

# Health Care in Motion

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## Discrimination in Health Care: Trump Administration Releases New Section 1557 Final Rule

We may be halfway through the year, but 2020 is far from done with monumental news impacting health care rights. On Friday, the Department of Health and Human Services (HHS) released the [final rule](#) interpreting Section 1557 of the Affordable Care Act (ACA). The new rule is the final step in a [year-long process](#) to roll back explicit nondiscrimination protections in the health care system, especially for transgender and gender non-conforming people, people with limited English proficiency, and people who have had abortions. Of note, the administration has asserted that sex-based protections in health settings do not extend to discrimination on the basis of gender identity. The new rule is scheduled to take effect 60 days from its official publication date, which is now scheduled for June 19.

Monday, however, brought drastically different news. The Supreme Court issued its much-awaited opinion on a trio of cases focusing on sex-based protections in employment law. In [Bostock v. Clayton County, Georgia](#), the Court held that statutory protections against sex-based discrimination includes discrimination due to a person's sexual orientation or gender identity. While these three cases are addressed to protections in the federal employment law known as Title 7, there are strong legal reasons to believe that the *Bostock* case will apply to gender identity and sexual orientation discrimination in health care settings through future interpretations of Section 1557. The Supreme Court case is likely to be viewed as a major turning point with cascading effects on nondiscrimination protections in employment, education, and health care, among other areas. **(Stay tuned for our analysis of the *Bostock* decision in the next installment of *Health Care in Motion*).**

Despite the impact such a ruling has on future rulemaking (one that we noted in our August 2019 [Section 1557 comments](#) and at our May 2020 meeting with the Office of Management and Budget), it remains unclear whether HHS will heed the Supreme Court's decision and halt the publication of Friday's erroneous and inadequately-reasoned interpretation of Section 1557. As we describe below, HHS appears intent on endorsing misinformed, harmful ideologies and emboldening entities to return to discriminatory practices previously deemed contrary to law.

### The Rewrite: 200,000 comments, 37 weeks, little substantive change

Despite receiving nearly 200,000 public comments about the Proposed Rule in August 2019 (and being responsible for guiding the country through a worldwide pandemic), HHS issued the final rewrite of Section 1557 regulation last week. Not much has changed from the proposed rule published in June 2019. In the final rule, HHS decided to eliminate large sections of the 2016 Final Rule and rolled back protections for transgender

people, people with limited English proficiency, and people who have had abortions, among others. Our prior coverage of the proposed rule is [here](#), [here](#) and [here](#).

### What does the rewrite do?

1. Eliminates the definitions section, which clearly explained that sex-based discrimination included discrimination on the basis of gender identity and sex stereotyping.
2. Narrows the scope of the regulation by limiting the types of covered entities that are required to comply and to what extent their activities are subject to the regulation.
3. Deletes explicit explanations of discriminatory insurer practices.
4. Adds in Title 9’s religious exemption (which was not incorporated explicitly or by reference in the ACA), along with other unrelated rules.
5. Repeals language access and tagline requirements, thereby eroding protections for people with limited English proficiency and people who are not familiar with health care rights.
6. Removes a provision that recognizes a private right of action in federal court for actions brought under Section 1557 (but takes no stand as to whether one exists).

### Sex

A large focus of the Preamble to Friday’s rule focuses on the agency’s understanding of “sex” and whether discrimination on the basis of gender identity naturally falls within Section 1557’s incorporation of Title 9’s sex-based protections. HHS repeatedly puts forth an understanding of “biological” sex, while sidelining (and minimizing) the lived experience of Americans who know biology does not ascribe to only two categories. Yet, even using the framework of sex being binary and immutable, HHS fails to come to the same conclusion as the Supreme Court in *Bostock v. Clayton County, Georgia*—that federal law already prohibits gender identity discrimination as discrimination “on the basis of sex.”

### Covered Entity

HHS also digs its heels in on many of the other problematic changes that were present in the Proposed Rule. The agency insists that, unlike its expansive approach in other rulemaking, the types of entities required to comply with the regulation should be limited to those principally engaged in the business of providing health care, and, where an entity does not principally engage in providing health care but accepts federal financial assistance, only the program that accepts federal dollars is subject to the rule. Under this scope, when a health insurer accepts advanced premium tax credits through offering a product on a state exchange, they need only comply with Section 1557 for that particular plan; products sold elsewhere (without accepting federal dollars) need not comply. This interpretation of Section 1557 produces a patchwork of nondiscrimination protections across the insurance market and across the country, and is one of the many wrongs this law was meant to remedy.

### HHS’ Approach

HHS couches the rollback of these protections in a framework of deregulation, rather than an ideological opposition to the protection of transgender people’s health care rights. In fact, HHS notes “[t]he Department believes that all people should be treated with dignity and respect, regardless of their characteristics including

their gender identity . . .” The rhetoric proves hollow, as the agency asserts that it is reasonable and nondiscriminatory for a health care provider to use pronouns that reflect a sex different than the one a person identifies with. In fact, the agency itself boldly misgenders people in the rule, including Kyler Prescott. Kyler was a 14 year-old transgender boy who faced repeated misgendering and inappropriate behavior from health care providers in May 2015 when seeking emergency medical care. Kyler committed suicide five weeks later. His mom Katharine [filed a lawsuit](#) against Rady Children’s Hospital-San Diego for discriminating against her son. Under Friday’s HHS rule, the hospital’s treatment of Kyler would likely not run afoul of the federal statute that prohibits discrimination in health care.

HHS has also woven in many of the substandard arguments and characterizations that transgender people have had to face in the fight for their civil rights. For example, HHS notes that “removing or weakening such reasonable sex-based distinctions could undermine the equality of women.” Additionally, HHS openly questions the value and effectiveness of gender affirming care and undermines the role that the World Professional Association for Transgender Health (WPATH) has in developing evidence-based medical guidelines (though the agency notes that even if medical providers were to reach a consensus about gender affirming care, it wouldn’t necessarily change the regulation).

Throughout the 344-page document, HHS repeatedly notes that deletions of regulatory language will improve clarity for the rule. Rather than explicitly spelling out how such prohibitions on discrimination will apply to health programs and activities (i.e. enhancing clarity), HHS instead asserts that individuals can simply revert to or operate under implementing regulations of the four civil rights laws incorporated by Section 1557. This fails to consider that some regulations were not written with the health care system in mind and adds administrative burdens to individuals and covered entities determining how conflicting regulations ought to be resolved.

### ***Protecting people living with chronic illness & disability***

In response to concerns that the new rule (with its sweeping deletions) would encourage health care plans to discriminate against people living with chronic illnesses through insurance benefit design, HHS reaffirmed its commitment to strong enforcement. “The Department will enforce vigorously Section 1557’s prohibition on discrimination on the basis of disability against all covered entities, including when discrimination is alleged to have taken place in benefit design.” While it is worth noting that the narrowed scope of the rule will make addressing benefit design much more difficult in the future, we must also remember that HHS has already been approving Healthcare.gov plans that have discriminatory benefit designs. For example, [Quartz](#) (available to residents of Madison, Wisconsin who want to enroll in a 2020 plan on Healthcare.gov) places every FDA-approved [co-formulated single tablet regimen](#) (used by people living with HIV) on the highest cost-sharing tier. This type of benefit design discourages people living with HIV, who due to their chronic condition rely on consistent, affordable access to medications in order to manage their health and well-being, from enrolling in certain plans. Under the 2016 rule, issuers were explicitly on notice that they could not use such benefit designs to discriminate on the basis of disability; promises to enforce such prohibitions “vigorously” when they are not explicitly included in regulation seem likely to remain unfulfilled.<sup>1</sup>

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<sup>1</sup> HHS also responded to concerns raised by people living with HIV and allies regarding the negative impact such a rollback would have on the president’s commitment to ending the HIV epidemic. HHS wrote that they “remain[] committed to ensuring that those living with HIV or AIDS receive full protection under the law . . .” Ensuring all people living with HIV have access to prescription

## Filing Complaints with HHS Office of Civil Rights

CHLPI has [filed several complaints](#) with HHS about similar plans that discriminate against people living with HIV. Investigations into a majority of the complaints have been closed due to the plan no longer being sold on the Marketplace. However, we are not aware of any public steps by the administration to proactively address this trend of discrimination.

## The Timing: 2,104,346 Coronavirus cases and counting

While the final rule has not been published in the Federal Register (and thus could technically undergo changes before it becomes official), the release at this moment in time is a misguided and harmful move given the severity of the COVID-19 pandemic. The health care system is one of the most vital and central parts to our country's pandemic response, and it sits under enormous pressure. The United States represents about [27% of global COVID-19 cases](#) as of June 15, 2020, and while many are energetically on the path to reopening, the pandemic is [far from over](#).

The health care system has reported difficulty with staffing, space, financial resources, and medical supplies, to name a few, and many face budgetary obstacles as uncompensated care increases and revenue from non-COVID-19 related surgeries plummeted. Over 260 hospitals [furloughed](#) workers, and many are considering or have filed for bankruptcy. HHS recognized last summer that their proposed rule would result in additional costs to the health care system; release of this rule introduces burdens that can and should be avoided—especially during a pandemic.

Most importantly though, this final rule's rollback of explicit protections and narrowed scope would harm the very communities these protections are meant to serve. The impact of stigma and discrimination has been well-documented and weigh even more heavily in the middle of a public health crisis. The [National Center for Transgender Equality](#) conducted a national survey of transgender people living in the United States and found one-third of respondents who had seen a health care provider in the year prior reported having at least one negative experience related to being transgender. This included verbal harassment and refusal of care.

This behavior, along with more systematic discrimination, can discourage people from seeking care, even when they have serious chronic conditions in need of medical attention. For example, the [Transgender Law Center](#) conducted a survey of transgender and gender non-conforming people living with HIV and found that 41% had gone more than 6 months or longer without medical care since their HIV diagnosis, and the most common reason why respondents reported going without medical care was previous or anticipated discrimination. Similar trends can be found in other vulnerable communities that have historically experienced discrimination, including people living with HIV, hepatitis C, and other chronic illnesses and people with limited English proficiency.

When we fail to protect vulnerable communities and give people cause to have deep mistrust in the health care system, we compromise their individual health and our country's ability to respond effectively to worldwide pandemics.

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medications and nondiscriminatory care is key to any effective strategy to address the epidemic. Any move that weakens these nondiscrimination protections threaten to undermine gains made thus far.

## Treating People with Dignity

Discrimination in the health care system can take many forms, including discriminatory health insurance benefit design and outright refusals of care. Discrimination also occurs through the refusal to treat people with dignity because of their gender identity. As [Chase Strangio](#) wrote on NBC:

“What the reporter didn't understand was that my friend [\[Lorena Borjas\]](#) had not only died from COVID-19 but also that her death was directly related to the kind of systemic refusal to honor trans existence that causes the paper of record to insist on publicizing our deadnames. Lorena had feared going to the doctor when she first became sick with COVID-19 because, as a trans person, she had faced so much discrimination in the health care system over the years — including the repeated use of her deadname — that it had become hard to endure unless it was a true emergency.”

## The Future

The new final rule fails to interpret 1557 properly or weigh adequately the costs of the changed rule. Barring last-minute decisions by the agency to drop the rule or court action to stop its implementation, we expect the final rule will be published in the Federal Register on June 19, 2020 and become effective sixty days after that.

Several LGBTQ+ and health care organizations (along with state attorneys general) have publicly promised to do everything in their power to fight back against this formalized sanctioning of discrimination. The Center for Health Law and Policy Innovation is [partnering](#) with Transgender Law Center, Transgender Legal Defense & Education Fund, and the National Women’s Law Center to fight back against this rule. If you or the communities that you work with have specific fears about how the new rule will cause harm, please be in touch with *Health Care in Motion* [directly](#).

In the meantime, stay tuned for the next installment of *Health Care in Motion* where we discuss the recent Supreme Court decision and its potential impact on this new Section 1557 final rule.

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