, 29 C.F.R. § 38.9(g)(3); USDA SNAP Bilingual Requirements, 7 C.F.R. § 272.4(b) and the 2003 HHS LEP Guidance.

²³ Youdelman, Mara, *Summary of State Law Requirements Addressing Language Needs in Health Care*, National Health Law Program, April 2019, <https://9kqpw4dcaw91s37kozms5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/04/Language-Access-NHeLP-50StateSurvey.pdf>.

²⁴ Nondiscrimination in Health Programs and Activities, Notice of Proposed Rulemaking, 45 CFR Part 92, September 8, 2015.

²⁵ *Id.*

More than 90% of WAO's clients speak languages other than English, from Micronesia, or Asian countries. More than 50% of their clients speak and read limited to no English. The majority of WAO's clients don't realize before going through the ACA enrollment process that they are legally entitled to an interpreter. Through the ACA enrollment process, WAO spends considerable staff time informing clients of their right to an interpreter. Clients see this message from WAO staff echoed in taglines on their ACA enrollment paperwork, in their local hospitals and FQHC, and then, finally, often by the provider themselves.

Especially for those who have more recently moved to Hawaii and may be getting health insurance for the first time, it is important to have their right to meaningful language access reiterated at multiple points of connection to the health care system. If clients were not able to be reminded in their language that they have rights to an interpreter, it would put significant strain on We Are Oceania staff. In particular, we estimate that our number of walk-in clients requesting assistance would become burdensome. If clients are reminded that they have the right to interpretation, they are more easily able to advocate for language access themselves in the hospital or doctor's office setting.”²⁶

c) Language Access Plans

While not required by the 2016 Final Rule, OCR proposes to eliminate all references to language access plans. We oppose this change for the following reasons.

First, the inclusion of language access plans in the current rule is voluntary and only a factor to be considered as “appropriate to its particular circumstances.” In the 2016 Final Rule, OCR notes that it is a voluntary planning device and will vary based on the entities’ program, size, location, and other factors. Similarly, as OCR noted in the 2016 Final Rule, language access plans are included as a voluntary component to be considered by the Director because they provide a reminder to covered entities who may wish to take action to provide language access services. There OCR stated: “We reiterate, however, that adoption of a language access plan is a voluntary measure that is not required by the rule.”²⁷

Language access plans are not required by Title VI or its regulations but have long been recognized as a way for a covered entity to ensure it is compliant with Title VI. OCR has required language access plans from covered entities as a key component of Title VI enforcement actions involving LEP individuals since before Executive Order 13166 was issued in 2000.²⁸ Executive Order 13166 also required HHS to create and implement a language access plan for its federally conducted programs and activities. That Executive Order also required HHS to issue Title VI LEP Guidance which provided multiple factors an entity could take into consideration when developing a language access plan. Planning is for the benefit of covered entities as well as for LEP persons. The HHS 2003 LEP Guidance states that written language access plans “may provide additional benefits to a recipient’s managers in the areas of training, administration, planning and budgeting. These benefits may lead recipients to document in a

²⁶ Story provided by We Are Oceania (WAO), a partner of the Asian & Pacific Islander American Health Forum.

²⁷ 45 CFR part 92.

²⁸ See OCR Letter of Finding, Oct. 21, 1999; Alabama DHR, Aug. 28, 2017.

written LEP plan their language assistance services, and how staff and LEP persons can access those services.” As such, repealing the voluntary language removes a tool that HHS has used for enforcement and that covered entities can use to support their compliance efforts. Covered entities may, as a result, fail to fully plan on how to best meet the needs of LEP patients and customers.

Without language access plans to assist providers, stop gap measures will be in place that could cause a disparity in treatment of LEP patients. Language access plans allow staff to recognize protocols for communication that are vital and life-saving. Further, while the Department provides cost saving in removing language access plans as a factor, it does not recognize the potential malpractice costs when health care providers fail to provide meaningful language access.

IV. The Regulatory Impact Analysis Inflates Costs to Covered Entities and Fails to Identify and Quantify Costs to Protected Individuals

The NPRM provides a regulatory impact analysis (RIA) that is wholly insufficient to justify the extensive scope of changes being proposed with respect to language access and that entirely fails to identify and quantify costs to protected individuals. Overall OCR’s estimate of the burden to covered entities for compliance with the nondiscrimination notice and tagline requirements is based on *voluntary* actions and interpretations by covered entities. OCR based the elimination of the notice and taglines on these estimates but did not consider whether alternatives, such as further clarification about the requirements, was warranted in the form of FAQs or other guidance. That is, OCR failed to consider alternatives to a complete repeal of notices and taglines that could have appropriately balanced the need to inform individuals of their rights while recognizing there may be a difference in the 2016 Final Rule and how covered entities have interpreted it.

a) Volume of Mail Estimates Are Based on Voluntary Actions

OCR notes that it did not fully account for the volume of mail inserts for the combined nondiscrimination notice and tagline. The 2016 Final Rule only required that the notices and taglines be included in all “significant publications and communications” (with exceptions for small size publications and communications). The Final Rule did not provide a single definition of “significant” but did provide clarification as to the types of documents that would be considered “significant” and how that standard contrasted with “vital” documents subject to translation requirements for Title VI purposes.

OCR states that many covered entities have “reasonably interpreted” the requirement to provide notice and taglines on “nearly every written communication” provided. Yet this interpretation, which OCR has not validated as correct or incorrect, is *voluntary*. OCR, through a series of Frequently Asked Questions (FAQs) available on its website, has provided clarification on what documents are and are not significant and continued to clarify that covered entities are in the best position to determine, within reason, which of their communications are significant. Here, OCR bases the elimination of the notice and taglines on these estimates but did not consider whether further clarification was warranted in the form of FAQs or other guidance and the impact such clarification would have had on covered entities.

In addition, OCR incorrectly provides as an example to justify the impact, an entity that operates in multiple states having interpreted the Final Rule as requiring them to include taglines in as many as 60 languages. The covered entity's actions are *voluntary* and may be accounted for by 1) misapplication of the 1557 standard by the covered entity and 2) combination of other state and/or federal requirements.

Further, one of the reasons why OCR did not provide an exhaustive and definite standard for the term "significant" was because of the broad nature of Section 1557, particularly compared to the underlying civil rights statutes on which it is based.

b) Majority of the Estimated Cost Claims Pertain to Only a Single Document Type

While we understand that covered entities, including health insurance plans and pharmacy benefit managers, have raised concerns about the scope of documents considered "significant," as provided in the NPRM, most of those concerns have pertained to the provision of a single type of document: the Explanation of Benefits (EOB). OCR did not consider alternatives as to how it would consider enforcement and interpretation of the significant document standard with respect to the provision of multiple EOBs sent during a coverage year.

c) Provision of Taglines Itself is Designed to Avoid Overly Burdensome Translation Requirements

In justifying the elimination of the notices and taglines, OCR references DOJ's 2002 and HHS's 2003 LEP Guidance documents noting they flagged concerns about "unrealistic" interpretations of translating written materials into languages. This is one of the reasons that the HHS LEP Guidance includes a four-factor test which allows an entity to properly evaluate the extent and mix of language access services required and includes a safe-harbor provision that provides guidance on what documents would be subject to translation thresholds.

Further, the adoption of taglines was carefully considered in the 2016 Final Rule. Taglines themselves are a compromise balancing the ability to notify the public of their rights and how to access language help with the potential burden of translating large numbers of documents into several languages. This is why the taglines are capped at the top 15 language spoken in the state or states that the covered entity operates in. In addition, OCR had already provided guidance that entities can aggregate the languages to avoid creating a burden for entities operating in multiple states.

d) Cost Estimates Are Based on Variable Paper Estimates

OCR estimates that in practice, the notices and taglines result in one to two sheets of paper (which may be double-sided) per each significant communication mailed by a covered entity. This would generate, at most, 2 double-sided pages per communication required by Section 1557. In the NPRM, OCR references one health insurer who claims it was required to add 2-5 pages of disclosure content on each document. We raise concerns that OCR is including the cost of compliance with other federal or state requirements in the cost of the Section 1557 nondiscrimination notice and tagline and using that inflated cost to justify their elimination.

e) OCR Ignores the Burdens on Entities Serving LEP Communities

APIAHF partners with community-based organizations that already struggle to fully serve their LEP clients protected by Section 1557. For example, HOPE Clinic, a community health center in Houston, Texas, serves thousands of LEP patients in 34 languages every year. HOPE is one of the few providers in the area with doctors that speak languages like Vietnamese, Burmese, Teochew, Persian, Arabic, Turkish, French, and many other languages and dialects spoken in Africa. HOPE provides more than medical care, as many clients need help understanding insurance and other documents in English. HOPE staffers take time out of their day to walk through these complex documents.

If this rule is finalized, organizations like HOPE will face increased burdens due to fewer clients being aware of their language access rights and the likelihood that more people will turn to them for help in their language, rather than the covered entities. Few of these organizations are funded or receive reimbursement for language services they provide. Only 15 states, for example, use the Medicaid option to reimburse for interpretation. If fewer patients are aware of their rights, or if health insurance and other companies simply stop offering language access services, community-based organizations will have to find a way to serve these patients or turn them away. As described throughout this letter, LEP communities already face barriers to knowing and exercising their rights to federally supported health care programs and activities. For example, HOPE provided the following client story:

We are proud to make our patients feel more comfortable when they come here. Being part of the Arabic community, a Syrian family contacted us through their son, seeking for health insurance for himself and his parents. We scheduled the appointment for him first, and he got enrolled in marketplace, and another appointment for the parents, both who got approved for ACA. The mother has been diagnosed with breast cancer and needs to start the treatment journey. The family still scheduling appointments for medical services with the clinic as well as, helping them to do their health assessment and the rewards with their insurance provider to get the points and rewards.²⁹

A community-based organization, Monsoon, in Iowa shared:

Monsoon's approach is to train clients to simply ask for an interpreter because urging them to "demand" their rights would not only be a difficult act for them as many Asians believe in respect for authority or have themselves faced oppressions from authority. Even if there are clients who are willing to act independently and raise issues of language access rights, they would still need an advocate to assist them as a "witness" to any interactions to ensure fair treatment. It is, therefore, incumbent on official systems with power to train their employees to support people lacking English-language skills rather than relying on capacity-strapped nonprofit community organizations to do the work all the time.³⁰

²⁹ Story provided by HOPE Clinic, a partner of the Asian & Pacific Islander American Health Forum.

³⁰ Story provided by Monsoon Asians & Pacific Islanders in Solidarity, a partner of the Asian & Pacific Islander American Health Forum.

f) Multiple Covered Entities Supported or Did Not Oppose the Requirements in the 2015 NPRM

OCR primarily relies on the claims of insurance companies and pharmacy benefit managers to justify elimination of the nondiscrimination notice and tagline requirements. However, many covered entities supported those requirements in the 2015 NPRM, including the American Academy of Pediatrics and the Association of Community Affiliated Plans. Even where covered entities, such as hospital associations, opposed the tagline requirement, those entities noted the importance of ensuring awareness of language access services by LEP individuals and proposed alternatives to taglines, such as adoption of a universal symbol. Most insurance providers did not oppose the tagline requirement explicitly and instead proposed modifications to ease their asserted financial and administrative burdens and potential duplication across other CMS programs, such as America's Health Insurance Plans (AHIP). Both AHIP and the Blue Cross Blue Shield Association suggested providing notices and taglines on an annual basis rather than in all significant communications. None of the comments from covered entities to the 2015 NPRM that AIAHF reviewed estimated the potential costs attributable to the notices and taglines as OCR now relies upon. The Pharmaceutical Care Management Association recommended sending taglines and notices in an appendix on an annual basis rather than with all significant communications. As such, in eliminating portions of the final 2016 rule in its entirety, OCR appears to be going beyond what any entity requested and in fact, doing a disservice to the covered entities that are potentially inaccurately framed as opposing language access and other civil rights protections.

V. Nondiscrimination Notice and Taglines *are* Justified by Need and Designed to Balance Cost Burdens and Benefits

Overall, we wholly dispute OCR's claim that Section 1557's regulations are not justified by need for the following reasons.

a) Compliance with State and Federal Requirements is Not an Adequate Justification for Eliminating Notice and Taglines

Section 1557 built upon the existing federal civil rights framework. As is often in federal regulation, covered entities are subject to multiple regulatory frameworks. OCR, in formulating the 2016 Final Rule, considered those existing regulatory frameworks. Section 1557 created a new expansion of civil rights into health care in areas of sex, for example. In addition, Section 1557 newly applied civil rights to entities newly created by Title I of the ACA, which were not previously in existence at the time other civil rights laws were established or implemented, though Title VI applies to those entities. Other existing regulations, such as those in Medicare, properly contain more specific requirements directly applicable to those programs and populations. OCR's claim that covered entities are struggling to comply with existing federal requirements is not sufficient. OCR has not considered, nor explained, why it has not provided clarification as to the relationship between Section 1557 and other regulations and how covered entities can support compliance with all provisions.

Nothing in Section 1557 prevents states or local jurisdictions from imposing additional civil rights protections. As such, it will always be the case that covered entities operating in different states will be subject to different and additional regulations. This is part of the cost of doing

business in multiple states. Indeed, it is one of the roles of OCR to provide clarification and support work with states to provide guidance on how entities can support comprehensive compliance. It is therefore inappropriate to reduce federal standards enacted by Congress through regulations simply because some states have chosen to create their own.

b) Claims by Covered Entities and Stakeholders Are Insufficient

OCR states that it heard from multiple stakeholders about the repetitive nature of the notice and taglines in publications diluting their message. Yet, OCR does not properly consider alternatives in how to avoid such repetition with the consultation of language access advocates and covered entity stakeholders, and instead proposes to eliminate them.

Further, OCR fails to mention reports that it has received in communications from other stakeholders supporting language access rights as well as providers serving persons with large numbers of LEP. These stakeholders have expressed a continuing need to ensure language access rights are both known and enforced. Similarly, OCR notes that beneficiaries have claimed they do not want to receive extra pages, yet OCR provides no verifiable justification for the claim, including self-selection bias on the part of English speakers, nor has it clarified any actual cost burden to the recipients that could justify the regulatory change. Complaints from individuals about additional information that is not intended for them is not justification for the sweeping changes in this proposed rule, as implementation of civil rights laws cannot be determined based on the whims of those whose rights are not at risk.

c) Lack of Data Demonstrating Increase in Language Access Services is Not Required

OCR states it has received little evidence that more beneficiaries are seeking language assistance and uses this claim as a justification to remove the notice and taglines. First, this claim, which relies on reports from health plans, is insufficient to justify their repeal. The regulation has been in effect for three years in which OCR, by its own admission, has had limited resources to conduct public outreach. Second, the protections guaranteed by Section 1557 are both continuing and many are new, warranting a public effort to conduct outreach. Third, the notices and taglines were selected as a compromise position, to avoid requiring covered entities to translate large numbers of documents. Fourth, LEP persons are uniquely at risk of facing barriers to knowing and asserting their rights. Lack of uptake of services raises questions about the extent to which the public knows its rights and what covered entities are doing to communicate those rights, as opposed to justifying elimination of notices and taglines. And finally, OCR failed to conduct any of its own research, focus groups, or outreach to LEP populations in making its determinations about the value of notices and taglines.

d) Census Data on English Proficiency Supports Notice and Taglines

OCR cites data that the majority of persons receiving the notice and taglines are English speakers. Yet, OCR ignores Census data showing that 25 million persons in the U.S. are LEP, meaning they speak little to no English. Nineteen million LEP are insured in the U.S.³¹

The 15 languages by state standard captures, on average, 90% of each state's LEP population, as provided in the 2016 Final Rule. Thus, while the majority of persons who may receive taglines

³¹ APIAHF Analysis of 2017 American Community Survey Data.

are English speakers, the inclusion of taglines targets 90% of a state’s LEP population, providing an effective method of providing notice in-language in the absence of more fully translated documents. While the majority of persons who registered for coverage at Healthcare.gov selected English, data collection for the Marketplace is a challenge with CMS reporting that one quarter of persons did not select a spoken language.³² In addition, 58% of Spanish-speaking adults, 55% of adults speaking other Indo-European languages, 44% of adults speaking Asian or Pacific Island languages, and 62% of adults speaking other languages lived in states utilizing the HealthCare.gov platform.³³ Importantly, however, the data OCR cites in the NPRM does not take into account states that do not use the Healthcare.gov platform comprise a large percentage of LEP speakers in the U.S., such as California and New York. Those states accounted for 43% of adult speakers of Asian or Pacific Island languages in 2015, 34% of Spanish speakers, and 30% of speakers of other Indo-European languages.³⁴

In making the claim that taglines are less useful because they are received by many English speakers, OCR fails to consider the point of taglines as a tool. Covered entities are often unaware of whether their customers or patients are LEP or not. Taglines provide a simple and unobtrusive compromise by broadly targeting all recipients as an alternative to targeted in-language communications. Their receipt by non-LEP individuals is a natural consequence of their existence and purpose and using that fact to justify their elimination is a failure of analysis by the agency.

e) OCR Failed to Consider Regulatory Alternatives

OCR provides no explicit rationale for why it rejected the option of limiting the frequency of required mailings. Further, OCR provides no explanation for alternatives for how protected classes are to be informed of their civil rights and instead claims that the elimination of the Section 1557 notice is duplicative and already covered by existing civil rights statutes. APIAHF disputes these claims, as explained further in this letter. This claim is not correct given Section 1557 does not just incorporate other civil rights statutes, it addresses the *intersection* of those protections as they impact individuals. Individuals do not just experience discrimination on one ground. An Asian American woman who is LEP, and with a disability, for example, can experience discrimination on multiple intersecting grounds. The provision of individual notices for the underlying civil rights statutes does not justify the elimination of the 1557 notice.

f) Methodology in the RIA is Flawed

The RIA adopts the list of covered entities and other assumptions identified in the 2016 RIA for the Final Rule. However, this assumption is incorrect because the NPRM seeks to make a number of changes that would dramatically narrow the scope of who is protected by Section 1557 and which entities are “covered entities” for purposes of Section 1557.

³² Centers for Medicare & Medicaid Services, Race, Ethnicity, and Language Preference in the Health Insurance Marketplaces 2017 Open Enrollment Period, April 2017, <https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/information-products/data-highlights/Race-Ethnicity-and-Language-Preference-in-the-Health-Insurance-Marketplace.html>.

³³ *Id.*

³⁴ *Id.*

The RIA fails to account for the difference in costs as to the size and resources available to the covered entity. For example, most of the cost estimates are based on large insurance plans and pharmacy benefit managers, operating in several states with significant revenue and resources. The five largest health insurers and pharmacy benefit managers alone generated nearly \$787 billion in revenue in 2019.³⁵

OCR did not conduct its own analysis of the impact on pharmacy benefit managers and instead accepted estimates from the Pharmaceutical Care Management Association.

For labor, OCR estimated the burden to download, print, and include notices in mailed communications. This estimate fails to account for or differentiate the number of notices that are generated by machine and included in bulk mailings and facilitated through the use of computers. In these cases, an office clerk may *not* be as involved in the effort. OCR also presumed that while electronic delivery would eliminate postage costs, it would shift costs of paper and printing to the consumer/beneficiary/patient. This assumption is unwarranted and provided without factual basis. It is unlikely that all, or even a significant percentage of individuals would download and print documents sent to them electronically. In addition, OCR fails to account for the significant degree to which communications can be provided electronically and the degree to which insurance plans, for example, have already been doing so for years.

g) OCR's Assumption that Other Tagline Requirements Would be Repealed is Incorrect

OCR assumes that two additional tagline requirements for the Health Insurance Exchanges and Qualified Health Plan issuers would be repealed as well, but that is incorrect. Section 1557 applies to a number of covered entities and establishes broad civil rights application to them. Nothing in Section 1557, however, prevents the implementation of additional requirements in more specific programs, such as those in Medicaid and Medicare. The requirements placed on Health Insurance Exchanges in 45 CFR 155.205(c)(2)(iii)(A) does not rely on Section 1557 and is instead an independent requirement. For example, 45 CFR 155.205(c)(2)(iii)(A) provides that "Exchanges, and QHP issuers that are also subject to § 92.8 of this subtitle, will be deemed in compliance with paragraph (c)(2)(iii)(A) of this section if they are in compliance with § 92.8 of this subtitle." As such, the requirements of 45 CFR 155.205(c)(2)(iii)(A) and § 92.8 are independent of one another.

VI. The NPRM Will Disproportionately Impact Protected Classes of Individuals Section 1557 Explicitly Protects and Ignores the Intersectional Protections Guaranteed by It

OCR has provided wholly insufficient analysis on the costs and burdens to protect individuals from removal of the notice and tagline requirement as well as to other entities that work closely with LEP persons. Instead, OCR provides only the cursory statement that repeal "may impose costs, such as decreasing access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services." OCR perfunctory labels the impact as "negligible" while providing no evidentiary basis for the claim.

³⁵ Herban, Bob, Health Insurance is as Big as Big Tech, *Axios*, February 11, 2019, <https://www.axios.com/health-insurers-pbms-revenue-big-tech-9bc7b8fd-5577-4ebe-a818-42f4f7fd2d36.html>.

OCR cites the top 15 languages in each State list, noting that some languages are spoken by only 0.004 percent of the population. However, OCR fails to identify that percentages alone are not sufficient to determine coverage and there must be consideration of the numerical equivalent, or how many people are covered. The Final Rule's standard of top 15 languages for each state allows a covered entity to adapt to the conditions in the state(s) they operate in.

a) Language Barriers in Health Programs and Activities are Well Documented

APIAHF and numerous other national, state, and local advocates for years have notified HHS and multiple operating divisions, including CMS and OCR, of the continued challenges that LEP individuals experience in knowing their rights and accessing health care. Indeed, it is for this reason and existing legal obligations that OCR, DOJ, and other federal entities have a long history of addressing the importance of language access, as protected by Title VI in *Lau v. Nichols*. This history demonstrates that, in contrast to OCR's analysis in the proposed rule, the rule may lead to higher costs to the health system and patients due to fewer LEP patients accessing services with assistance in their language.

Language access in health care is just as critical now as when the Civil Rights Act was originally passed in 1964. Over 25 million Americans are LEP, and AAs and NHPs make up 22% of the LEP speakers in the country.³⁶ An estimated 6.5 million LEP adults are uninsured.³⁷ Among AAs, 66% of them speak a language other than English at home, and 29% percent are LEP, meaning that English is not their primary language and they have a limited ability to read, write, speak or understand English.³⁸ Of NHPs, 28% percent speak a language other than English at home.³⁹ Within the overall AANHPI community, 63% of Burmese, 45% of Nepalese, 44% percent of Bangladeshis are LEP, as are 16% of Micronesians.⁴⁰

Numerous studies have documented the consequences of language barriers in health care. The nonpartisan National Academy of Medicine (formerly Institute of Medicine) found that language barriers “may affect the delivery of adequate care through poor exchange of information, loss of cultural information, misunderstanding of physician instruction, poor shared decision-making or ethical compromises (e.g., difficulty obtaining informed consent). Linguistic difficulties may also result in decreased adherence with medication regimes, poor appointment attendance, and decreased satisfaction with services.”⁴¹ Moreover, patients who are LEP are often “unfamiliar with [the health system's] cultural norms, vocabulary, and procedures.”⁴² This unfamiliarity can

³⁶ APIAHF Analysis of 2017 American Community Survey Data.

³⁷ APIAHF analysis of 2017 American Community Survey Public Use Microdata.

³⁸ APIAHF Analysis of 2017 American Community Survey Data.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* 17 (2002) (citation omitted); see also Jane Perkins, Mara Youdelman & Doreena Wong, National Health Law Program, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities* (2003). http://www.healthlaw.org/index.php?option=com_content&view=article&id=326:ensuring-linguistic-access-in-health-care-settings-legal-rights-and-responsibilities&catid=45; E. Jacobs, et al., *Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature*, The California Endowment (2003), http://www.calendow.org/uploadedFiles/language_barriers_health_care.pdf.

⁴² Vikki Katz, *Children as Brokers of their Immigrant Families' Healthcare Connections*, at 24 (2013) (under review).

result in the provision of inadequate and substandard care for LEP individuals. Furthermore, the lack of language assistance services negatively impacts communities at large, not just LEP individuals. When interpreter services are inadequate, children often serve as language brokers for their parents.⁴³

For example, here is a story from an APIAHF partner that reflects the experience of many children of LEP individuals.

Language barrier[s] ha[ve] has always been an issue in my family. Before I went off to college, I was always there to interpret for my parents during their hospital visits. I had to advocate for my parent's health by talking with our caseworker numerous times about the application of Medi-Cal [Medicaid] and figure out all the policy and available resources...most of the information I found was in English. Since I moved to college, my parents have stopped getting [Media-Cal] coverage because they did not know how to navigate the system to renew the application.

-- Thanh⁴⁴

LEP persons and families such as those described above would have significant barriers to knowing and accessing their right to language access services if the NPRM is finalized.

It is for this reason that health care providers also long recognized the need to provide language assistance services for LEP patients. One study surveyed four major metropolitan areas where physicians identified language difficulties as a major barrier to immigrants' access to health care and a serious threat to medical care quality. These providers also expressed concern that they could not get information to make good diagnoses and that patients might not understand prescribed treatment.⁴⁵

Patient experiences that have resulted in malpractice claims are documented in *The High Costs of Language Barriers in Medical Malpractice*, a joint publication by the National Health Law Program and the University of California, Berkeley, School of Public Health.⁴⁶ As a result, language barriers can also increase the cost of care by creating what has been called a "language-barrier premium."⁴⁷ Such barriers are a primary reason why LEP populations disproportionately

⁴³ Katz, *Children as Brokers of their Immigrant Families' Healthcare Connections*, at 31.

⁴⁴ Story as collected by partners of the Asian & Pacific Islander American Health Forum.

⁴⁵ L. Ku & A. Freilich, Urban Institute, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston* at ii-iii (2001), available at

<http://aspe.hhs.gov/hsp/immigration/caring01/excecsum.htm>; see also Jennifer Cho & Beatriz M.

Solis, L.A. Care Health Plan, *Healthy Families Culture & Linguistic Resources Survey: A Physician Perspective on their Diverse Member Population* (2001) (51% of doctors reported their patients do not adhere to treatments because of culture and language barriers).

⁴⁶ Kelvin Quan & Jessica Lynch, *The High Costs of Language Barriers in Medical Malpractice* (2010), http://www.healthlaw.org/images/stories/High_Costs_of_Language_Barriers_in_Malpractice.pdf.

⁴⁷ See, e.g., Judith Bernstein et al., *Trained Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-Up*, 4 J. IMMIG. HEALTH 171 (2002) (finding interpreters improved clinic follow-up and reduced post emergency room visits and charges); L.C. Hampers, *Language Barriers and Resources Utilization in a Pediatric Emergency Department*, 103 PEDIATRICS 1253 (1999)

underutilize less expensive and quality-enhancing preventive care.⁴⁸ In addition, an inability to comprehend the patient, mixed with a fear of liability, can lead some providers to avoid LEP patients altogether or, in the alternative, to order expensive, otherwise avoidable tests.⁴⁹

Persons with language barriers are less likely overall to receive needed care and report lower quality care when they do receive it. Language barriers can lead to misinterpretation of medical diagnosis and treatment and affect medicine adherence.⁵⁰ In addition, language barriers can generate costs beyond the health impact to the LEP person, including inefficient care where medical providers are unable to communicate with LEP persons and more expensive diagnostic procedures.⁵¹

A survey by the Kaiser Family Foundation found that Spanish-speakers were less likely than English-speakers to say they understood the services offered by their health insurance plans and more likely to experience gaps in coverage.⁵²

Language barriers to health care are further compounded by immigration status and citizenship status, educational attainment, and poverty. Sixty percent of Asian Americans are foreign-born, representing every immigration status. Medically underserved AA and NHPI communities—including communities where AAs and NHPIs lack access to health care, have high rates of poverty, and have high numbers of LEP populations—are growing across the country. As of the 2000 Census, there were 282 counties or 13.1% of counties classified as medically underserved or severely underserved AA and NHPI communities.⁵³

Even with strong federal protections under Section 1557, LEP individuals face continued barriers to meaningful access, as supported by stories provided by community-based organizations working with APIAHF. Our domestic-violence-serving partner organization shared the following example:

I had to meet a victim of domestic abuse and sexual violence from the Burmese ethnic Hakka Chin community to a gynecological appointment at a hospital clinic in Iowa. I was late by 5 minutes, during which time the client's intake was being done by a nurse and the client's new boyfriend from her own community, who was

(finding patients with a language barrier had higher charges and longer stays).

⁴⁸ See, e.g., Michelle M. Doty, The Commonwealth Fund, *Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English*, at vii–viii, 8, 11–14 & 21 (2003); D. Andrulis et al., The Access Project, *What a Difference an Interpreter Can Make* 1–2 (2002).

⁴⁹ See, e.g., Barry Newman, *Doctors' Orders Can Get Lost in Translation for Immigrants*, WALL STREET J., Jan. 9, 2003.

⁵⁰ Cindy Brach, et. al, *Crossing the Language Chasm*, *Health Affairs*, Vol 24 No 2: Health Disparities, March/April 2005, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.24.2.424>.

⁵¹ Leighton Ku and Glenn Flores, *Pay Now or Pay Later: Providing Interpreter Services in Health Care*, *Health Affairs*, Vol 24, No 2, March/April 2005, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.24.2.435>.

⁵² Samantha Artiga, et. al, *The Role of Language in Health Care Access and Utilization for Insured Hispanic Adults*, Kaiser Family Foundation, November 9, 2015, <https://www.kff.org/report-section/the-role-of-language-in-health-care-access-and-utilization-for-insured-hispanic-adults-issue-brief/>.

⁵³ Rosy Chang Weir, Linda Tran & Winston Tseng, *Medically Underserved AAPI Communities*, Association of Asian Pacific Community Health Organizations (2005), <http://www.aapcho.org/wp/wp-content/uploads/2012/07/MUAC-Fact-Sheet.pdf>.

*well-meaning but not only was he not English-proficient, he was an inappropriate interpreter for that kind of medical discussion. I had to demand that the nurse get an interpreter on the phone although the nurse persisted in saying: “But he speaks English.” I also asked the nurse not to mention the client’s name to the interpreter because the scarcity of competent interpreters in certain languages can compromise confidentiality and many Asian communities are close-knit.*⁵⁴

Due to systemic and institutionalized discrimination on the basis of race and national origin, many LEP persons either do not know their rights or are afraid of asserting them.

*One of my Arabic-speaking clients appears to speak English well, but has problems with comprehension. This can be a problem in official settings when it is assumed that because she speaks “good English” she comprehends English well. When she told me about taking her young daughter to a children’s hospital for a facial contortion check-up recently, I asked her about what the doctors had said. She replied that she wasn’t quite sure, so I asked her to get the child’s medical records to take a look at and explain them to her. By the way, she did not ask for an interpreter at the doctor’s office, although she often needs to me to repeat myself, leading me to requesting another Arabic speaker to step in to help.*⁵⁵

The intersection of immigration status with LEP can create further challenges to meaningful access as community-based organizations working with APIAHF have reported that immigrants and refugees need an advocate to accompany them to health care appointments to help enforce their civil rights. Many immigrants and refugees have oral traditions of community or are not literate in their own native languages. Here is how the domestic violence focused organization describes their work and challenges to meet those needs.

*Monsoon’s advocates accompany immigrant and refugee clients with limited English skills to “crucial” health care appointments, such as those related to mental health issues, surgeries, gynecological exams, severe allergies to medicines, etc. The advocates either share cultures and languages with the clients or they ask for a phone interpreter, and also make sure the medical personnel agrees to any kind of advocate intervention during this process whenever necessary. While this has been Monsoon’s policy from the time of its inception, advocates have learned through their communities that most adults and older adults continue to face challenges with communicating in English in systems such as education, law enforcement, the Department of Human Services, etc. Further, many immigrants and refugees are not literate in their own languages.*⁵⁶

b) Proposed Changes Will Disproportionately Impact AAs and NHPs

Language access in health care services and activities particularly impacts AAs and NHPs given the population’s demographics. AAs and NHPs represent the fastest growing communities in

⁵⁴ Story provided by Monsoon, a partner of the Asian & Pacific Islander American Health Forum.

⁵⁵ *Id.*

⁵⁶ *Id.*

the United States⁵⁷ and similarly represent incredible diversity. AAs and NHPs trace their heritage to nearly 100 different ethnic groups and speak more than 250 different languages. Sixty six percent of AAs speak a language other than English at home and twenty nine percent are LEP, meaning that English is not their primary language and they have a limited ability to read, write, speak or understand English.⁵⁸ Twenty-eight percent of NHPs speak a language other than English at home. Sixty-three percent of Burmese, 45 percent of Nepalese and 44 percent of Bangladeshis are LEP, as are 16 percent of Micronesians. AAs and NHPs make up twenty-two percent of LEP individuals in the country.

As stated previously, language barriers to health care are further compounded by immigration and citizenship status, educational attainment, and poverty. Sixty percent of Asian Americans are foreign-born, representing every immigration status. Medically underserved AA and NHP communities—including communities where AAs and NHPs lack access to health care, have high rates of poverty, and have high numbers of LEP populations—are growing across the country. As of the 2000 Census, there were 282 counties or 13.1% of counties classified as medically underserved or severely underserved for AA and NHP communities.⁵⁹

HHS seeks comment on continuing unaddressed civil rights barriers, which are significant when it comes to language access. For example, over the past Open Enrollment periods for the Marketplace, language has presented a significant barrier for AAs and NHPs attempting to enroll in coverage. Once enrolled, many LEP consumers continued to have difficulties understanding their benefits and coverage. For example, AA and NHP community-based organizations reported cases in which individuals did not know their rights and did not realize they were sent legal notices because notices were not provided in their language. Without enforcement of language assistance services, legal notices, and taglines to inform persons of their rights, discrete communities, such as those AAs and NHPs, with large numbers of LEP individuals will be systematically excluded from opportunities to achieve better health and have their civil rights violated. It is this rationale and strong data record that guided the intent behind including the Section 1557 nondiscrimination provision in the ACA and corresponding incorporation of existing civil rights protections.

c) Section 1557 Uniquely Addresses the Intersection of Discrimination

Section 1557 is unique in that it addresses not only the individual ways in which discrimination can occur for several protected classes, but the *intersection* of those types of discrimination. An individual interacting with health care programs or services does not interact on the basis of only their race, color, national origin, sex, age or disability, but the intersections of those various factors and identities. As such, the changes proposed in the NPRM will particularly impact racial and ethnic minorities, including AAs and NHPs, Latinx, and African Americans. These communities have faced and continue to face systemic and institutional racism and

⁵⁷ Asian American Center for Advancing Justice, *A Community of Contrasts: Asian Americans in the United States: 2011*, Executive Summary (2011), https://www.advancingjustice-la.org/sites/default/files/ENTERED_Community_of_Contrasts_2011.pdf.

⁵⁸ Asian & Pacific Islander American Health Forum Analysis of 2017 American Community Survey Data.

⁵⁹ Rosy Chang Weir, Linda Tran, & Winston Tseng, *Medically Underserved AAPI Communities*, Association of Asian Pacific Community Health Organizations (2005), <http://www.aapcho.org/wp/wp-content/uploads/2012/07/MUA-Fact-Sheet.pdf>.

discrimination and face considerable barriers to achieving health equity and meaningful access to federally supported health programs and activities.

On the Basis of Race and National Origin

For example, similar to the challenges faced by AAs and NHPs described in this comment letter, Latinx communities face communication barriers in health care and health programs.

In a 2018 poll, about 6 in 10 Latino adults reported having trouble communicating with their providers about their health care needs due to language or cultural barriers⁶⁰ The nondiscrimination language access protections that the proposed rule seeks to weaken are crucial to minimizing the health care risks LEP Latinos face in the health care system, including avoidable hospital readmissions, lower rates of outpatient follow up, limited use of preventive services, poor medication adherence, and lack of understanding discharge diagnosis and instructions.⁶¹ Spanish-speaking LEP Latinos are more likely to report experiencing worse health outcomes than Latinos who are monolingual in English or bilingual in English and Spanish.⁶²

On the Basis of Disability

Further, Section 1557 and its 2016 implementing regulations prohibit health insurance companies from discriminating through marketing practices and benefit design. These protections are especially important for people with disabilities and chronic conditions. The proposed rule seeks to exempt most health insurance plans from Section 1557's nondiscrimination protections and eliminate the regulation prohibiting discriminatory benefit design and marketing, which could result in 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.

The proposed rule will impede health care access for people with HIV/AIDS and other serious or chronic conditions. Section 1557 and the 2016 Final Rule prohibit health insurance companies from discriminating through marketing practices and benefit design. These protections are especially important for people with HIV/AIDS or other serious/chronic conditions. The proposed rule seeks to exempt most health insurance plans from Section 1557's nondiscrimination protections and eliminate the regulation prohibiting discriminatory benefit design and marketing, which could result in health insurers excluding benefits or designing their prescription drug formularies in a way that limits access to medically necessary care for those living with HIV and other chronic conditions.

⁶⁰ Swanson, Emily and R. Contreras, "AP-NORC Poll: Latinos health care communication woes," (Associated Press, July 2018), available at <https://apnews.com/c64161775eca4ebcbedee919d6102428>, (Accessed June 20, 2019).

⁶¹ Joseph R. Betancourt et al., "Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries," (Centers for Medicare & Medicaid Services, 2015), available at https://www.cms.gov/About-CMS/Agency-information/OMH/Downloads/OMH_Readmissions_Guide.pdf, (accessed July 16, 2019).

⁶² Showstack, Rachel, et.al., "Improving Latino Health Equity Through Spanish Language Interpreter Advocacy in Kansas," Hispanic Healthcare International, (2018), available at <https://journals.sagepub.com/doi/abs/10.1177/1540415318818706#articlePermissionsContainer>, (accessed June 20, 2019).

On the basis of age – older adults

Many communities of color are made of older adults. U.S. Census data estimates that in 2017, more than 10 million older adults over age 60 speak a language other than English at home, and 6 million speak English less than “very well.” It is especially critical that older adults have robust language access resources and protections from discrimination. Due to their age and physical barriers, it is unrealistic to expect many LEP seniors to attain full English proficiency.

In the health care context specifically, four million Medicare beneficiaries—older adults and people with disabilities—are limited English proficient, and 12% of Medicare beneficiaries 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. In addition, nearly eight million Medicare beneficiaries are deaf or hard of hearing and four million have blindness or low vision. Over 1.8 million LEP seniors and people with disabilities are also low-income and rely on the tagline and notice requirements in the 2016 implementing regulations to get the information they need across both Medicaid and Medicare.⁶³

The risks for older adults who are unable to access health care due to language or other barriers are even greater because most people need more health care as they age. 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 notices and taglines are critical and help to counter the stigma of asking for help. If an older LEP adult does not understand a statement they receive or is not told or has no notice of how to get help in their primary language, they may not ask for an interpreter, resulting in failing to follow up as necessary or paying for a service when their insurer denies coverage because they are not adequately informed of their right to appeal. Especially for older adults with limited income or high health care needs, the consequences of an erroneous bill or forgoing care can be catastrophic.

LGBTQ+ and On the Basis of Sex

If finalized, this proposed rule would severely threaten LGBTQ+ patients’ access to all forms of health care, create confusion among patients and providers about their rights and obligations, and promote discrimination. The proposed rule would encourage hospitals to deny care to LGBTQ+ people, and enable insurance companies to deny transgender people coverage for essential health care services that they cover for non-transgender people. By proposing to eliminate protections against discrimination based on transgender status and sex stereotyping, HHS is contradicting over 20 years of federal case law and clear Supreme Court precedent.

VII. Requests for Comments

⁶³ 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, <https://www.liebertpub.com/doi/full/10.1089/heq.2017.0036>.

HHS provides an extensive list of issues on which it solicits comments, in addition to seeking comment on all issues raised by the proposed regulation. The list of issues in Section IX, however, provides insufficient clarity in both the questions and the context such that APIAHF is unable to fully comment. To justify proposed changes in existing regulations, HHS must provide its own explanation and rationale for the changes, documenting a need for these changes based not on an opposition to the policy undergirding a particular regulation but based on reason and data. Given that the public must be provided an opportunity to comment on HHS's alleged justifications for these proposed changes, HHS's attempt to solicit feedback on a list of additional issues that it may then use to promulgate unanticipated changes in a final rule violates requirements of public notice and comment as required by the Administrative Procedures Act.

Further, while not a request for comment, we echo the comments of the National Health Law Program and oppose HHS's suspension of all subregulatory guidance related to Section 1557 while the rulemaking is in process, and in particular the preamble to the current Section 1557 regulation. HHS is bound by the Administrative Procedures Act to provide justification for its proposed changes and cannot change current regulations without going through the notice and comment period, considering those comments, and then providing justification for its changes in a new final regulation. Particularly with respect to the preamble to the current regulations, the information provided helps covered entities understand the parameters of the regulations, how to comply, and what HHS considered in evaluating comments. Rescinding the subregulatory guidance while the current regulations remain will only sow confusion for covered entities as well as individuals protected by Section 1557. The harm of suspending the guidance and the preamble greatly outweighs any benefit.

a) Unaddressed discrimination on the basis of race, color, national origin, sex, disability, and age as applied to State and Federally-facilitated Exchanges

Based on our history of working with LEP immigrant and other minority communities and core understanding of their varied needs, we raise serious concerns that, despite having protections for language access rights well documented under federal law, there remains continuing enforcement challenges as applied to the Federal Marketplace.

Communication is a core component of quality patient care. Even with gains in health insurance coverage, language barriers continue to present challenges for LEP persons. APIAHF and partners have long-identified language access barriers and concerns with enforcement of federal civil rights protections. Most recently, APIAHF and language access advocates have raised serious compliance concerns with respect to Healthcare.gov and CMS operations, detailed in an article in *Health Affairs*.⁶⁴ In this article, partners in Arkansas, for example, noted they continue to have to translate important documents pertaining to legal rights and notices provided by the Marketplace in the absence of translated resources.

During the past five Open Enrollment periods, language has presented a significant barrier for AAs and NHPs attempting to enroll in coverage through the Health Insurance Marketplace. Once enrolled, many LEP consumers continued to have difficulties understanding their benefits

⁶⁴ Kathy Ko Chin, HHS Must Improve Language Access to Make Meaningful Access a Reality, *Health Affairs*, July 22, 2016, <https://www.healthaffairs.org/doi/10.1377/hblog20160722.055907/full/>.

and coverage. As a co-founder of Action for Health Justice with the Association of Asian Pacific Community Health Organizations, Asian Americans Advancing Justice-Los Angeles, and Asian Americans Advancing Justice-AAJC, APIAHF worked with 72 community based organizations and health centers to outreach, educate, and enroll a million AAs and NHPs in ACA and Medicaid coverage.

Based on survey data analyzed about this cohort, among the uninsured clients served by our partner organizations, 87% of the uninsured were clients whose primary spoken language was not English, and 83% of the uninsured were clients whose primary written language was not English.⁶⁵ While this data provides only a snapshot of the eligible uninsured population who are LEP, it offers insight into how necessary language services are for individuals with LEP to meaningfully access federally funded programs and activities in the healthcare system. It also provides a view into the vulnerable populations that will be harmed by this rule, in contrast to the fairly well-resourced entities that may benefit. As APIAHF and partners have found through numerous documented examples, without language assistance services, discrete communities such as those AAs and NHPs with large numbers of individuals with LEP will be systematically excluded from opportunities to achieve better health. It is this rationale and strong data record that guided the intent behind including the Section 1557 nondiscrimination provision in the ACA and corresponding incorporation of existing civil rights protections.

A number of actions taken by the Trump Administration seek to undermine the protection of civil rights, particularly on the basis of national origin. For example, in 2018, HHS announced only a small amount of Navigator grants for organizations providing health insurance enrollment assistance under the Navigator program as HHS had previously stated that it would dramatically cut funding to \$10 million, a 72% cut. As a result, in 2018, only 39 organizations received funding, compared to 83 in 2017. This critical program, a core part of the ACA, reduces barriers to enrollment and ensures that consumers from all walks of life are informed about their coverage options. HHS previously cut Navigator funding by 43% from \$62.9 to \$36.1 million in 2017. Under this year's even deeper cut, states could see as much as 87% fewer dollars than last year, and certain communities could be left without any assistance. For example, one previous grantee, Light and Salt Association in Texas, was not funded, and as a result, there are no funded organizations in Texas in 2018 targeting the AAPI community. Similarly, numerous other APIAHF partners that provided in-language enrollment assistance in ACA marketplaces have had to scale back or eliminate their enrollment programs.

APIAHF has worked with navigator grantees and subgrantees since the first ACA open enrollment period and these organizations have shared the dire impact that funding cuts have had on their ability to serve LEP populations:

We had received Navigator funding since 2015 through a sub-grant, primarily supporting families from Chinese, Bhutanese, Laotian, and Indonesian communities. However, due to the new unsustainable approach to funding, our partner declined to renew their application. The culturally and linguistically specific outreach and enrollment work that SEAMAAC conducts requires a deep level of support to families and is not sustainable under these cuts. Not having

⁶⁵ November 2013 to April 2014. Survey results on file with APIAHF.

these funds will significantly hurt Asian Americans in Philadelphia whom SEAMAAC and partners have been helping to enroll.

—Amy Jones, Director of Health & Social Services of SEAMAAC, Inc., in Philadelphia, PA

As such, OCR's proposals to eliminate language access and notice protections in Section 1557 must be considered in the context of other actions taken by this Administration.

Since the start of the ACA's first enrollment period, APIAHF, working with advocates around the nation,⁶⁶ has shared our significant concerns related to the lack of translated versions of legally required notices in the ACA marketplace which has interfered with meaningful access for LEP persons. As part of APIAHF's work with community-based organizations who work with navigators or who are certified application assistants, we have heard numerous stories of clients mistakenly throwing notices away or ignoring them, not realizing they require responses and affect health care rights because these consumers are unable to read the notice as it is not in their preferred language.⁶⁷ Section 1557 makes clear that language should not be a barrier to accessing health coverage or services, yet the experiences of our partners continue to demonstrate that is indeed the case.

Currently, to the best of our knowledge, HHS only provides Marketplace notices in two languages: English and Spanish. This leaves out the millions of individuals who speak some of the most commonly spoken languages nationwide, including Chinese, Vietnamese, and Korean. If a legal notice is not sent in their language, consumers have no idea about its importance or the appropriate response. Failure to reply to such a notice can lead to substantially reduced tax credits or terminated coverage. This would be further compounded if the NPRM's proposals eliminating notice and taglines as such consumers would have no means of knowing their rights or asserting their right to language access. While we cannot estimate the number of consumers who do become aware of the availability of language assistance due to the taglines, as our partners primarily assist those who are not aware of their rights, it is likely that those who fail to discover this information should the taglines and notices be eliminated, will have fewer or no other resources to turn to given the lack of resources available to community-based organizations highlighted in this letter.

b) Whether the proposed LEP provisions are practical, effective, fiscally responsible, reasonable, responsive to the particular circumstances relevant to health care programs or activities, and capable of being readily implemented

With respect to the cost to protected individuals, the LEP provisions proposed for repeal or elimination are effective and responsive to the particular needs of LEP persons in health care programs and activities, as noted throughout this comment letter.

⁶⁶ Action for Health Justice, *Improving the Road to ACA Coverage: Lessons Learned on Outreach, Education & Enrollment for Asian American, Native Hawaiian and Pacific Islander Communities*, September 2014, https://www.apiahf.org/wp-content/uploads/2014/10/2014.10.14_Improving-the-Road-to-ACA-Coverage_National-Report-1.pdf.

⁶⁷ Kathy Ko Chin, *HHS Must Improve Language Access to Make Meaningful Access a Reality*, Health Affairs Blog, July 22, 2016, <https://www.healthaffairs.org/do/10.1377/hblog20160722.055907/full/>.

c) Whether HHS’s Title VI regulations at 45 CFR part 80 should be amended to address the *Lau v. Nichols* precedent applicable to LEP individuals under any program or activity receiving Federal financial assistance from HHS

We do not believe that HHS’s Title VI regulations need to be amended to address *Lau v. Nichols* given that HHS and DOJ have followed the Supreme Court precedent for decades.

d) Whether the proposed provisions on language assistance services adequately balance an LEP individual’s meaningful access to effectively participate in the covered health program or activity with the resources available and costs to the covered entity

No, as described in detail in this letter, the proposed provisions on language access services do not adequately balance an LEP individual’s meaningful access because they eliminate cost-effective means of supporting notification of rights and facilitating access through repeal of the notice and tagline requirement. Further, the NPRM ignores the costs to LEP persons and the health system overall by failing to address the impact on health of LEP persons, access to care and loss of economic opportunity due to these barriers.

The impact of language access barriers can be profound in any aspect of an LEP individual’s life but has particularly life-changing consequences in the context of health programs or activities. The National Academies of Sciences, Engineering, and Medicine has found that LEP persons have a higher risk of being uninsured and experiencing medical errors.⁶⁸ CMS found, “Communication and language barriers are associated with decreased quality of care and poor clinical outcomes, longer hospital stays, and higher rates of hospital readmissions. Evidence suggests that access to communication and language assistance for patients and consumers is important to the delivery of high quality care for all populations.”⁶⁹ One study found that 52 percent of adverse events amongst LEP patients were likely the result of communication efforts and nearly half involved physical harm.⁷⁰ Similarly, a survey of LEP patients in Colorado found that such patients reported difficulty making appointments and the lack of qualified interpreters prevented them from seeking care in a timely manner.⁷¹

The context of language access rights must be considered in the context of long-standing and historical racial and ethnic discrimination that have been well substantiated across both federal agencies and programs, as well as those on the state level. For example, a recent article published

⁶⁸ The National Academies of Sciences, Engineering, and Medicine. 2018. *A Proposed Framework for Integration of Quality Performance Measures for Health Literacy, Cultural Competence, and Language Access Services: Proceedings of a Workshop*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/24918>.

⁶⁹ *Understanding Communication and Language Needs for Medicare Beneficiaries, Centers for Medicare & Medicaid Services, April 2017*. Available here: <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf>.

⁷⁰ Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in U.S. hospitals: a pilot study. *Int J Qual Health C*. 2007;19:60-67.

⁷¹ https://www.coloradotruster.org/sites/default/files/CT_LanguageAccessBrief_final-1.pdf

in the *Journal of the American Medical Association* found that race and other demographic factors continue to influence health outcomes and impede progress toward health equity.⁷²

VIII. The Proposed Rule Impermissibly Attempts to Narrow the Definition of Sex Discrimination

Sex discrimination in health care has a disproportionate impact on women of color, LGBTQ+ people, and individuals living at the intersections of multiple identities—resulting in them paying more for health care, receiving improper diagnoses at higher rates, being provided less effective treatments, and sometimes being denied care altogether. As the first broad prohibition against sex-based discrimination in health care, Section 1557 is crucial to ending gender-based discrimination in the health care industry. In addition to personal stories, there have been surveys, studies, and reports documenting discrimination in health care against these communities and their families.

The 2016 Final Rule made clear that sex discrimination under Section 1557 includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth, or related conditions. The proposed rule attempts to roll back these protections. Although HHS acknowledges in the preamble to this proposed rule that Title IX prohibits discrimination based on pregnancy, including termination of pregnancy, it refuses to state whether the Department would enforce those protections. While the scope of protection under Section 1557 is clear, without unambiguous implementing regulations, and enforcement, illegal discrimination is likely to flourish.

The proposed rule would disproportionately impact LGBTQ+ people, and especially transgender, nonbinary, and gender nonconforming people, who already face unique barriers to accessing care, such as high insurance rates, discrimination, and harassment. Under the proposed rule, those barriers would only increase. For example, transgender, nonbinary, and gender nonconforming people assigned female at birth whose gender marker is male or nonbinary could be denied coverage for necessary care such as a pap smear or mammogram. Similarly, transgender, nonbinary, and gender nonconforming people assigned male at birth whose gender marker is female or nonbinary could be denied coverage for necessary care, such as a prostate exam.

The proposed rule would disproportionately impact women and people of color who are pregnant, especially those living in rural areas. Women of color already face unique barriers to accessing pregnancy-related and/or abortion care, such as a discrimination, harassment, refusals of care, and high rates of pregnancy-related complications. For example, AAPI women are two times as likely to die from pregnancy-related causes than white women, Black women are three to four times more likely to die from pregnancy related complications than white women, and Native American women were four and a half times more likely to die during or immediately after pregnancy than white women.

⁷² Zimmerman FJ, Anderson NW. Trends in Health Equity in the United States by Race/Ethnicity, Sex, and Income, 1993-2017. *JAMA Netw Open*. Published online June 28, 2019;2(6):e196386. doi:10.1001/jamanetworkopen.2019.6386.

The proposed unlawful incorporation of Title IX’s exemptions would cause further harm to LGBTQ people and women of color. For example, the proposed rule impermissibly tries to add Title IX’s religious exemption to Section 1557’s protection against sex discrimination, which could embolden providers to invoke personal beliefs to deny access to a broad range of health care services, including birth control, sterilization, certain fertility treatments, abortion, and gender-affirming care. Similarly, the Administration once again attacks abortion access by impermissibly incorporating the “Danforth Amendment,” which carves out abortion care and coverage from the ban on discrimination of sex in the education context. Both attempts to incorporate exemptions from other laws violate the plain language of Section 1557.

IX. The Proposed Rule Impermissibly Attempts to Amend Unrelated Regulations to Exclude Sexual Orientation and Gender Identity Protections

The 2016 Final Rule did not touch other HHS health care regulations. The proposed rule attempts to erase all references to gender identity and sexual orientation in all HHS health care regulations. If implemented, this rule would eliminate express prohibitions on discrimination based on gender identity and sexual orientation from regulations that govern a range of health care programs, including private insurance and education programs. This could result in less health care and poorer health outcomes for communities across the country.

Prior to the passage of the ACA, being transgender was treated as being a pre-existing condition. As a result, transgender people could not get insurance coverage or affordable insurance. Under the proposed rule, states and Marketplaces could discriminate against LGBTQ+ people in eligibility determinations, enrollment periods, and more. Similarly, agents and brokers who assist with enrollment in marketplace plans could discriminate against LGBTQ+ people.

Under the proposed rule, Programs of All-Inclusive Care for the Elderly (“PACE”) organizations, which serve people over 55 years old, could discriminate against LGBTQ+ people.⁷³ There are more than 3 million LGBTQ+ people age 55 or older in the U.S. That number is expected to double within the next 20 years.⁷⁴ Many older LGBTQ+ adults already feel reluctant to discuss their sexual orientations and gender identities with health providers due to fear of judgment and/or substandard care.⁷⁵ The proposed rule would only further discourage older LGBTQ+ adults from sharing information that may be relevant to the health services they need.

Conclusion

It is for these reasons that APIAHF opposes the proposed changes and urges OCR not to finalize the proposed rule.

⁷³ MaryBeth Musumeci et al., *HHS’s Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), <https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/>.

⁷⁴ Robert Espinoza, Servs. & Advocacy for Gay, Lesbian, Bisexual, & Transgender Elders, *Out & Visible: The Experiences and Attitudes of Lesbian, Gay, Bisexual, and Transgender Older Adults, Ages 45-75*, 5 (2014), <https://www.sageusa.org/wp-content/uploads/2018/05/sageusa-out-visible-lgbt-market-research-full-report.pdf>.

⁷⁵ Robert Espinoza, Servs. & Advocacy for Gay, Lesbian, Bisexual, & Transgender Elders, *Out & Visible: The Experiences and Attitudes of Lesbian, Gay, Bisexual, and Transgender Older Adults, Ages 45-75*, 8 (2014), <https://www.sageusa.org/wp-content/uploads/2018/05/sageusa-out-visible-lgbt-market-research-full-report.pdf>.

Thank you for the opportunity to submit this comment. Please note that all citations of articles, research, and other documents should be considered as part of this comment letter and fully reviewed. For questions, contact Ben D'Avanzo, bdavanzo@apiahf.org, APIAHF Senior Policy Analyst.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kathy Ko Chin', with a long horizontal line extending to the right.

Kathy Ko Chin

President & CEO
Asian & Pacific Islander American Health Forum