Congress of the United States
House of Representatives
Washington, D.C. 20515

October 3, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Becerra:

We write as Chairs of House committees with primary jurisdiction over the Patient Protection and Affordable Care Act (ACA) in support of the Department of Health and Human Services's (HHS) proposed rule, *Nondiscrimination in Health Programs and Activities.*[1] The rule effectuates statutory text and congressional intent in enacting Section 1557 of the ACA to ensure that individuals' civil rights are protected while receiving health care services. Simultaneously, the proposal rectifies key gaps in prior iterations of the rule that were inconsistent with the ACA's statutory mandate and undermined the purpose of the law. The proposed rule reflects evolving judicial precedent, technological developments affecting patient access to care, and is particularly imperative given the continually growing threats to reproductive health and LGBTQI+ health. We strongly support the proposed rule and urge HHS to swiftly finalize the rule following the public comment period.

The proposed rule will reduce barriers and increase access to health care for LGBTQI+ individuals who have long faced discrimination in health care settings.

We strongly support HHS's clarification in the proposed rule that discrimination on the basis of sex includes discrimination on the basis of sexual orientation and gender identity. LGBTQI+ people face both health disparities and barriers to accessing health care—reporting poorer overall health, being more likely to acquire a disability, and experiencing refusal of care or blame for their condition from health care providers.[2] Studies have found such discrimination to be associated with mental and physical health harms for LGBT people.[3] Discrimination on the basis of sexual orientation and gender identity is considered a form of sex-based

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[1] Department of Health and Human Services, *Nondiscrimination in Health Programs and Activities*, 87 Fed. Reg. 47824 (Aug. 4, 2022) (proposed rule).

[2] National Academies of Sciences, Engineering, and Medicine, *Understanding the Well-Being of LGBTQI+ Populations* (Oct. 21, 2020); Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* (2010).

[3] Cornell University, *What Does the Scholarly Research Say about the Effects of Discrimination on the Health of LGBT People?* (2019) (https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-scholarly-research-say-about-the-effects-of-discrimination-on-the-health-of-lgbt-people/) (accessed Sept. 26, 2022).

discrimination under the Supreme Court's *Bostock v. Clayton County* decision and formally incorporating *Bostock* into the final rule will increase access to health care and lead to improved health outcomes. [4] We urge HHS to finalize this provision, adopting a uniform, more expansive description of prohibited sex discrimination (such as the proposed § 92.101). Moreover, we urge HHS to specifically include the term "transgender status" in the rule's relevant provisions to make it unequivocally clear that gender identity discrimination is intended to encompass transgender individuals.[5]

The proposed rule will ensure that all individuals can access high quality, affordable health coverage without being subjected to discrimination.

We applaud HHS's commitment to ensuring that all individuals are able to access health care coverage without being subject to discrimination on the basis of race, color, national origin, sex, age, or disability. We strongly support the application of Section 1557's regulatory requirements to the Federally-facilitated Exchanges (FFEs), the State-based Exchanges (SBEs), and to all health insurance issuers that receive federal financial assistance, consistent with the statute's intent. We also appreciate HHS's clarification that covered health programs or activities include all products sold by health insurance issuers, even grandmothered or grandfathered plans, short-term limited duration insurance plans, and excepted benefits plans. We similarly support the clarification that issuers that receive federal financial assistance are covered entities in instances in which they are acting as a third-party administrator for a self-funded group health plan, even if the group health plan itself does not receive federal financial assistance. These proposed policies will reverse the Trump Administration's harmful actions that narrowed the scope and application of Section 1557 and left many consumers without fundamental civil rights protections. The proposals will also help achieve health equity, improve health outcomes, and ensure that all individuals can access health care without unnecessary barriers.

We further commend HHS's proposal to interpret Medicare Part B funding as federal financial assistance, thereby expanding the application of Section 1557 to Part B providers. This change will ensure that Medicare beneficiaries have the same nondiscrimination protections regardless of which part of Medicare they are enrolled in. We urge HHS to finalize these policies as proposed.

[4] *Bostock v. Clayton County, Georgia,* 590 U.S. _, 140 S. Ct. 1731 (2020).

[5] *See, e.g., Williams v. Kincaid*, No. 21-2030 (4th Cir. Aug. 16, 2022) (In a landmark decision, the Fourth Circuit found that the Americans with Disabilities Act and the Rehabilitation Act protects individuals with gender dysphoria and recognized that "a transgender person's medical needs are just as deserving of treatment and protection as anyone else's.").

The proposed rule prioritizes patients' rights to access nondiscriminatory health care while clarifying existing laws that ensure a fair process for religious- and conscience-based requests for exemptions or accommodations.

We applaud HHS's efforts to ensure patient access to health coverage and care while clarifying when covered entities can claim religious and conscience exemptions. By specifying that objections are limited to those religious freedom and conscience laws permissible under Title I of the ACA, HHS brings the rule in alignment with statutory text, congressional intent, and a commitment to health equity.[6] Further, we applaud HHS's recognition that consideration of requested accommodations must evaluate potential harms that any accommodation has on third parties or affected individuals and follow applicable legal standards for these laws, including that any requested accommodations under the Religious Freedom Restoration Act must be considered on a case-by-case basis.[7]

Moreover, we strongly support HHS's proposal, as in the 2016 rule, not to import the religious exemption and other exceptions under Title IX into Section 1557 that are limited to certain education programs or activities. This proposal clarifies the Trump Administration's 2020 rule that indicated the application of such exemptions in its preamble but not explicitly in the rule itself. Nothing in Section 1557's antidiscrimination prohibition supports the incorporation of the cited statutes' exceptions, including Title IX's religious exemption.[8] Specifically, incorporation of Title IX's exceptions is inappropriate here because those exceptions were crafted for education programs and activities where students choose which educational institution to attend in order to best fit their needs, including single-sex schools or religiously affiliated schools. Individuals who need health care services, however, especially historically disadvantaged individuals, such as people of color, individuals with disabilities, and LGBTQI+ individuals, among others, may have little to no choice regarding where they can obtain services. We strongly support HHS's proposal not to import the religious exemption and other exceptions under Title IX as they are contrary to the plain statutory text of Section 1557, misapplied outside of the education context, and deeply harmful to individuals accessing health care services.

We urge HHS to implement all sections of this rule—particularly the provision allowing covered entities to proactively notify HHS of their understanding that Section 1557 does not apply to them—in a manner that prioritizes transparency and acknowledges the potential impacts for patients who will be seeking coverage or care and may face denial of critical services from those providers.

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[6] 42 U.S.C. § 18001.

[7] 42 U.S.C. §§ 2000bb to 2000bb-4.

[8] 42 U.S.C. § 18116.

The proposed rule guards against the impermissible use of race- and ethnicity-based inputs in the use of medical algorithms.

We support proposals to provide guardrails for the use of race- and ethnicity-based inputs to medical algorithms, which, when used improperly, can result in discrimination against people of color.[9] While race, ethnicity, and socioeconomic indicators can improve covered entities' understanding of, and response to, health disparities, these inputs can also create disparities when they interfere with a provider's individualized clinical judgment. For example, the use of race and ethnicity data as input variables in medical algorithms and algorithm-informed decision-making in nephrology and cardiology, among other contexts, have contributed to disparities in care between white patients and people of color; this has led to a shift from overreliance on such tools.[10] As a result, we are encouraged that the proposed rule explicitly prohibits the use of clinical algorithms when used in a discriminatory way. The Office for Civil Rights's commitment to a case-by-case factual inquiry into compliance and the development of technical assistance programs to guide implementation appropriately balances the complexity of this issue while ensuring that providers rely primarily on their clinical judgment in treating patients from historically marginalized communities.

The proposed rule facilitates access to health care services for people with disabilities.

We are pleased that the proposed rule creates standards that seek to create equity in quality of care for all patients, including those with disabilities who often experience stigma, bias, and discrimination in the health care system that adversely affects their ability to access needed care and can lead to missed, delayed, or inaccurate diagnosis and treatment, sometimes with deadly consequences.[11] The proposed rule ensures that those with disabilities—including mobility impairments—are not excluded from competent care based on a facility's physical design, ensures that people are informed of the accommodations available to them, and requires that covered entities provide auxiliary aids for those with sensory, manual, or auditory disabilities. To further aid those with disabilities in accessing quality care, we encourage the incorporation of an enforceable standard for covered entities that would ensure that accessible medical diagnostic equipment is widely available.

We support the proposed rule's provisions to address issues at the nexus of disability rights and technology, ensuring that web-based and mobile-based services are accessible to those with disabilities. Recognizing that people with disabilities may face overlapping forms of

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[9] *See, e.g.,* Majority Staff, House Committee on Ways and Means, *Fact Versus Fiction: Clinical Decision Support Tools and the (Mis)Use of Race*, 116th Cong. (Oct. 14, 2021).

[10] Agency for Healthcare Research and Quality, *Impact of Healthcare Algorithms on Racial and Ethnic Disparities in Health and Healthcare*, (Jan. 25, 2022) (https://effectivehealthcare.ahrq.gov/products/racial-disparities-health-healthcare/protocol); Letter from James L. Madara, Executive Vice President and CEO, American Medical Association, to David Meyers, Acting Director, Agency for Healthcare Research and Quality (May 3, 2021).

[11] *See, e.g.,* National Council on Disability, *Enforceable Accessible Medical Equipment Standards: A Necessary Means to Address the Health Care Needs of People with Mobility Disabilities* (May 20, 2021).

discrimination, we appreciate that the proposed rule stipulates that providing auxiliary aids and services for individuals with disabilities includes ensuring that such services are available in languages appropriate for an individual with limited English proficiency (LEP). We urge the adoption of these provisions in the final rule.

The proposed rule reduces discriminatory barriers to health care for individuals with LEP.

Discrimination against individuals with LEP has undermined their ability to access high quality, accurate, and timely care.[12] We are encouraged that the proposed rule creates robust communication standards for covered entities and requires them to notify patients of the accommodations available to them. We are also pleased that, as telehealth and machine translation become more common, HHS is committed to safeguarding against deficiencies in such services, including by setting quality standards for video remote interpreting service and requiring human review for critical matters. We urge HHS to adopt these proposed provisions in the final rule.

We support the explicit prohibition of discrimination on the basis of pregnancy or related conditions as a form of sex-based discrimination in the final rule.

The proposed rule notes that HHS believes it could be "beneficial" to include a provision specifically prohibiting discrimination on the basis of pregnancy or related conditions as a form of sex-based discrimination. We wholeheartedly agree. Following the devastating decision in *Dobbs v. Jackson Women's Health Organization*, it is critical, more than ever before, that HHS clarify in the final rule that discrimination on the basis of pregnancy or related conditions—including termination of pregnancy—is explicitly considered a form of sex-based discrimination throughout the regulation.[13] The *Dobbs* decision has upended abortion access for millions of people throughout the United States, and the impacts of this decision are most acutely felt by those who already face barriers to health care services, including low-income individuals, women of color, young women, those with disabilities, and LGBTQI+ individuals.[14]

Additionally, because of the *Dobbs* decision, state efforts to restrict access to abortion have resulted in further challenges to accessing other sexual and reproductive health care, including contraception, fertility care and treatment, and miscarriage management. We urge HHS to similarly consider that restrictions that deny access to sexual and reproductive health care should also be an enumerated form of sex discrimination.

As noted above, we are pleased that HHS proposed not to incorporate the Title IX of the Education Amendments of 1972 religious exemption and abortion neutrality exception commonly referred to as the Danforth Amendment into the rule and agree that HHS is not bound

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[12] *See, e.g.,* Alexander R. Green and Chijioke Nze, *Language-Based Inequity in Health Care: Who is the "Poor Historian,"* AMA Journal of Ethics (Mar. 2017).

[13] *Dobbs v. Jackson Women's Health Organization,* 597 U.S. _, 142 S. Ct. 2228 (2022).

[14] *See, e.g., 1 in 3 American Women Have Already Lost Abortion Access. More Restrictive Laws are Coming*, Washington Post (Aug. 22, 2022).

to include these provisions in its Section 1557 regulation.[15] Applying these provisions to health care delivery has detrimental impacts on care and we applaud HHS for recognizing that this should not be incorporated into Section 1557.

We support continued efforts to encourage covered entities to collect data on care to protected populations to ensure compliance and promote effective program planning.

We share HHS's understanding that high-quality and comprehensive data is critical to measure disparities, adequately tailor health care services, and ensure that covered entities comply with the statute. We urge HHS to continue to emphasize the importance of data collection to covered entities, encourage them to collect data as part of routine compliance and program-design, and, when necessary, request data from covered entities to evaluate their compliance.

In conclusion, over the past decade, the ACA has enabled the historic expansion of access to both health care coverage and health care services for tens of millions of individuals. For too many individuals, however, including those who face intersectional discrimination based on gender identity, sexual orientation, disability, and/or race and ethnicity, among other factors, discrimination remains a key barrier to health care access. The implementation of this final rule is imperative to addressing these barriers and fulfilling the statutory text and commitment of the ACA. We urge HHS to finalize the proposed rule to strengthen access to health care services and fundamental civil rights protections afforded by this historic law.

Sincerely,

Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
U.S. House of Representatives

Richard E. Neal
Chairman
Committee on Ways and Means
U.S. House of Representatives

Robert C. "Bobby" Scott
Chairman
Committee on Education and Labor
U.S. House of Representatives

[15] 20 U.S.C. §1681 *et seq.*

cc: The Honorable Cathy McMorris Rodgers, Ranking Member, Committee on Energy and Commerce
The Honorable Kevin Brady, Ranking Member, Committee on Ways and Means
The Honorable Virginia Foxx, Ranking Member, Committee on Education and Labor