UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, STATE OF CALIFORNIA, COMMONWEALTH OF MASSACHUSETTS, STATE OF COLORADO, STATE OF CONNECTICUT, STATE OF DELAWARE, DISTRICT OF COLUMBIA, STATE OF HAWAII, STATE OF ILLINOIS, STATE OF MAINE, STATE OF MARYLAND, STATE OF MICHIGAN, STATE OF MINNESOTA, STATE OF NEVADA, STATE OF NEW JERSEY, STATE OF NEW MEXICO, STATE OF NORTH CAROLINA, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, STATE OF RHODE ISLAND, STATE OF VERMONT, COMMONWEALTH OF VIRGINIA, and STATE OF WISCONSIN, Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX M. AZAR II, *in his official capacity as Secretary of Health and Human Services*, and ROGER SEVERINO, *in his official capacity as Director of the Office for Civil Rights at the United States Department of Health and Human Services*, Defendants.	Civil Action No. 1:20-cv-5583 BRIEF OF AMICI NATIONAL HEALTH LAW PROGRAM ET AL., IN SUPPORT OF PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT

TABLE OF CONTENTS

TABLE OF AUTHORITES

CASES

STATUTES

REGULATIONS

ADMINISTRATIVE MATERIALS

OTHER AUTHORITIES

INTRODUCTION AND STATEMENT OF INTEREST

A decade ago, discrimination in health care was the normal course of business. The ACA said "no more" with provisions to end insurers denying coverage for people with disabilities or chronic health conditions, annual and lifetime benefit limits, and drastically more expensive premiums for women and older adults. Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148 (2010), as amended in the Health Care and Education Reconciliation Act, Pub. L. No. 111-152 (2010). Section 1557 of the ACA also prohibits discrimination in health care based on race, sex, age, and disability. 42 U.S.C. § 18116. Another part of the ACA, Section 1554, prohibits HHS from issuing regulations that create unreasonable barriers to obtaining appropriate medical care, impede timely access to care, interfere with communications between the patient and provider, and limit the availability of health care for the full duration a person needs. *Id.* § 18114.

Amici the National Health Law Program, Disability Right Defense and Education Fund, Justice in Aging, American Association of People with Disabilities, American Association on Health & Disability, Arizona Center for Law in the Public Interest, Asian & Pacific Islander American Health Forum, Asian Resources, Inc., Association of Asian Pacific Community Health Organizations, Autistic Self Advocacy Network, California Advocates for Nursing Home Reform, California Pan-Ethnic Health Network, Center for Civil Justice, Center for Elder Law & Justice, Center for Law and Social Policy ("CLASP"), Center for Medicare Advocacy, Center for Public Representation, Children Now, CommunicationFIRST, Community Legal Aid Society, Inc. (Delaware), Disability Law

Center of Alaska, Disability Rights California, Disability Rights North Carolina, Disability Rights Wisconsin, Equip for Equality, Georgia Advocacy Office, Health Law Advocates, Inc., Hispanic Federation, Kentucky Equal Justice Center, Legal Aid Society of San Mateo County, Legal Council for Health Justice, Maternal and Child Health Access, Medicare Rights Center, Mississippi Center for Justice, National Association of Councils on Developmental Disabilities, National Council on Aging, National Council on Independent Living, National Council on Interpreting in Health Care, National Federation of the Blind, National Hispanic Council on Aging, National Immigration Law Center, Pennsylvania Health Law Project, PRC, Public Citizen Foundation, Public Justice Center, SAGE (Advocacy and Services for LGBT Elders), SC Appleseed Legal Justice Center, Southeast Asia Resource Action Center, Tennessee Justice Center, Virginia Poverty Law Center, and Western Center on Law and Poverty are health, disability, elder justice, legal services, and civil rights advocacy organizations dedicated to eliminating disparities in health care.[1] Proposed amici have a strong interest in ensuring that the regulations adhere to the statute and that people receive the full protection of Section 1557. *See* 5 U.S.C. § 702.

The initial rulemaking process for Section 1557 resulted in 25,000 comments that highlighted existing discrimination that impeded access to health care, resulting in

[1] None of the proposed Amici is a subsidiary of any other corporation and no publicly held corporation owns 10% or more of any proposed Amici's stock. No party's counsel authored the brief in whole or in part; no party or party's counsel contributed money that was intended to fund preparing or submitting the brief; and no one other than the Amici contributed money that was intended to fund preparing or submitting the brief.

denied and delayed care, incorrect treatment, mistreatment by providers and staff, increased costs, and many other harmful impacts. The rulemaking culminated in the U.S. Department of Health and Human Services ("HHS") issuing a final rule in 2016. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) (codified at 45 C.F.R. pt. 92), https://perma.cc/47EC-4NZL ("2016 Final Rule").[2] The Trump Administration has issued new rules and, in doing so, illegally jettisoned protections against discrimination that will harm Lesbian, Gay, Bisexual, Transgender, Queer Plus ("LGBTQ+") individuals, women, pregnant people, limited English proficient ("LEP") individuals, people with disabilities, and older adults. Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020), https://perma.cc/P2TJ-AN54 ("2020 Revised Rule").[3]

I. The Rule Illegally Narrows the Scope of Health Entities Subject to Section 1557's Nondiscrimination Mandate.

Section 1557 prohibits discrimination by "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance," "any program or activity that is administered by an Executive Agency," or "any entity established under [Title I of the ACA]." 42 U.S.C. § 18116(a). The 2020 Rule impermissibly attempts to narrow the scope of health care entities covered by this

[2] All comments received by HHS in response to the 2015 NPRM can be found at https://perma.cc/X267-26UZ. In this brief, individual comments have been identified by their comment ID number the first time they are cited and then by the organization's name thereafter.

[3] All comments received by HHS in response to the 2019 NPRM can be found at https://perma.cc/4VCN-Y2DK. In this brief, individual comments have been identified by their comment ID number the first time they are cited and then by the organization's name thereafter.

statutory provision, specifically by enacting regulations that exclude private health insurers receiving federal funding and most HHS programs from its purview. 85 Fed. Reg. at 37,244-45 (codified at 45 C.F.R. § 92.3). This Rule is contrary to the plain language of Section 1557. It cannot stand.

A. The Rule Impermissibly Exempts the Programs and Activities of Health Insurers from Section 1557's Scope.

The 2020 Rule incorrectly attempts to limit the definition of "health program[s] or activit[ies]" to only "the operations of entities principally engaged in the business of providing healthcare." *Id.* at 37,244 (codified at 45 C.F.R. § 92.3(b)). It states that "an entity principally or otherwise engaged in the business of providing health insurance shall not, by virtue of such provision, be considered to be principally engaged in the business of providing healthcare." *Id.* at 36,244–45 (§ 92.3(c)). These provisions contradict the plain meaning of Section 1557 and the rest of the ACA, as well as Congress's intent in enacting the ACA. *See* Am. Med. Ass'n., Comment ID HHS-OCR-2019-0007-137131, Ex. 1 at 61-62 (describing how the text of the ACA statute "is clear that it applies to health programs or activities, *any part of which* received federal financial assistance."); Cities of New York et al., Comment ID HHS-OCR-2019-0007-147950, Ex. 1 at 139-41 (same).

The statutory language that Congress used in Section 1557 is extremely broad, covering "any health program or activity, any part of which is receiving Federal financial assistance." 42 U.S.C. § 18116(a). It reaches health insurers. The ACA does not define the term "health program or activity," but uses the term health program at least 30 times, broadly and inclusively, to reference the provision both of care and of insurance. *See, e.g.*,

42 U.S.C. § 18051; *id.* § 299b-31 (cross-referencing 42 U.S.C. § 1320a-7b); 25 U.S.C. § 1623. Health insurers, both public and private, have a significant role in the provision of health care, including controlling access to health care services through benefit design and utilization management. Health insurers also frequently accept federal funding, for example, by participating in federal programs like Medicaid and Medicare. Congress recognized the central role of health insurers in the provision of health care through the enactment of the ACA, the primary purpose of which was to expand the availability and scope of health insurance and assist individuals in securing and enrolling in health insurance coverage. If Congress meant to exclude health insurance from the term "health program or activity"—particularly in a law that is about health insurance—it would have made this point clear. As the Supreme Court has repeatedly observed, "Congress does not hide elephants in mouseholes." *Cyan, Inc. v. Beaver Cty. Emps. Ret. Fund.*, 138 S. Ct. 1061, 1071 (2018) (internal quotation marks and citations omitted); *see* Am. Med. Ass'n. Comment, Ex. 1 at 62 ("If Congress had intended that only the product receiving such assistance was bound by the nondiscrimination provisions, it could have easily stated as much in very simple terms."). Instead, as HHS recognized in its 2016 Rule, Congress crafted a law that improved access to health coverage for all, and it closed a gap in nondiscrimination law that had infringed on the basic rights of people with disabilities, women, LGBTQ+ individuals, LEP individuals, and others for decades. 81 Fed. Reg. at 31445.

Prior to the ACA, private health insurers could discriminate in the administration and design of health care benefit plans without federal legal consequence. The business

model of health care incentivized insurers to "lemon drop and cherry pick" by denying coverage to individuals with high health needs or who would otherwise be costly to the plan. *See* Disability Rights Education & Defense Fund ("DREDF"), Comment ID HHS-OCR-2019-0007-147108, Ex. 1 at 244-45 ("Prior to the ACA, people with disabilities were commonly denied or terminated from health coverage, faced annual and lifetime benefit limits, and could not find affordable coverage."); Lambda Legal, Comment ID HHS-OCR-2019-0007-154936, Ex. 1 at 480 (describing how 2020 Revised Rule will undermine progress resulting from the ACA to eradicate health care discrimination against LGBTQ+ people, particularly transgender people seeking transition-related care). While there was some federal and state regulation of restrictive coverage policies, insurers had a large array of discriminatory mechanisms at their disposal to deny enrollment, limit benefits, and impose high premiums and special cost-sharing on enrollees with disabilities and pre-existing conditions. Nat'l Health Law Program ("NHeLP"), Comment ID HHS-OCR-2019-0007-127004, Ex. 1 at 559 (describing how health insurance companies routinely discriminated against people with preexisting conditions, women, and people with serious, chronic, or life-threatening conditions).

Before the ACA, lower court interpretations of the Americans with Disabilities Act ("ADA") and Section 504 of the Rehabilitation Act prevented people with disabilities from challenging the discriminatory actions of private insurers. For example, if an insurer excluded coverage of services and devices such as wheelchairs or ventilators that disabled people uniquely relied on, or imposed exorbitant limitations or cost-sharing on such coverage, then such policies were largely insulated from legal challenge. This was

because the ADA included a "safe harbor" for providers of insurance. 42 U.S.C. § 12201(c). Further, Section 504, even before the development of insurance marketplaces, had been incorrectly interpreted by many lower courts to prohibit claims challenging the discriminatory design of health insurance plan benefit design. *See, e.g.*, *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557 (7th Cir. 1999) (citing *Alexander v. Choate*, 469 U.S. 287 (1985); *see also* Samuel R. Bagenstos, *The Future of Disability Law*, 114 Yale L.J. 1, 41 (2004).

The ACA included reforms to address these situations, ushering in a new era for health equity. It implemented sweeping reforms to expand coverage; created protections in enrollment, cost-sharing, and benefit design; and improved the scope and quality of private health insurance. *See* Disability Rights North Carolina ("Disability Right NC"), Comment ID HHS-OCR-2019-0007-151930, Ex. 1 at 286 (describing how the ACA and Section 1557 implemented protections critical for the ability of people with disabilities to receive appropriate, accessible care and nondiscriminatory insurance coverage). On the other side of the equation, private health insurers were offered the opportunity to participate in federal and state insurance marketplaces. As an integral component of these reforms, Congress included Section 1557, which deliberately extended civil rights to the private health insurance context. Correcting decades of injustice, Congress used Section 1557 to expressly prohibit insurers from designing plan benefits and employing marketing practices that discourage people with disabilities from enrolling. 42 U.S.C. § 18022(b)(4)(B).

The U.S. Court of Appeals for the Ninth Circuit recently affirmed Section 1557's application to private health insurers in *Schmitt v. Kaiser Foundation Health Plan of*

Washington, 965 F.3d 945 (9th Cir. 2020). In *Schmitt*, the Ninth Circuit considered whether a private insurer's exclusion of all treatments for hearing loss (except cochlear implants) constituted discrimination within the meaning of Section 1557. *Id*. at 954. Among other conclusions, the court held that Section 1557 applies to "health insurance contracts," *id*. at 951, and "prohibits discrimination in the design of plan benefits," *id*. at 954.

HHS has offered no legitimate justification for reading health insurance companies out of "health care." First, it cites to another federal statute (5 U.S.C. § 5371) with an entirely different purpose, which defines "health care" for purposes of that law as "direct patient-care services or services incident to direct patient care-services." 85 Fed. Reg. at 31,172. That law, however, concerns pay rates and personnel practices for federal employees, and it uses the term "health care" simply to describe a category of federal employees who work in that sector. It would make little sense for that law to include individuals engaged in providing health insurance, as the federal government does not employ a large set of individuals to provide health insurance. Using an unrelated law with a different purpose to define health insurance out of the nondiscrimination provisions of a law that is about health insurance is without foundation and inconsistent with the unambiguous statute that HHS attempts to rewrite. If Congress had meant to use the terms of the pre-existing law rather than what it said in Section 1557, it certainly could have done so.

Second, the Rule incorrectly incorporates the Civil Rights Restoration Act of 1987 ("CRRA") into Section 1557. *See* 85 Fed. Reg. at 37,171. The CRRA was enacted to restore the full reach of federal civil rights laws after court decisions narrowed their scope. Pub.

L. 100-259, § 2. The CRRA clarifies that Section 504, Title VI, Title IX, and the Age Discrimination Act cover entities if their programs or activities receive federal financial assistance "as a whole" or if the entity is "principally engaged in the business of providing . . . health care . . . ."). Pub. L. 100-259, 102 Stat. 28 (Mar. 22, 1988). In enacting the ACA, Congress did not incorporate the CRRA into Section 1557, though it obviously could have done so. *See* 42 U.S.C. § 18116(a); Gender Justice, Comment ID HHS-OCR-2019-0007-153601, Ex. 1 at 423-24 (explaining why the CRRA's definition of "program or activity" is not applicable); NHeLP Comment, Ex. 1 at 565-67 (explaining the embedded functions of insurers in health care). Ignoring the words of the ACA, HHS arbitrarily defined health insurance out of "the business of providing health care." HHS's proposal is illogical. Congress has already answered the question of whether coverage under Section 1557 requires federal financial assistance for part of a program or activity or for its operations as a whole: the statute says that any health program or activity is covered if "any part" of it receives federal financial assistance. 42 U.S.C. § 18116(a). The Rule erroneously ignores this language and inappropriately limits how receipt of federal financial assistance applies. *See also* NHeLP Comment, Ex. 1 at 562 (explaining that this definition is inconsistent with other HHS regulations such as the 2019 health care refusals rule). HHS's labored use of the CRRA to narrow the application of Section 1557, in light of a non-contemporaneous definition of "the business of providing health care," subverts the purpose of both laws.

B. The Rule Impermissibly Excludes HHS Programs from the Scope of Section 1557.

The 2020 Rule also attempts to narrow the scope of Section 1557 as it applies to HHS activities and programs receiving federal financial assistance. It seeks to exclude a wide range of important HHS activities, including, for example, programs administered by the Health Resources and Services Administration ("HRSA"), which support the health care workforce and improve health care for people who are geographically isolated or medically vulnerable.

Section 1557, by its statutory terms, applies to "any program or activity that is administered by an Executive Agency" or to "any entity established under [Title I of the ACA]." 42 U.S.C. § 18116(a). HHS's new interpretation of Section 1557 impermissibly changes the word "or" to "and" while deleting "any entity" as a distinct subject in the second clause, all in an attempt to narrow the statute's application to the limited subset of health programs or activities administered by an Executive agency "and" created under Title I of the ACA. 85 Fed. Reg. at 37,244–45. This reading is inconsistent with the statute, which uses the word "or," thereby plainly prohibiting discrimination by both programs or activities "administered by an Executive Agency" as well as those entities "established under" ACA Title I. If Congress had intended to limit Section 1557 to only those entities created under Title I, it would not have included the additional clause pertaining to executive agencies.

Moreover, this proposal would produce illogical results. It would create a situation whereby recipients of federal financial assistance would be subject to Section

1557's nondiscrimination requirements, but agencies administering or funding such programs would be exempt. For example, state Medicaid programs would be subject to Section 1557 as recipients of federal financial assistance, but the Centers for Medicare & Medicaid Services ("CMS"), which oversees these programs, would be exempt. In addition, executive agencies are covered other civil rights statutes, like Section 504, through similar language. Thus, Section 1557's must be interpreted to require compliance by executive agencies; the 2020 Revised Rule's interpretation that Section 1557 does not reach executive agencies is inconsistent with courts' interpretation of the applicability of civil rights statutes to executive agencies and the language of Section 1557 itself.

Finally, the narrowing of Section 1557's application will have a disproportionate impact on people with disabilities, contrary to the purposes of the ACA. *See* DREDF Comment, Ex. 1 at 253 ("The elimination of the benefit design regulation will disproportionately harm people with disabilities, who rely on Section 1557's enforcement mechanisms to hold health insurers and health providers accountable for discriminatory practices."). People with disabilities have been and continue to be systemically disadvantaged by the U.S. health system, which, among other things, has fragmented funding and delivery systems, an institutional bias in its provision of long-term services and supports (that many people with disabilities rely on to live, work, attend school, and participate in their communities), and a long history of exclusion of people with disabilities from research and clinical trials. This narrow and incorrect interpretation of Section 1557's application to HHS programs will only serve to exacerbate these systemic discriminatory disparities; disparities the ACA was intended to address. *See* Disability

Law Ctr., Comment ID HHS-OCR-2019-0007-127904, Ex. 1 at 240 ("Section 1557 and its implementing rules are critical because people with disabilities are routinely discriminated against in the provision of health care."). The topical specificity of Section 1557 in its broad application across the gamut of health care activities and programs is a key part of what distinguishes it from both Section 504 and the ADA which apply across a narrower range of activities and programs. Before Section 1557's enactment, health care entities ranging from Medicare Advantage plans to any of the external researchers that received billions in National Institutes of Health grants, paid little practical attention to what nondiscrimination meant in their particular health care context. Section 1557 helped fill this gap by unequivocally holding private health care entities to such requirements as providing effective communications to the public and fully including people with disabilities in the design and assessment of health prevention research, emergency management, and public health issues such as vaccination allocation. Sharply reducing the types of covered entities creates significant harm to individuals served by those entities who may now have very limited recourse for addressing discrimination in those programs. *See, e.g.*, ACLU Founds. of Cal., Comment ID HHS-OCR-2019-0007-149859, Ex. 1 at 17 ("the Proposed Rule displays no awareness of the potential harm to individuals denied coverage of and access to health care due to the proposed limitations on Section 1557's application."). HHS's cramped reading of Section 1557 is contrary to the statute, including the provision of Section 1554 limiting HHS's rulemaking authority, and is arbitrary and capricious. 42 U.S.C. § 18114.

II. Removal of Effective Communication Requirements Will Harm Individuals with Limited English Proficiency ("LEP"), Older Adults, and People with Disabilities.

Before the ACA, individuals who needed communication assistance confronted barriers to exchanging important information between providers and patients. The result? People went without preventive visits, were unable to comply with their prescribed treatment regimens, and missed important follow-up appointments. 81 Fed. Reg. at 31,459. Congress passed the ACA to "help uninsured and underserved populations gain access to care[.]" 81 Fed. Reg. at 31,443. The 2016 Final Rule recognized the ACA and Section 1557's purposes to "expand access to care and eliminate barriers to access." *Id.* at 31,377.

In spite of 1557's mandate, HHS removed provisions that ensure that individuals with limited English proficiency ("LEP") and people with disabilities can access quality health care. The 2020 Revised Rule eliminates notice requirements that are critical for people to understand their rights. *See* 85 Fed. Reg. at 37,204. Specifically, the new Rule removes requirements for taglines—short statements commonly added to documents that inform individuals in their language of their right to free language assistance and how to seek such assistance. *Id.* at 37,175. The 2020 Revised Rule also harms people with disabilities by limiting access to necessary effective communication. *Id*. at 37,213-37,215; *see also* CCD Comment, Ex. 1 at 222-23.

A. Harm of Repealing the Notice and Tagline Requirements

The 2016 Final Rule contained provisions to ensure that patients understand their rights and are able to communicate with health care staff. The Rule also required covered

entities to provide posted notices, on site and on their websites, of nondiscrimination policies, including notice of how to access auxiliary aids and services necessary for patients with disabilities and language assistance services for LEP patients. 81 Fed. Reg. at 31,469.

In crafting the 2016 Final Rule, HHS found that "the use of incompetent or ad hoc interpreters, such as family members, friends, and children, is not uncommon and can have negative implications." 80 Fed. Reg. at 54,184. Accordingly, the 2016 Final Rule required covered entities to include taglines on all significant documents in the top 15 languages spoken by individuals with LEP in their state. 45 C.F.R. § 92.8(d)(1); *see* 81 Fed. Reg. at 31,469.

Commenters to the 2019 Proposed Rule repeatedly warned HHS that, without these provisions, individuals will not understand or assert their rights. *See, e.g.*, Disability Law Ctr., Ex. 1 at 241 ("Without the notice, members of the public will have limited means of knowing that auxiliary aids and services are available."); Leadership Conference Educ. Fund, Comment ID HHS-OCR-2019-0007-138231, Ex. 1 at 503 ("Protections for language access are also required in order to combat discrimination based upon national origin."); Asian Health Services, Comment ID HHS-OCR-2019-0007-146378, Ex. 1 at 110 (Oakland, California-based health organization that serves 28,000 individuals per year, 73% of whom are LEP, noting that the elimination of notice and tagline provisions would leave their clients "excluded from programs and services they are legally entitled to"); ACLU of Haw., Comment ID HHS-OCR-2019-0007-144355, Ex. 1 at 26 ("LEP individuals face unique risks and barriers to knowing and asserting their

rights in the health care context…LEP individuals in the state routinely face barriers to care due to denied access to interpreters and translators."). Commenters explained that the notice and tagline provisions are necessary to inform individuals of their rights to free communication services and protection against discrimination based on disability and national origin. For example, Connect for Health Colorado explained:

> Connect for Health Colorado has experienced an increase in use of language line services over time in a wide range of languages. We routinely utilize a language line to communicate with customers in Vietnamese, Karen, Mandarin, Tigrinya, Amharic, Cantonese, Korean, Arabic, Mongolian, French, Sorani, Nepali, Burmese, Albanian, Tamil, Somali, Russian, Thai, Bosnian, and Spanish, (among others) and have done so since our inception. Language line services provide Coloradans from diverse backgrounds with access to information about their coverage, and the ability to ask questions and improve health literacy. Without tagline requirements, these communities may not know that translation services are available, and may underutilize programs that they are eligible for, resulting in increased health disparity and higher costs in accessing emergency care.

Connect for Health Colorado, Comment ID HHS-OCR-2019-0007-147312, Ex. 1 at 202; *see also* Cal. Pan-Ethnic Health Network, Comment ID HHS-OCR-2019-0007-152828, Ex. 1 at 114 ("Current statistics show that more than 40% of Californians do not speak English at home, and an estimated 6 to 7 million Californians are limited English proficient (LEP) . . . For some populations, such as Vietnamese and Korean speakers, over 60% are limited English proficient, and as a result, they and other LEP individuals are faced with language and cultural barriers when seeking care" (citing 2007 American Community Survey)); Medicare Rights Ctr., Comment ID HHS-OCR-2019-0007-145479, Ex. 1 at 527 ("LEP beneficiaries rely on notice requirements that allow them to understand and fully engage in their health care through meaningful communication with providers.").

Commenters provided clear examples of the impact of removing the notice and tagline requirements, including that people with communication needs will receive inadequate care, delayed care, or no care at all. *See, e.g.*, NHeLP Comment, Ex. 1 at 578-79 (citing examples of irreparable harm from medical errors and lower quality of care due to language barriers documented in Nat'l Health Law Prog., *The High Costs of Language Barriers in Medical Malpractice* (2010), https://perma.cc/5KB4-MHT9); Leadership Conference Educ. Fund Comment, Ex. 1 at 503-04 (citing The Joint Comm'n, *Overcoming the Challenges of Providing Care to LEP Patients* (May 2015), https://perma.cc/BE6A-5QYP); Commonwealth of Mass., Comment ID HHS-OCR-2019-0007-136510, Ex. 1 at 198 ("[LEP p]atient safety can be impacted by poor patient comprehension of their medical condition, treatment plan, discharge instructions, complications, and follow-up; inaccurate and incomplete medical history; ineffective or improper use of medications or serious medication errors; improper preparation for tests and procedures; and poor or inadequate informed consent."). As the 2016 Final Rule recognized, studies have shown that "when reliable assistance services are utilized, patients experience treatment-related benefits, such as enhanced understanding of physician instruction, shared decision-making, provision of informed consent, adherence with medication regimes, preventive testing, appointment attendance, and follow-up compliance." 81 Fed. Reg. at 31,459 (citing Inst. of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* 17 (2002), https://perma.cc/RQK2-U9RA) (citation omitted). This is particularly true for LEP older adults, including the four million plus LEP Medicare beneficiaries. Justice in Aging, Comment ID HHS-OCR-2019-

0007-149354, Ex. 1 at 452 (citing CMS, Office of Minority Health, *Understanding Communication and Language Needs of Medicare Beneficiaries* (2017), https://perma.cc/YS5Q-BDJ6); *see also id.* at 453, n. 5 (describing how Social Security data shows that low-income seniors are disproportionately LEP). The record also establishes that, without these protections, it will be more onerous for LEP patients to navigate complex documents or deal with erroneous billing. *See id.* at 453 ("Especially for [LEP] older adults with limited income and high health care needs, the consequences of an erroneous bill or forgoing care can be catastrophic."); Int'l Comm. Health Servs., Comment ID HHS-OCR-2019-0007-142469, Ex. 1 at 460 (comment of Federally Qualified Health Center noting that if notice and tagline "protections were eliminated, if an LEP older adult does not understand a billing statement they receive, and is not notified of their right or informed of how to get help in their primary language, then they may . . . fail to follow up or pay for a service when Medicare denies coverage because they were not adequately informed . . . .").

B. The 2020 Revised Rule Discriminates by Limiting Access to Effective Communication for People with Disabilities.

The lack of effective communication has "significant adverse effects on . . . access to, participation in, compliance with, and decision-making in health care." American Speech-Language-Hearing Association, Comment ID HHS-OCR-2019-0007-127462, Ex. 1 at 56; *see also* ANCOR, Comment ID HHS-OCR-2019-0007-104180, Ex. 1 at 72 ("The individuals that ANCOR members work with often have significant disabilities, may be

nonverbal, and require effective communicative devices to communicate. It is essential that this access is protected to ensure they can be active in decision making for their health and to reach the best outcomes."); Disability Law Ctr. Comment, Ex. 1 at 240 (discussing challenges for persons with sensory impairments). To address this problem, the 2016 Final Rule provided clear definitions regarding auxiliary aids and services, interpreters, and other disability related definitions. The 2016 Final Rule required that all auxiliary aids and services be provided timely and free of charge as is required by other disability nondiscrimination laws. By contrast, the 2020 Final Rule eliminates these provisions and requires that a subset of auxiliary aids and services—interpreters—be provided free of charge and in a timely manner. *Compare* 81 Fed. Reg. at 31,466-67 (former 45 C.F.R. § 92.4, § 92.202) *with* 85 Fed. Reg. at 37,213-16 (new § 92.102). Significantly, interpreters provide effective communication for a very narrow subset of people with disabilities. Auxiliary aids and devices include a broad range of services such as closed captioning, qualified readers, Braille materials, telephone handset amplifiers, and other similar devices. They also include using people with training, skill, or experience to assist an individual who has unique communication support needs. For example, a person who is hard of hearing may not always know American Sign Language or be able to use closed captioning but may be able to use an amplifying device compatible with their hearing aid. These aids and devices are also important given the increasing use of technology in health care, including websites, that is not always fully accessible. As commenters noted, the 2016 Final Rule's clarity was necessary, given the importance of these aids, the ongoing issues with communication access, and the impact of not providing them. *See, e.g.*, Comment of

Disability Rights NC, Ex. 1 at 286 (noting largest health system in the state often fails to fulfill its auxiliary aid obligations); Lenox Hill Neighborhood House, Comment ID HHS-OCR-2019-0007-147088, at 512 (describing the auxiliary aid needs of an older New York resident with paralysis from a stroke to access and communicate with physical and mental health providers and the health deterioration that would result without those aids).

The 2020 Final Rule's distinction between type of auxiliary aids and devices that will be provided free and timely discriminates against people who need other auxiliary aids and devices, in direct contravention of Section 1557's statutory prohibition on disability-based discrimination.

III. HHS's Justifications for Repealing the Notice and Tagline Provisions Rely on Inaccurate and Biased Data and Incorrect Calculations of the Costs and Benefits of the Provisions

Without providing a reasoned analysis for the change, the 2020 Revised Rule eliminates the 2016 Final Rule's notice and tagline protections. *See* 85 Fed. Reg. at 37,204. The court in *Whitman-Walker* determined that HHS "discharge[d] its obligation to consider an important aspect of the problem" when it eliminated these protections. *Whitman-Walker v. U.S. Dep't Health & Human Servs.*, No. 20-1630, 2020 WL 5232076, at *29 (D.D.C. Sept. 2, 2020) (citation omitted). But a close examination of the record shows that the agency's actions fell short. In promulgating the 2020 Revised Rule, HHS completely ignored its own prior factual findings, without explanation. Moreover, it relied on an incomplete and inaccurate cost-benefit analysis and failed to meet its statutory obligation to consider and be responsive to hundreds of comments detailing the benefit that the

provisions confer and the harm that would result from repealing them. As such, the agency's action was arbitrary and capricious.

HHS's cost-benefit analysis conflicts with the agency's own prior findings. Thus, the agency needed to provide a detailed and reasoned justification for the new policy. *FCC v Fox Television, Inc.*, 556 U.S. 502 (2009) ("[W]hen, for example, its new policy rests upon factual findings that contradict those which underlay its prior policy . . . [i]t would be arbitrary or capricious to ignore such matters.") (internal citation omitted). Here, HHS failed to provide that justification. In the 2016 Final Rule, HHS cited numerous studies that demonstrated numerous tangible and intangible benefits that notices and taglines provide to LEP individuals, and numerous benefits to providers, including cost-savings from avoided malpractice claims. 81 Fed. Reg. at 31,459. HHS explicitly recognized that the notice and tagline provisions would "create substantial benefits to patients and providers by improving access to quality care." *See id.* (citing U.S. Dep't Justice, *Report to Congress, Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency* 20 (2002), https://perma.cc/5C54-4WWH). But in 2019, HHS said, without providing a reasoned explanation or analysis, that the taglines do not help the vast majority of recipients. 85 Fed. Reg. at 37,211. This rationale ignores the benefit to the millions of recipients that would benefit from the taglines and the benefit to all recipients of the notices. *See, e.g.*, Volunteers of Legal Service, Comment ID HHS-OCR-2019-0007-130443, Ex. 1 at 706 (noting that "more than 400,000 New York City residents over the age of sixty who speak English less than very well," who benefit from notice and tagline provisions); Ass'n of

Am. Med. Colls., Comment ID HHS-OCR-2019-0007-115960, Ex. 1 at 44-45 ("[R]epeal[ing] notice and tagline requirements would impede access to critical language assistance services for millions of LEP individuals, contributing to and exacerbating existing racial and social inequities related to healthcare access and utilization."). HHS ignored the majority of comments which argued that the costs of notice and tagline requirements were outweighed by the significant benefits identified. *See, e.g.,* Leadership Conference Educ. Fund Comment, Ex. 1 at 504 (HHS "fails to adequately capture the immeasurable benefits of language access, including increased access and participation from underserved communities, improved health outcomes, and compliance with anti-discrimination laws. The cost-benefit analysis also fails to account for the costs to a consumer (as well as their family) when they are denied or delayed language assistance and their health suffers.").

In the 2020 Revised Rule, HHS relied exclusively on two comments that asserted costs associated with providing notices and taglines; those comments citied internal studies and reports from insurers and pharmacy benefit managers that were not explained with any detail or provided to the public. *See, e.g.,* 84 Fed. Reg. at 27,258-59; *see also, e.g.,* Ass'n of Am. Med. Colls., Ex. 1 at 45 ("Relying primarily on cost assessments and feedback from select covered entities/stakeholders to measure the impact of the notice and tagline requirements does not provide a complete and accurate perspective on the value of the current regulations."). This rationale ignores the record and the original factual findings and basis of the 2016 Final Rule. HHS cannot show that it has "articulate[d] any rational connection between the facts found and the choice made,"

when it ignored the evidence in the record, and manipulated the calculation of costs and benefits to achieve its desired outcome. *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962). Thus, the repeal of the notice and tagline provisions is arbitrary and capricious.

Commenters specifically described the value of notices, which HHS did not incorporate into its analysis, thus failing to meet its obligations under the APA. *See, e.g.*, ACLU Founds. of Cal., Ex. 1 at 18-19 (notice "is crucial to ensure that individuals are aware of the safeguards in place and of the steps they can take to effectuate the protections under Section 1557"); Cal. Pan-Ethnic Health Network, Ex. 1 at 113-14 (notice is consistent with civil rights law requirements and HHS provides no explanation for how people will know their rights); Colorado Ctr. Law & Pol'y, Comment ID HHS-OCR-2019-0007-147722, Ex. 1 at 192-93 (notice requirement assisted people in "easily accessing information about their rights," and increased "public understanding of the importance of nondiscriminatory access, a key component of the ACA"); New Mexico Asian Family Ctr., Comment ID HHS-OCR-2019-0007-60940, Ex. 1 at 692 ("LEP persons are uniquely at risk of facing barriers to knowing and asserting their rights [so that l]ack of uptake of services raises questions about . . . what covered entities are doing to communicate those rights, as opposed to justifying elimination of notices . . . .").

Similarly, HHS's analysis did not account for many of the benefits that taglines provide to LEP individuals identified by numerous comments. *See* Health Care for All, Comment ID HHS-OCR-2019-0007-127657, at Ex. 1 at 439 (nothing that "taglines are necessary to ensure that people are notified of their rights under law," including

"awareness of language services by LEP persons" and "awareness by the general public about their rights as protected by Section 1557," especially Massachusetts residents "whose first language is Spanish, Portuguese, Chinese, French Creole, Vietnamese"); Am. Speech-Language-Hearing Ass'n, Ex. 1 at 55 ("[T]aglines inform LEP individuals about how to access language assistance services and encourage those individuals to identify themselves and the languages in which they communicate[which confers] benefits of improved access to and understanding of health care services for LEP individuals.").

Commenters also discussed the cost-effectiveness of taglines, which was not addressed by HHS. *See e.g.,* ACLU of Haw. Comment, Ex. 1 at 25 ("In Hawai'i, there are 163,995 people with limited English proficiency ("LEP"), taglines are cost-effective ways to maintain access for LEP individuals without translating entire documents."). HHS therefore "entirely failed to consider an important aspect of the problem." *Burlington Truck Lines*, 371 U.S. at 168.

Moreover, HHS wrongly discounted the benefits provided to LEP individuals under the 2016 Final Rule by incorrectly declaring that the tagline requirements are duplicative of existing requirements. 85 Fed. Reg. 37,223. For example, HHS cites the Medicare Advantage (Part C) and Prescription Drug Plans (Part D) as requiring taglines in Medicare Communications and Marketing Guidelines ("MCMG"), but the Centers for Medicare & Medicaid Services eliminated this requirement effective this year. *See* CMS, *MCMG* (2018), https://perma.cc/2T3G-DTAR; see also CMS, Medicare Communications and Marketing Guidelines (Aug. 6, 2019), https://perma.cc/JZ85-S3TC (removing the

tagline requirements). HHS also cites requirements in Medicare and Medicaid managed care, but those differ from the requirements of the 2016 rule. For example, the rules governing Medicare Advantage and Prescription Drug Plans only require written translation when a 5% population threshold is triggered in a plan's service area; it does not include any tagline requirements. *See* 42 C.F.R. §§ 422.2268, 423.2268. Similarly, the Medicaid managed care rules only require plans to include "taglines in the prevalent non-English languages in the State" on their written materials and allows states to determine what languages are considered "prevalent." 42 C.F.R. § 438.10(d). By contrast, the 2016 Final Rule required taglines to be provided in the "at least the top 15 languages spoken by individuals with limited English proficiency of the relevant State or States," which may exceed the languages determined to be "prevalent" in a particular state. 81 Fed. Reg. at 31,469 (formerly codified at § 92.8(d)(1)). Thus, HHS's justification that the 2016 Final Rule's tagline requirements are duplicative of existing requirements is false.

The same is true with respect to notices. HHS asserts that notices of nondiscrimination are already required under Title VI, Section 504, the Age Discrimination Act, and Title IX. 85 Fed. Reg. at 37175-76. However, none of these notice requirements achieve what was intended by Section 1557 and implemented by the 2016 Final Rule. For instance, notice under the Age Discrimination Act requires only that individuals are made aware of the statute's protections. *See* 45 C.F.R. § 91.32. By contrast, notices under the 2016 Final Rule provided significantly more detail to inform people not only about their rights, but also how to enforce them, including requirements that each notice provide contact information for a person responsible to handle complaints and

directions on how to file a complaint with HHS. Like taglines, the 2016 Final Rule also required these notices to be translated into the top 15 languages in the state, to ensure they apprised LEP individuals of their rights. Not only did the 2016 Final Rule harmonize notice requirements across various federal civil rights statutes, it improved upon them to set forth a streamlined and clear standard for covered entities to follow.

In addition, HHS ignored hundreds of comments submitted in response to the 2019 NPRM which detailed the harms that would result from repealing the notice and tagline requirements. HHS admitted that "[r]epealing the notice and tagline requirements may impose costs, such as decreasing access to, and utilization of, healthcare for non-English speakers by reducing their awareness of available translation services" 85 Fed. Reg. at 37,232, but nevertheless said it was unaware of "a way to quantify those potential effects." *Id*. at 37,234. In fact, HHS ignored numerous comments providing ways to quantify the harmful effects. *See, e.g.*, Ass'n of Am. Med. Colls., Ex. 1 at 45 (noting that the HHS's cost estimates related to notice were inflated and notice, at most adds incremental burden given hospital operating procedures); ACCESS, Comment ID HHS-OCR-2019-0007-144346, at 4 (noting that the majority of the costs estimated by HHS are associated with provision of EOBs); City of New York, Comment HHS-OCR-2019-0007-150529, Ex. 1 at 180 (citing independent analysis of notice and tagline requirements that found the benefits and cost savings occurred without materially affecting the operations of covered entities); *see also, e.g.,* Children's Hosp. Colo., Comment ID HHS-OCR-2019-153400, Ex. 1 at 123 (stating the notice and tagline requirements have not imposed any undue burden and weakening those requirements

would jeopardize health and well-being of their patients and ratchet up delayed diagnoses and unnecessary costs). HHS also made no effort to account for the number of people who would no longer receive notices and documents with taglines, despite information in the record making clear that they would experience illegal discrimination as a result. *See, e.g.,* Am. Fed'n of State, Cnty. & Mun. Emps., Comment ID HHS-OCR-2019-0007-123853, Ex. 1 at 48 (noting that there an estimated 25 Million LEP individuals in the U.S., and the organization's own investigations prior to implementation of notice and tagline requirements "revealed numerous examples of serious harm to patients, as well as patients' everyday struggles trying to communicate in health care settings and encountering acts of discrimination by providers"); Lenox Hill Neighborhood House Comment, Ex. 1 at 513 (eliminating the notice policies will result in increased discriminatory practices). Commenters also pointed out that HHS had already provided a sample notice translated into 64 languages, thus alleviating entities from the cost of developing their own notice, while providing significant benefit to LEP individuals. *See* Asian Americans Advancing Justice – Los Angeles, Comment ID HHS-OCR-2019-0007-155779, Ex. 1 at 99-100 (noting burdens of wall space and posting outweighed by benefits of conspicuous notice). HHS's refusal to fully account for the costs associated with repealing the notice and tagline provisions renders the change arbitrary and capricious. *See, e.g., Ctr. for Biological Diversity v. Nat'l Highway Traffic Safety Admin*., 538 F.3d 1172, 1190, 1200 (9th Cir. 2008) (finding agency reasoning arbitrary and capricious where agency argued that benefits of carbon dioxide reductions were "too uncertain to support their explicit valuation and inclusion" in a regulatory cost-benefit analysis).

HHS relied on inaccurate and incomplete information to suggest that the "financial burden on covered entities" posed by the notice and tagline requirements was "not justified by the protections or benefits it provided to LEP individuals." 85 Fed. Reg. 37,176. In doing so, HHS ignored its own prior factual findings, failed to account for the myriad tangible and intangible benefits that these provisions provide to LEP individuals, overstated the extent to which those benefits are also conferred by other requirements, and discounted the harm that removing the notice and tagline provisions would cause. As such, it failed to consider important aspects of the problem, and its reversal of its prior, factually-supported policy is arbitrary and capricious.

IV. Allowing Exemptions Will Cause Significant Harm to Women, LGBTQ+ People, People with Disabilities, and Older Adults.

Section 1557 creates rights, remedies, and procedures that other, existing nondiscrimination laws may add to, but not take away from. *See* 42 U.S.C. § 18116(b) ("Nothing in this title . . . shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards" available under the cited nondiscrimination statutes or supersede more protective State law). The 2020 Revised Rule violates the ground rule by incorporating harmful exemptions from other laws, including Title IX of the Education Amendments Act of 1972 ("Title IX") and the Americans with Disabilities Act ("ADA"). 20 U.S.C. § 1681 et seq.; 42 U.S.C. § 12101 et seq. *See* Exhibit 2 (providing a side-by-side comparison of the language).

This change also ignores ample record evidence that these exemptions will cause harm, especially to women, LGBTQ+ people, people with disabilities, and older adults.

Notably, the question of including exemptions to Section 1557 was thoroughly assessed in the 2016 rulemaking process, and HHS found that doing so would be inappropriate in the health care context. 81 Fed. Reg. at 31,380. Nothing significant has changed in the interim, and HHS has not provided a reasoned justification for its changes. In fact, as the District Court for the District of Columbia found, "HHS failed to sufficiently consider" the harms that would result and that the agency "'said almost nothing' about these important issues" rendering HHS's discussion of the issue "patently insufficient" relative to its obligation under the APA to provide a "reasoned explanation" for the policy change. *Whitman-Walker*, 2020 WL 5232076, at *28.

For example, HHS first solicited comment on whether it should incorporate any religious exemptions from the sex discrimination component of Section 1557 in 2013. See 78 Fed. Reg. 46,558 (Aug. 1, 2013), https://perma.cc/NJ8P-2VKJ ("RFI") (referencing Title IX).[4] Commenters gave numerous examples of how these exemptions would result in discrimination and harm. *See, e.g.*, Lambda Legal, Comment ID HHS-OCR-2013-0007-0161, Ex. 1 at 816 ("The quality of medical care provided to patients who are, or are perceived to be, LGBT and/or HIV-positive must not be compromised due to the anti-LGBT religious views of either individual health professionals or religiously affiliated organizations providing health services . . . ."); Nat'l Latina Inst. Repro. Health, Comment ID HHS-OCR-2013-0007-0101, Ex. 8 at 863 ("Providers, hospitals, or clinics that refuse to

[4] All comments received by HHS in response to the 2013 RFI can be found at https://perma.cc/T7J9-YALK. In this brief, individual comments have been identified by their comment ID number the first time they are cited and then by the organization's name thereafter.

provide reproductive health services to a woman who is not married or because she does not conform to sex stereotypes force women to seek care elsewhere or forgo it completely."); Whitman-Walker Health, Comment ID HHS-OCR-2013-0007-0063, Ex. 1 at 910 (sharing recent examples from their clients in D.C., including: "Lesbian and gay patients at an inpatient psychiatric treatment center were repeatedly harassed by nurses and other staff members, who expressed their moral and religious disapproval of homosexuality. Some of the patients were told that they were being 'prayed for.' This exacerbated the acute distress of patients being treated for serious depression, anxiety and other mental health disorders, and for addiction issues. . . . [A] transgender woman, was told by her new doctor that she was not welcome at her practice because her lifestyle was not compatible with the doctor's moral beliefs.").

HHS solicited comment on the exemption question again in 2015. Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,173 (proposed Sept. 8, 2015), https://perma.cc/LTK9-5YET (noting its goal was to "ensure that the rule has the proper scope and appropriately protects sincerely held religious beliefs to the extent that those beliefs conflict with provisions of the regulation"). In response, "[m]ost of the organizations that commented on this issue, including professional medical associations and civil rights organizations, and the overwhelming majority of individual commenters—many of whom identified themselves as religious—opposed any religious exemption on the basis that it would potentially allow for discrimination on the bases prohibited by Section 1557 or for the denial of health services . . . ." 81 Fed. Reg. at 31,379. *See also* Nat'l Women's Law Ctr., Comment ID HHS-OCR-

2015-0006-0837, Ex. 1 at 759-60 (citing ACLU & Merger Watch, *Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care* (2013), https://perma.cc/SV62-NDCQ); Nat'l Ctr. Lesbian Rights, Comment ID HHS-OCR-2015-0006-1829, Ex. 1 at 726-27 (citing numerous studies on the negative impact of the growth in religiously-affiliated hospitals on access to care for women seeking reproductive health services, LGBTQ people, and rape survivors).

After assessing the various comments, HHS stated that while "applying the protections in [existing] laws . . . offers the best and most appropriate approach for resolving any conflicts between religious beliefs and Section 1557 requirements." 81 Fed. Reg. at 31,380. With respect to Title IX's exemptions, HHS emphasized that these exemptions are limited to educational institutions and noted key differences between the educational and health care contexts, concluding, "[t]hus, it is appropriate to adopt a more nuanced approach in the health care context, rather than the blanket religious exemption applied for educational institutions under Title IX." *Id.* HHS recognized that in health care, people often have little choice as to where an ambulance takes them or may have few choices of providers in rural areas heavily populated with religious providers. *See id.*

Nevertheless, in 2019, the Administration proposed to add Title IX's blanket exemption for religiously affiliated entities along with a range of other religious exemptions. *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27,846, 27,892 (proposed June 14, 2019), https://perma.cc/FY4Z-ZUBA. HHS finalized these new exemptions in the 2020 Revised Rule. *See* 85 Fed. Reg.

at 37,245 (to be codified at § 92.6). This 180 degree turn is all the more significant given the growing percentage of the health care market that is occupied by religiously affiliated hospitals and health systems. *See* ACLU of Ill., Comment ID HHS-OCR-2019-0007-138982, Ex, 1 at 36-7 (citing Louis Uttley & Christine Khaikin, *Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage of Medicine Report,* MergerWatch, (2016), https://perma.cc/A9TW-Y6P5 & Amelia Thomson-DeVeaux and Anna Maria Barry-Jester, *Insurers Can Send Patients to Religious Hospitals that Restrict Reproductive Care*, FiveThirtyEight (Aug. 1, 2018), https://perma.cc/3V2Z-CYGV); *see also* ACLU Founds. of Cal. Comment, Ex. 1 at 16 (sharing stories of five California residents who had been "turned away or denied services for medically necessarily, life-saving care" due to religiously-affiliated providers refusal to provide care). The inclusion of sweeping religious exemptions to Section 1557's protections, if permitted to go into effect, will cause serious harm and disproportionately affect women, especially Black, Indigenous, and women of color. *See* Ass'n Am. Med. Colls. Comment, Ex. 1 at 43-4 ("Racial and ethnic minority women have reported experiencing race-based discrimination when receiving family planning care. Religious exemptions may exacerbate this problem and the consequences for women of color and their children."); Nat'l Hisp. Leadership Agenda, Comment ID HHS-OCR-2019-0007- 147313, Ex. 1 at 678 (citing research showing that Latinx individuals have gone without the birth control method they wanted because of access issues); *see also* ACLU of Ill. Comment, Ex. 1 at 36 (stating close to 30 percent of patients in Illinois are treated in a Catholic facility each year); APLA Health Comment ID HHS-OCR-2019-0007-128354, Ex. 1 at 82 ("The Proposed Rule would . . . shift[] the cost

of religious and moral accommodations for health insurers and health care providers onto LGBTQI+ individuals and women by denying them access to services and forcing them to delay or forgo care, which can come with a cost to both their health and their pocketbook."); In Our Own Voice: Nat'l Black Women's Reproductive Justice, Comment ID HHS-OCR-2019-0007-140963, Ex. 1 at 450 (describing how the religious exemption unlawfully narrows the definition of sex discrimination and how the exemption opens the door to illegal discrimination); Nat'l Women's Law Ctr. Comment ID HHS-OCR-2019-0007-149018, Ex. 1 at 652-48 (arguing that the proposed rule unlawfully rolls back the sex discrimination prohibition, unlawfully creates a religious exemption to the prohibition on sex discrimination, and unlawfully targets abortion).

The 2020 Revised Rule's religious exemptions would also disproportionately harm LGBTQ+ people. As discussed above, a recent study found that 8% of LGBQ people were refused health care because of their sexual orientation and 29% of transgender people because of their gender identity. *See* NHeLP Comment, Ex. 1 at 601 (citing Mirza & Rooney)). In *Whitman-Walker*, the Court found that the 2020 Revised Rule is likely to injure LGBTQ+ individuals, noting that the Rule will result in "a significant increase in demand for their health-care services from LGBTQ patients who fear discrimination at the hands of external providers." *Whitman-Walker*, 2020 WL 5232076, at *38. The Court also found that the Rule would lead to the need for "increasingly difficult treatment for LGBTQ patients who arrive with more acute conditions, either because they refrain from being fully transparent with their external providers given their heightened fears of discrimination, or because such apprehension causes them to delay in seeking necessary

care entirely." *Id.* In the 23 Plaintiff States, over 7.2 million LGBT people age 13 and over would be unprotected in places of public accommodation, like health care settings, because even the states with nondiscrimination statutes would not protect them to the extent the 2016 Final Rule does. Funders for LGBT Issues, Comment ID HHS-OCR-2019-0007-126602, Ex. 1 at 290 (citing Williams Institute, *LGBT People in the US Not Protected by State Nondiscrimination Statutes* (2019), https://perma.cc/9DD3-3SRV (noting over 13 million LGBT individuals not protected nationwide)).

HHS also acted contrary to the ACA and Section 1557 by incorporating the religious exemptions, private club exclusions, and exclusions related to drug use found in the ADA but not Section 1557. NHeLP Comment, Ex. 1 at 574. The same is true for its incorporation of the ADA's safe harbor provision that exempts risk underwriting entities from complying with the provisions in Titles I through III of the ADA. 42 U.S.C. § 12201(c). This safe harbor provision has allowed insurers and others to discriminate against people with disabilities. *See, e.g.,* Bagenstos, *supra*, at 41 nn.168-70 (collecting ADA and Section 504 of the Rehabilitation Act cases upholding exclusions); Consortium for Citizens with Disabilities ("CCD"), Comment ID HHS-OCR-2019-0007-146162, Ex, 1 at 204-09.

HHS lacks the authority to promulgate regulations interpreting Section 1557 that "create[] any unreasonable barriers to the ability of individuals to obtain appropriate medical care." 42 U.S.C. § 18114. Yet the evidence in record makes plain that the addition of exemptions to the regulations does exactly that. Further, as the District Court for the District of Columbia held, HHS failed to comply with its requirements under the APA

because it did not "'adequately consider the effect of' a blanket religious exemption on the ability for individuals to access care on a prompt and nondiscriminatory basis." *Whitman-Walker*, 2020 WL 5232076, at *26 (quoting *Stewart v. Azar*, 313 F. Supp. 3d 237, 272 (D.D.C. 2018)). The 2020 Revised Rule's addition of exemptions and exclusions is contrary to law and is arbitrary and capricious.

V. The 2020 Revised Rule's Illegal Changes to the Definition of Sex Discrimination will Harm Residents of the Plaintiffs States.

The 2020 Revised Rule repeals the 2016 Final Rule's definition of discrimination "on the basis of sex," without providing a different definition. In so doing, the 2020 Revised Rule threw away important protections against discrimination on the basis of sex that remediated long-standing discrimination against LGBTQ+ individuals and individuals who have previously terminated a pregnancy. In the preamble, HHS suggests that OCR will not investigate complaints or enforce the law with respect to discrimination against people based on the gender identity, sexual orientation, sex stereotypes, or past termination of pregnancy. *See, e.g.*, 85 Fed. Reg. at 37,225, 37,235-36. Thus, HHS invited covered health care providers and insurers to discriminate against LGBTQ+ people and people who have terminated pregnancies, knowing, based on the evidence in the record, that this would result in significant harm.

These changes are plainly contrary to law. Although HHS's 2019 Notice of Proposed Rulemaking stated that HHS was declining to define the term because "of the likelihood that the Supreme Court will be addressing the issue in the near future," 84 Fed. Reg. at 27,857, HHS did not wait for the Supreme Court to decide whether discrimination

on the basis of "sex" encompasses discrimination against LGBTQ+ people. HHS instead went beyond the district court's narrow decision in *Franciscan Alliance, Inc. v. Burwell*, which merely enjoined OCR from enforcing the gender identity and termination of pregnancy components of the sex discrimination prohibition in the 2016 Final Rule. 227 F. Supp. 3d 660, 687 (N.D. Tex. 2016). The 2020 Revised Rule instead codified the government's position in the pending *Bostock* litigation "that discrimination 'on the basis of sex' in Title VII and Title IX does not encompass discrimination on the basis of sexual orientation or gender identity." 85 Fed. Reg. at 37,168. HHS's position reflected the reasoning of *Franciscan Alliance*, which centered on the very question before the Supreme Court in *Bostock*. Despite comments urging HHS to wait to issue the rule regarding related subjects until the Supreme Court decided *Bostock*, HHS stated it believed its position was correct and "need not delay a rule based on speculation on what the Supreme Court might say" even after acknowledging the decision was pending this term and its outcome was relevant. 85 Fed. at 37,168.

One business day after HHS issued the 2020 Revised Rule, the Supreme Court ruled against HHS's position and held that "it is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual on the basis of sex." *Bostock v. Clayton Cty*, 590 U.S. __, 2020 WL 3146686, at *7 (2020). Applied to other, similar contexts, the Court's decision in *Bostock* means that other federal laws prohibiting discrimination based on sex, including Section 1557, will protect people from discrimination based on their sexual orientation or gender identity. *See, e.g.*, *Grimm v. Gloucester Cty. Sch. Bd.*, __ F.3d __, 2020 WL 5034430, at *1, 21 (4th Cir. Aug. 26,

2020) (applying *Bostock* in Title IX case to find that prohibition on sex discrimination protects transgender student); *Adams v. Sch. Bd. of St. Johns Cty.*, 968 F.3d 1286, 1304-05 (11th Cir. 2020) (same). Thus, as the District Court for the District of Columbia recently concluded: "it was arbitrary and capricious for HHS to eliminate the 2016 Rule's explication of that prohibition without even acknowledging — let alone considering — the Supreme Court's reasoning or holding" in *Bostock*. *Whitman-Walker*, 2020 WL 5232076, at *24 .

Similarly, the law also makes clear that prohibiting sex-based discrimination means prohibiting discrimination based on someone's past termination of pregnancy. Discrimination on the basis of pregnancy status or termination of pregnancy is clearly prohibited under HHS's regulations pursuant to Title IX, rules promulgated in 1975 and amended in 2005. 45 C.F.R. § 86.40(b); *see also* 29 C.F.R. § pt. 1604, App. (U.S. Equal Employment Opportunity Commission FAQ stating: "An employer cannot discriminate in its employment practices against a woman who has had an abortion."). Moreover, courts have consistently interpreted Title VII's prohibition on sex discrimination to include discrimination on the basis of seeking, or having previously obtained, an abortion, as prohibited sex-based discrimination. *See, e.g., Doe v. C.A.R.S. Prot. Plus, Inc.*, 527 F.3d 358, 364 (3d Cir.), order clarified, 543 F.3d 178 (3d Cir. 2008) ("[A]n employer may not discriminate against a woman employee because she has exercised her right to have an abortion."); *Turic v. Holland Hosp.*, 85 F.3d 1211, 1214 (6th Cir. 1996) ("[A]n employer who discriminates against a female employee because she has 'exercised her right to have an abortion' violates Title VII.") (citation omitted).

Moreover, the record clearly demonstrated that the elimination of these protections would cause significant harm, including to residents of the Plaintiff States. For example, a large safety net system in Minnesota reported that as a result of the 2016 Final Rule it "saw firsthand many patients gain access to vital, life-saving, transition related care that was withheld from them previously. By removing anti-discrimination protections for gender identity, these exclusions will certainly recur [and] the transgender community will be even more marginalized and will have no recourse against this discrimination." Hennepin Healthcare System, Comment ID HHS-OCR-2019-0007-143600, Ex. 1 at 441-42. The Boulder County Department of Public Health in Colorado provided a concrete example: "[A] transgender woman from Boulder County, Colorado, with a significant family history of breast cancer had to struggle with her insurance provider at length, on multiple occasions to obtain a covered breast cancer screening." Boulder County Dep't Pub. Health, Comment ID HHS-OCR-2019-0007-145054, Ex. 1 at 111. The ACLU of Illinois shared another example: "A transgender man working as a bus operator for the Chicago Transit Authority . . . made the decision to get reconstructive chest surgery in 2017. Yet, he was initially denied coverage of the surgery because his . . . insurance policy excluded coverage of reconstructive chest surgery except for patients with cancer." ACLU of Ill. Comment, Ex. 1 at 32. Many commenters highlighted a study published in 2018 found that 8% of LGBQ people were refused health care because of their sexual orientation, and 29% of transgender people were denied care because of their gender identity. *See, e.g.*, NHeLP Comment, at 601 (citing Mirza & Rooney, *supra*)); Justice in Aging Comment, Ex. 1 at 467 ("Many [LGBTQ+] older adults report having to go back

'in the closet' because of stigma and fear when transitioning to a long-term care facility . . . .").

Commenters also emphasized the harm that would be caused by removing express protection against discrimination on the basis of past termination of pregnancy. The New York Department of Health noted that removing this protection would "prevent individuals from seeking safe, quality healthcare and promote poor outcomes for infants and their families. Individuals seeking emergency care after a termination could be denied services or referred to a facility at great distance due to healthcare providers' moral or religious objections to the individual's reproductive health choice." N.Y. Dep't Health, Comment ID HHS-OCR-2019-0007-80207, Ex, 1 at 697-98. As the American Psychiatric Association points out, the rule would allow "people who have had abortions [to] be lawfully denied access to treatment for cancer, heart disease or mental illness." Am. Psych. Ass'n, Comment ID HHS-OCR-2019-0007-107673, Ex. 1 at 67. The City of New York noted that the change would disproportionately impact "survivors of sexual assault, particularly women of color who already experience difficulty in accessing reproductive health care." City of New York Comment, Ex. 1 at 171. Maine Family Planning shared that allowing discrimination based on past termination of pregnancy would further stigmatize abortion care, emphasizing that already, in their experience, "abortion stigma impacts patients—even deterring them from seeking information related to abortion care." Maine Family Planning, Comment ID HHS-OCR-2019-0007-146079, Ex. 1 at 519. The National Council of Jewish Women elaborated: "Women who have exercised their rights to services such as abortion also face a real, harmful stigma

that can affect their ability to seek and access care. These effects can extend to not seeking or receiving social support, or experiencing economic costs when women feel they must conceal their abortions." Nat'l Council of Jewish Women, Comment ID HHS-OCR-2019-0007-121179, at 10 (citations omitted). The Woman's Law Project in Pennsylvania noted that the impact of this provision would be profound in their state, where 30,011 people accessed abortion care in 2017. Woman's Law Project, Comment ID HHS-OCR-2019-0007-145461, Ex. 1 at 541.

Despite the weight of evidence in the record, and the controlling legal authority at the time of publication, the 2020 Revised Rule eliminated the definition of "on the basis of sex" and the specific prohibition on discrimination on the basis of gender identity, sex stereotyping, and past termination of pregnancy, and indicated that HHS would not enforce the law when it receives complaints about discrimination against LGBTQ+ people or people who have previously had an abortion. These changes are arbitrary and capricious and should be vacated.

CONCLUSION

This Court should grant New York's request for partial summary judgment.

DATED: September 17, 2020.

NATIONAL HEALTH LAW PROGRAM

/s/ Cathren Cohen

Cathren Cohen
Abigail Coursolle*
Elizabeth Edwards*
Jane Perkins*
3701 Wilshire Blvd., Suite 750
Los Angeles, CA 90010
Tel. (310) 204-6010
Email:
cohen@healthlaw.org
coursolle@healthlaw.org
edwards@healthlaw.org
perkins@healthlaw.org

Silvia Yee*
Carly A. Myers*
Disability Rights Education & Defense Fund
3075 Adeline Street, Suite 210
Berkeley, CA 94703
Tel. (510) 644-2555
Email:
syee@dredf.org
cmyers@dredf.org

Denny Chan*
Carol A. Wong*
Regan Bailey*
Justice in Aging
1444 Eye Street, N.W., Suite 1100
Washington, DC 20005
Tel. (202) 683-1990
Email:
dchan@justiceinaging.org
cwong@justiceinaging.org
rbailey@justiceinaging.org

*Not admitted to S.D.N.Y.

CERTIFICATE OF SERVICE

I hereby certify that on September 17, 2020, I caused the foregoing to be electronically filed with the Clerk of the Court using the CM/ECF system, causing it to be served on all counsel who have entered an appearance.

DATED: September 17, 2020, at Los Angeles, California.

/s/ Cathren Cohen
Cathren Cohen