

October 3, 2022

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: 1557 NPRM (RIN 0945-AA17)
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

RE: Nondiscrimination in Health Programs and Activities - RIN 0945-AA17

Rooted in LGBTQ+ liberation, Howard Brown Health provides affirming healthcare and mobilizes for social justice. Based in Chicago and serving people from all over the Midwest, we are one of the largest LGBTQ+ community health centers in the nation. We envision a future where healthcare and transformative social policies actualize human rights and equity for all. That is why we strongly support the finalization of this proposed rule.

Far too many LGBTQ+ and intersex people across the country continue to experience discrimination in healthcare. Based on a recent survey by the Center for American Progress (CAP), in the past year alone, 15% of LGBQ respondents, including 23% of LGBQ people of color, experienced care refusal by a provider.¹ For trans and non-binary (TNB) individuals, 32% reported that they experienced care refusal by a health care provider in the past year. Rates of discrimination were even higher for TNB people of color, with 46% reporting care refusal.² The CAP survey also showed that 55% of intersex respondents reported a health care provider refused to see them because of their sex characteristics or intersex variation.³ For TNB patients, having their insurance cover necessary and affirming medical care has become an ever-increasing obstacle with states all across the country introducing bills to ban gender-affirming care for TNB people. In the past year, 30% of TNB patients, including 47% of TNB patients of color, reported at least one form of denial by a health insurance company, including denials for necessary gender-affirming hormone therapy or gender-affirming surgery.⁴

Delaying or avoiding healthcare due to discrimination contributes to poorer health outcomes for LGBTQI+ individuals, including higher rates of chronic disease like heart

¹ Medina, Caroline, Mahowald, Lindsay. "Advancing Health Care Nondiscrimination Protections for LGBTQI+ Communities." Center for American Progress, 15 Oct. 2020, www.americanprogress.org/article/advancing-health-care-nondiscrimination-protections-for-lgbtqi-communities/.

² *Ibid.*

³ *Ibid.*

⁴ *Ibid.*

disease, certain cancers, asthma, and strokes.⁵ Discrimination also takes a toll on mental health, with LGBTQI+ patients having higher rates of mental health distress and suicidality.⁶

The passing of the Affordable Care Act (ACA) and Section 1557 went a long way toward addressing pervasive discrimination in healthcare against the LGBTQI+ community. Section 1557 prohibits discrimination by federally funded health programs on the basis of race, color, national origin, age, disability, or sex in covered healthcare programs and activities.⁷ The Obama Administration's final rule implementing Section 1557 helped many LGBTQI+ individuals gain access to healthcare and insurance with its nondiscrimination protections on the basis of gender identity and sex stereotyping. While the Obama's Section 1557 rule was a big step forward in advancing LGBTQI+ health equity, the Trump Administration's 2020 Section 1557 rule undermined that progress and caused confusion and fear around accessing healthcare for the LGBTQI+ community. The Trump Section 1557 rule not only removed protections for LGBTQI+ patients from Obama's Section 1557 rule, but also eliminated sexual orientation and gender identity nondiscrimination protections in several CMS programs. This included many programs that disproportionately benefit LGBTQI+ individuals, such as insurance enrollment, qualified health plans, and the Program of All-Inclusive Care for the Elderly (PACE). Removal of these critical nondiscrimination protections has left LGBTQI+ patients confused and fearful of accessing necessary healthcare, which is especially concerning given the recent COVID-19 pandemic as well as the surge of anti-LGBTQI+ legislation sweeping the nation.

We strongly support the new proposed rule for Section 1557 as a welcome and much needed update to the harmful rule finalized in 2020. LGBTQI+ patients still face pervasive discrimination when seeking healthcare, so having strong systems to report and minimize discrimination is imperative for achieving health equity for all. In the current political and cultural climate, the necessity of strong anti-discrimination provisions is especially important for TNB people who are currently caught in a wave of harmful and potentially life-threatening politically motivated attacks. This new Section 1557 rule is urgently needed. Below, we would like to highlight some especially important provisions from the proposed rule that we support, as well as some recommendation and answers to questions:

⁵ Fredriksen-Goldsen, Karen I, et al. "Chronic Health Conditions and Key Health Indicators among Lesbian, Gay, and Bisexual Older US Adults, 2013-2014." *American Journal of Public Health*, American Public Health Association, Aug. 2017, www.ncbi.nlm.nih.gov/pmc/articles/PMC5508186/.

⁶ *Ibid.*

⁷ Medina, Caroline, Mahowald, Lindsay. "Advancing Health Care Nondiscrimination Protections for LGBTQI+ Communities." Center for American Progress, 15 Oct. 2020, www.americanprogress.org/article/advancing-health-care-nondiscrimination-protections-for-lgbtqi-communities/.

Reinstatement of the scope of 1557 to cover all Health and Human Services (HHS) programs and activities, including making it applicable to private health insurance issuers receiving federal funding.

We strongly support the restoration of 1557's application to all health programs or activities receiving federal funding as LGBTQI+ patients still face many instances of discrimination in healthcare that can be life threatening. For example, one Howard Brown provider recounted the story of a client, a trans woman, who was physically attacked during a burglary in her apartment. When the EMTs arrived and realized she was trans, they refused to touch her and properly treat her injuries. When she arrived at the ER, no provider would see her. It was not until a shift change this patient was finally able to locate a provider who would see her. She would later come to Howard Brown for aftercare for her injuries. Insurance companies also routinely discriminate against TNB individuals in particular, and our patient navigators often must help our TNB patients navigate complex and burdensome prior authorization processes only to be eventually denied coverage for gender affirming care. These experiences are reflected in scientific research that shows that 1 in 4 trans patients were denied hormone therapy by their insurance providers in the past year.⁸

We also support the omission of Title IX's overly broad religious exemption. There are already many federal laws around conscientious objections for healthcare providers, so an additional religious exemption in Section 1557 is unnecessary. Title IX's religious exemption in particular is extremely broad and could be interpreted to allow providers to deny essential healthcare services to marginalized and vulnerable communities. We ask that HHS require that any entity receiving a religious exemption under proposed section 92.302 include the existence and scope of such exemption in its required notices. Patients should be aware ahead of time if certain healthcare organizations may refuse to serve them based on religious objections.

Reversal of adverse "conforming amendments" from the Trump administration in various CMS programs

We are delighted to see previous conforming amendments from the 2016 rule restored to CMS programs including the Children's Health Insurance Program (CHIP); Programs of All Inclusive Care for the Elderly (PACE); and qualified health plan (QHP) issuers. For programs such as PACE, the importance of reinstating the strong nondiscrimination protections cannot be understated. Older LGBTQI+ adults face many barriers to accessing and receiving healthcare and experience specific health needs and disparities, including

⁸ *Ibid.*

higher rates of poor physical health and disability, more difficulty managing an HIV status, and higher rates of isolation and psychological distress.⁹ As such, LGBTQI+ older adults could greatly benefit from PACE program services that they may have otherwise avoided if strong nondiscrimination protections were not in place.

The language around sex discrimination in these CMS “conforming amendments” does not match the proposed sex discrimination language in 1557 itself. We encourage HHS and CMS to adopt identical language to avoid confusion and ensure consistency of implementation.

Explicit prohibition of discrimination on the basis of sexual orientation, gender identity and sex characteristics. We also strongly urge to clearly state that gender identity includes trans status.

We applaud expansive explanation of discrimination on the basis of sex. Supreme Court case law, including *Price Waterhouse v. Hopkins* and *Bostock v. Clayton County*, makes clear that federal sex discrimination law includes sex stereotypes, sexual orientation, and gender identity, including transgender status. The explicit inclusion of sexual orientation is a welcome addition to the Obama Section 1557 rule.

We also support the explicit inclusion of discrimination based on sex characteristics, including intersex traits, as such discrimination is inherently sex-based. Health disparities among intersex populations are primarily driven by stigma and discrimination, especially with the lack of data around the experiences and needs of intersex people.¹⁰ A 2018 survey of intersex individuals found that 43% of adult intersex individuals reported their physical health was fair or poor while 53% reported their mental health was fair or poor.¹¹

The addition of intersectional discrimination is much appreciated, and we feel it would strengthen the rule to include more explicit references to intersectional discrimination within the regulatory text. We propose the following change to section 92.101(a)(1):

- “Except as provided in Title I of the ACA, an individual must not, on the basis of race, color, national origin, sex, age, or disability, **or any combination thereof**, be excluded from participation in, be denied the benefits of, or otherwise be subjected

⁹ Emler, Charles A. “Social, Economic, and Health Disparities among LGBT Older Adults.” Generations (San Francisco, Calif.), U.S. National Library of Medicine, 2016, www.ncbi.nlm.nih.gov/pmc/articles/PMC5373809/.

¹⁰ Medina, Caroline, Mahowald, Lindsay. “Key Issues Facing People with Intersex Traits.” Center for American Progress, 22 Aug. 2022, www.americanprogress.org/article/key-issues-facing-people-intersex-traits/.

¹¹ *Ibid.*

to discrimination under any health program or activity operated by a covered entity.”

Nondiscrimination protections in clinical algorithms and telehealth.

We strongly support the addition of comprehensive nondiscrimination protections to the use of clinical algorithms and telehealth. Even though telehealth has been used in the past, the expansion of telehealth due to the COVID-19 pandemic has presented new opportunities for LGBTQI+ patients to engage with and maintain affirming care. At Howard Brown we see clients from all over the state of Illinois and neighboring states. For patients not living in Chicago, or in rural areas, this would result in them having to travel many hours, and for some across state lines, in order to see affirming providers. For these reasons, telehealth, especially during the COVID pandemic, was a bridge to help eliminate barriers to affirming care for many. Telehealth has also proven to be an effective alternative to in-person care, with a recent study of LGBTQI+ youth and their caregivers showing that 91.7% of patient and 88.9% of caregiver respondents reported the comfort of communicating with providers though telehealth was the same or better than in-person visits.¹² Telehealth is here to stay and will be a vital tool to help expand healthcare access and retention for LGBTQI+ patients, so having strong nondiscrimination protections in place is vital.

Inclusion of Medicare Part B providers.

We strongly support the revised definition of Federal Financial Assistance (FFA) that, at long last, include payments made under Medicare Part B. The previous exclusion of Medicare B physicians was based on outdated interpretations of civil rights laws and insurance.¹³ The inclusion of Medicare Part B providers in the proposed rules comprehensive nondiscrimination requirements would close decades-long gaps in discrimination policy and eliminate providers ability to deny services or discriminate under the umbrella of Part B.

Recommendations and responses to HHS questions

Below we provide answers to regarding the Department’s specific request for comment on:

¹² Apple DE, Lett E, Wood S, Freeman Baber K, Chuo J, Schwartz LA, Petsis D, Faust H, Dowshen N (2022) Acceptability of telehealth for gender-affirming care in transgender and gender diverse youth and their caregivers, *Transgender Health* 7:2, 159–164, DOI: 10.1089/trgh.2020.0166.

¹³ Frank, Matthew. “Section 1557 of the ACA Should Not Allow Some Physicians to Discriminate.” *Health Affairs Forefront*, 6 Jan. 2016, www.healthaffairs.org/doi/10.1377/forefront.20160106.052553.

Whether the application of this rule to health programs and activities that receive Federal funding, to health programs and activities of executive agencies, and to all programs and activities of executive agencies should be considered in a different manner:

Protections of 1557 should be expressly extended to health programs and activities administered by or receiving federal funding from agencies other than HHS but done so in a separate rule so as to not potentially confuse or dilute the importance of this rule.

Whether, and if so how, the proposed rule addresses clarity and confusion over compliance requirements and rights of people to be free from discrimination on protected bases:

We recommend revising the indicated language in Section § 92.206 (b)(4), as a provider could engage in a discriminatory denial of care even if a claimant cannot show that the care in question was on other occasions provided for other purposes. For example, there are certain procedures that trans people seek for medically necessary gender affirming care that may typically be seen as cosmetic procedures for the general population. This can sometimes cause denial of care for trans people trying to access these services with the current regulatory language. These suggested changes would be reflected in 92.206 as follows:

“In providing access to health programs and activities, a covered entity must not:

- (1) Deny or limit health services, including those that are offered exclusively to individuals of one sex, to an individual based upon the individual’s sex assigned at birth, gender identity, or gender otherwise recorded;
- (2) Deny or limit a health care professional’s ability to provide health services on the basis of an individual’s sex assigned at birth, gender identity, or gender otherwise recorded if such denial or limitation has the effect of excluding individuals from participation in, denying them the benefits of, or otherwise subjecting them to discrimination on the basis of sex under a covered health program or activity;
- (3) Deny or limit health services sought for purpose of gender transition or other gender-affirming care if the denial or limitation is based on a patient’s sex assigned at birth, gender identity including transgender status, or gender otherwise recorded.

Unaddressed discrimination on the basis of race, color, national origin (including limited English proficiency and primary language), sex (including pregnancy, sexual orientation, gender identity, and sex characteristics), age, and disability as applied to State and Federally-

facilitated Exchanges, with any detailed supporting information, facts, surveys, audits, or reports:

The addition of intersectional discrimination is much appreciated inclusion, and we feel it would strengthen the rule to include more explicit references to intersectional discrimination within the regulatory text. The concept of intersectional stigma involves examining when a patient possesses multiple stigmatized identities. This includes co-existing health conditions such as HIV, mental illness or substance use; demographics such as race, ethnicity, gender, or sexual orientation; and behaviors or experiences such as substance use and sex work.¹⁴ According to the Center for American Progress (CAP), 24% of LGBTQ people of color reported some form of negative or discriminatory treatment from a doctor or health care provider in the year prior.¹⁵ This is in comparison with 17% of white LGBTQ respondents.¹⁶ In addition to the previously mentioned language revision to section 92.101(a)(1), it would strengthen the rule to include more specific examples of what constitutes intersectional discrimination. Intersectional discrimination can take many forms such as a trans person of color living with HIV being discriminated against due to their gender identity as a trans person, their race, and HIV status. Similarly, we would also recommend adding specific examples and best practices around addressing discrimination specifically against people with nonbinary gender identities.

Whether covered entities seek guidance on best practices for compliance with Section 1557, and on what topics.

We believe that many covered entities will likely seek guidance on best practices for LGBTQI+ cultural competence/responsiveness. A recent study found that medical students who received more LGBTQI+ education, reported being more effective in increasing comfort, knowledge, and confidence when providing care for LGBTQI+ patients.¹⁷ There are a number of existing resources that provide guidance and best practices for providing culturally responsive and affirming care to LGBTQI+ patients that will help with compliance with Section 1557;

¹⁴ “Promoting Reductions in Intersectional Stigma (Prism) to Improve the HIV Prevention Continuum.” National Institute of Mental Health, U.S. Department of Health and Human Services, www.nimh.nih.gov/funding/grant-writing-and-application-process/concept-clearances/2018/promoting-reductions-in-intersectional-stigma-prism-to-improve-the-hiv-prevention-continuum.

¹⁵ Lindsay Mahowald, et al. “LGBTQ People of Color Encounter Heightened Discrimination.” Center for American Progress, 22 Aug. 2022, www.americanprogress.org/article/lgbtq-people-color-encounter-heightened-discrimination/.

¹⁶ *Ibid.*

¹⁷ Nowaskie, Dustin Z., and Anuj U. Patel. “How Much Is Needed? Patient Exposure and Curricular Education on Medical Students' LGBT Cultural Competency - BMC Medical Education.” BioMed Central, BioMed Central, 7 June 2022, bmcmededuc.biomedcentral.com/articles/10.1186/s12909-020-02381-1.

- Howard Brown Health – LGBTQI+ cultural competency trainings: <https://howardbrown.org/era/education/curriculum/>
- The Fenway Institute – Education and Trainings: <https://fenwayhealth.org/the-fenway-institute/education/>

Providing affirming and nondiscriminatory healthcare is at the heart of everything that we do at Howard Brown. We know firsthand that there are still far too many instances of LGBTQI+ patients being refused care, harassed, and discriminated against in healthcare. This proposed rule would go a long way in establishing and strengthening nondiscrimination protections in healthcare for LGBTQI+ patients. As the country sees more and more anti-LGBTQI+ legislation specifically aimed at criminalizing affirming healthcare, it is more important now than ever to finalize and enforce these nondiscrimination protections in the proposed Section 1557 rule. Healthcare is a human right, and all people deserve to be able to access necessary and vital healthcare regardless of how they identify.

Sincerely,