CENTER for HEALTH LAW and POLICY INNOVATION
HARVARD LAW SCHOOL

May 6, 2021

Laura Durso, Chief of Staff
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

RE: The Future of Preventing Discrimination in the Health Care System

Dear Ms. Durso:

On behalf of the Center for Health Law and Policy Innovation of Harvard Law School (CHLPI), congratulations on your appointment as Chief of Staff at the Office of Civil Rights for the U.S. Department of Health & Human Services (OCR). CHLPI advocates for legal, regulatory, and policy reforms to improve the health of disinvested populations, with a focus on the needs of low-income people, LGBTQ+ people, and people living with chronic illnesses and disabilities. We would welcome the opportunity to work with OCR to make real the promise of nondiscrimination in the health care system, and believe that a strong, transparent, and committed OCR can make meaningful progress in securing access to coverage and care for people too often left out.

For years, much of CHLPI's advocacy and coalition leadership has involved addressing discrimination in the health care system. During the Obama Administration, we worked with OCR as the Affordable Care Act was being implemented. CHLPI has also filed complaints with OCR in the past few years, and conducted impact litigation in federal courts to seek redress for discrimination in the health system. CHLPI's work focuses in two main practice areas: Health Care Access seeks to assure and improve access to care for disinvested communities, and Whole Person Care focuses on addressing the social determinants of health, including systemic racism, that drive disparate health experiences and outcomes.

As part of our mission to reduce health inequities and improve access to care, CHLPI has long worked with community and organizational partners on health law and policy reform. Currently, we lead the Chronic Illness and Disability Partnership, a broad-based collaboration of more than 30 organizations seeking to identify and address common opportunities and challenges facing chronic illness and disability communities. CHLPI also co-chairs the HIV Health Care Access Working Group of the Federal AIDS Policy Partnership, a coalition of 100+ national and community-based HIV services organizations.

CHLPI and our partners believe that with some changes in priorities and practices, OCR's significant authority to enforce federal antidiscrimination law can promote increased equity in the U.S. health care system. We think that prioritizing the following areas would help root out and prevent discrimination, improve transparency, and increase OCR's efficiency and effectiveness:

- Renewing the proper scope and enforcement of the ACA's Section 1557 via a new regulation;
- Promoting a vision and enforcement approach that prevents discrimination against health care consumers with historically marginalized identities;
- Building upon proactive enforcement strategies and reviewing discriminatory insurance plan designs;
- Improving OCR's process of handling administrative complaints and its complaint backlog; and
- Realigning OCR's priorities and resources by dissolving the Conscience and Religious Freedom Division.

These areas are described in more detail below.

1. New ACA Section 1557 Regulation

Given the difficulty of passing legislation in the current Congress, other than through budget reconciliation, the best way to restore and expand Section 1557's protections against discrimination is for HHS to issue a Notice of Proposed Rulemaking under the Administrative Procedure Act.

Scope: Section 1557 applies to "any health program or activity, any part of which is receiving [f]ederal financial assistance."[1] The new rule should reestablish the definition of "health program or activity" to include any health insurance program. It should also clarify that Section 1557 extends to every part and subdivision of a covered entity and to instances where an insurer serves as a third party administrator for a discriminatory product. The new rule should also apply to Medicare Part B providers, who historically have been exempt from non-discrimination provisions.[2]

Enforceability in court: HHS should clarify that Section 1557 creates a single and separate private right of action.[3] This would help with both the overall scheme of enforcement,[4] and with ensuring that Section 1557 remedies are available to those who have experienced intersectional discrimination. The new regulation should expressly acknowledge that discrimination can be proven via disparate impact, which occurs when a facially neutral policy disproportionately affects a protected class of people without meaningful justification.

Protections: HHS should strengthen protections, including but not limited to: improved rules for language access, more robust protections against disability discrimination, an explicit extension of sex-based protections to discrimination on the basis of pregnancy/pregnancy termination, and a clear application of the recent Supreme Court *Bostock* decision to discrimination on the basis of sex (including gender identity and sexual orientation). Furthermore, religious exemptions should not be used to circumvent these protections.

2. Promote a Vision and Enforcement Approach that Prevents Discrimination against Health Care Consumers with Historically Marginalized Identities

OCR should think about discrimination broadly, and consider intersectionality when it comes to enforcement mechanisms. For people with multiple marginalized identities, a narrow understanding of nondiscrimination law could require that they artificially split their identities (e.g., Black and disabled) to fit within different statutes' enforcement mechanisms. OCR should address this inefficiency and contradiction via rulemaking and enforcement decisions.

OCR should issue a new mission statement that clearly identifies the agency's priorities, and emphasizes its commitment to enforcing antidiscrimination law in health care for all people, and to the rule of law, scientific rigor, and integrity. Additionally, OCR should conduct a review of external communications to ensure its public-facing materials, like the agency website, clearly reflect its commitment to civil rights, including examples of discriminatory health plan design and discrimination on the basis of gender identity.

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[1] 42 U.S.C. § 18116.

[2] "Section 1557 Of The ACA Should Not Allow Some Physicians To Discriminate," Health Affairs Blog, Jan. 6, 2016. DOI: 10.1377/hblog20160106.052553

[3] Section 1557 incorporates the "enforcement mechanisms" of four anti-discrimination statutes, all of which contain a private right of action. *See* 42 U.S.C. § 18116(a); *see, e.g., Callum v. CVS Health Corp*., 137 F. Supp. 3d 817, 845, 848 (D.S.C. 2015).

[4] Under other statutes where there is clearly no private right of action, the federal government should dedicate concerted attention to investigating claims, as individuals submitting complaints will have no other recourse. *See e.g. Blessing v. Freestone*, 520 U.S. 329 (1997) (framework to evaluate the private right for suit under § 1983); *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27,846, 27,883-84 (proposed Jun. 14, 2019) (removing language specifying a private right of action under § 1557 of the ACA).

3. Build Upon Proactive Enforcement Strategies and Review Discriminatory Insurance Plan Design in Qualified Health Plans

Proactive enforcement: OCR should take a proactive role in enforcing antidiscrimination law by building partnerships with stakeholders and continuing outreach programs that facilitate compliance in prophylactic and cost-effective ways. OCR should develop more partnerships with state entities and other federal offices (e.g., CCIIO, OSHA, CDC) to create best practices germane to health and antidiscrimination, and give direction to covered entities.

Insurance plan design: Some Qualified Health Plans (QHPs) on the Marketplace employ discriminatory plan design, including drug formularies, that can discourage enrollment of individuals with chronic conditions. Over the last several years, the federal government has ceded oversight responsibility for various certification activities, including "active certification reviews for prescription drug formulary and cost sharing outliers for states that perform plan management functions."[5] OCR should work with CCIIO and state regulators to delineate clear, public lines of responsibilities and identify where deference to states over monitoring and enforcement should be rescinded.

4. Update and Improve the Complaint Process and Address the Civil Rights Complaint Backlog

Complaint process: OCR should update its complaint process to improve transparency, efficiency, and accountability. Under the current process through the Operations and Resources Division's Centralized Case Management Operations (CMMO), it is nearly impossible to know where a complaint stands. The lack of any available information undermines confidence in the process among complainants and the public.

OCR should provide status updates that clearly indicate where a complaint is in the process. These status indicators could inform the creation of new performance metrics that track the time complaints spend in each point along the review process, as well as identify outcomes. Such metrics could identify roadblocks to efficient complaint review and track process improvement. OCR should also create a searchable database of complaints which includes information similar to Freedom of Information Act databases (as allowable under health information privacy law).

Civil rights complaint backlog: With a possibility of increased complaints given a renewed focus on antidiscrimination enforcement, OCR should dedicate significant resources to its civil rights complaint review process. In handling the civil rights complaint backlog, OCR should prioritize informing complainants about the status of their complaints. Regarding the complaint backlog in the Conscience and Religious Freedom Division: OCR is not obligated to enforce complaints based on theories that are contrary to law, and many have used religious freedom as a license to discriminate. OCR should dismiss these complaints with care, and prioritize complaints that do not undermine the civil rights protections of LGBTQ people and people seeking reproductive care.

5. Dissolution of the Conscience and Religious Freedom Division

OCR should dissolve, or alternatively redirect the focus of, the CRFD. The establishment of CRFD was part of larger efforts by the Trump Administration to encourage the use of religion as a license to discriminate against patients and deny care. The very small number of complaints at CRFD's inception did not merit the division's

[5] Ctrs. for Medicare and Medicaid Servs., Ctr. for Consumer Info. and Ins. Oversight, *Guidance to States on Review of Qualified Health Plan Certification Standards in Federally-facilitated Marketplaces for Plan Years 2018 and Later*, https://perma.cc/3UMS-2FER; Ctrs. for Medicare and Medicaid Servs., Ctr. for Consumer Info. and Ins. Oversight, *Initial Guidance to States on Exchanges*, https://perma.cc/K85Y-5WKS; Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,375, 31,440 (May 18th, 2016) ("OCR is responsible for enforcement with respect to benefit design issues under Section 1557. States have an important role in ensuring compliance with nondiscrimination requirements respecting insurance, including benefit design, under CMS regulations and applicable State laws").

creation, especially considering the Civil Rights Division had been investigating health care conscience laws already.[6] The creation of CRFD has reduced the budget and staffing of other OCR divisions.[7] The small number of complaints filed under conscience laws does not justify such high costs at the expense of other divisions that routinely handle significantly more complaints. OCR should redirect CRFD resources to align with the agency's commitment to preventing discrimination against health care consumers who come from historically marginalized communities.

Conclusion

We are excited to have a new administration in office, and believe that the Biden Administration OCR can regain the public's trust as a protector of civil rights. We would very much like to meet with you and OCR colleagues soon to discuss ways that OCR can leverage law and policy to fight discrimination, reduce health inequities, and improve access to care for all, as well as ways that CHLPI and our coalition partners can help in these efforts. We appreciate your time and consideration, and look forward to hearing from you about this meeting request.

Best Regards,

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[6] See Sharita Gruberg, Center for American Progress, *HHS Budget Would Fund Discrimination at Expense of Civil Rights Enforcement* (April 25, 2019), perma.cc/8FAH-P7KZ). Only ten complaints alleging violation of conscience laws were filed from 2008 to November 2016. Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880, 3886 (proposed Jan. 26, 2018). Even the reported "uptick" in the number of complaints filed during fiscal year 2018 is misleading, with the majority of filed complaints (266 of 336 unique complaints, or 79%) falling outside of the scope of the relevant conscience laws. "New York Court Vacates Conscience Rule," Health Affairs Blog, Nov. 7, 2019. DOI: 10.1377/hblog20191107.342050.

[7] Memorandum from Roger Severino, Director, Office for Civil Rights, to Eric D. Hargan, Acting Secretary, at 3-4, Tab C, D (Oct. 24, 2017), https://perma.cc/59EY-GR3Q (requesting a $1.6 million budget and eight career staff positions in CRFD by reducing positions and budgets in other divisions); The memorandum is part of the records American Oversight obtained from HHS through a FOIA request in 2019. *See* Am. Oversight, *HHS Records regarding Memos Authorized by Roger Severino* (Aug. 26, 2019), https://perma.cc/YX2B-WUTG.