August 13, 2019

Roger Severino
Director, Office for Civil Rights
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

RE: HHS Docket No. HHS-OCR-2019-0007, RIN 0945-AA11, Comments in Response to Section 1557 NPRM

Dear Mr. Severino:

The Consortium for Citizens with Disabilities (CCD) is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

We write to express our opposition to the U.S. Department of Health and Human Services (HHS) notice of proposed rulemaking (NPRM) on Section 1557 of the Affordable Care Act. The proposed rule would severely undermine well-established rights of individuals with disabilities, negatively impacting people with disabilities and chronic conditions, their families, and communities. The proposed rule lacks any reasonable basis for altering settled law, and increases the likelihood of discrimination against people with disabilities in the critical area of health care financing and access to care. The undersigned members of the CCD therefore urge HHS not to finalize this regulation in whole or in part.

Section 1557 and its implementing rules are critical because people with disabilities are routinely discriminated against in the provision of health care. People with disabilities experience significant health disparities and barriers to health care, as compared with people who do not have disabilities, and too often, people with disabilities have been

and continue to be denied equal access to quality health care.[1] In addition, people from minority groups who also have disabilities confront an enormous health disparity amplifying phenomenon.[2]

Prior to the ACA, health insurance companies routinely discriminated against people with disabilities by simply denying coverage to individuals with preexisting conditions, charging higher premiums to people with disabilities, and imposing annual and lifetime caps on benefits – all of which disproportionately affect people with disabilities.[3] Congress passed the ACA to put an end to these discriminatory practices.[4] The ACA also sought to end discrimination in the types of health benefits offered by requiring most individual and small group health plans to provide comprehensive health benefits in ten broad categories of coverage, known as Essential Health Benefits (EHBs).[5] Section 1557 of the ACA is one important mechanism to enforce these statutory mandates.

Health care entities also discriminate against people with disabilities by failing to provide accessible facilities, effective communication, and reasonable modifications to enable people with disabilities to access health care. Section 1557 and the 2016 Final Rule implementing it created straightforward and comprehensive rules to remedy these

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[1] *See, e.g.,* Tara Lagu et al., *The Axes of Access – Improving Care Quality for Patients with Disabilities*, 370 N ENG. J. MED. 1847 (2014); Tara Lagu et al, *Ensuring Access to Health Care for Patients with Disabilities*, 175 J. AM. MED. ASS'N INTERNAL MED. 157 (2014); Tim Gilmer, *Equal Health Care: If Not Now, When?*, NEW MOBILITY (July 1, 2013), http://www.newmobility.com/2013/07/equal-health-care-if-not-now-when/; Gloria L. Krahn et al., *Persons with Disabilities as an Unrecognized Health Disparity Population*, 105 AM. J. PUB. HEALTH (S198-S206) (2015); Kristi L. Kirschner et al., *Structural Impairments That Limit Access to Health Care for Patients With Disabilities*, 297 J. AM. MED. 1121-5 (2007); Lisa I. Iezzoni, *Eliminating Health and Health Care Disparities Among the Growing Population of People with Disabilities*, 30 HEALTH AFFAIRS 1947-54 (2011).

[2] *See, e.g.,* R. N. Blick et al., *The Double Burden: Health Disparities Among People of Color Living with Disabilities,* OHIO DISABILITY AND HEALTH PROGRAM (2015); R. Whitley & W. Lawson, *The Psychiatric Rehabilitation of African Americans With Severe Mental Illness*, PSYCHIATRIC SERVICES, 508-11 (2010) (African Americans with severe mental health disabilities are less likely than whites to access mental health services, more likely to drop out of treatment, more likely to receive poor-quality care, and more likely to be dissatisfied with care).

[3] *See generally, e.g*. Valarie K. Blake, *An Opening for Civil Rights in Health Insurance After the Affordable Care Act,* 36 B.C. J.L. & SOC. JUST. 235 (2016) (describing pre-ACA health insurance discrimination and how the ACA addressed those issues); Sara Rosenbaum et al., *Crossing the Rubicon: The Impact of the Affordable Care Act on the Content of Insurance Coverage for Persons with Disabilities*, 25 NOTRE DAME J. L. ETHICS & PUB. POL'Y 235 (2014) (describing ACA nondiscrimination provisions and focusing on the function of essential health benefits).

[4] 42 U.S.C. §§ 300gg–4; 300gg-11.

[5] 42 U.S.C. § 18022.

barriers. We see no reason for HHS to muddy these waters and undermine these important protections.

HHS underwent an extensive process to develop regulations for Section 1557, including a Request for Information, proposed rule, and final rule.[6] HHS considered more than 24,875 public comments prior to finalizing the 2016 rule.[7] This new proposed rule ignores the reasoned process HHS has already undertaken. Furthermore, Congress has repeatedly rejected attempts to repeal the ACA.[8] HHS' proposal to rewrite or eliminate regulations implementing Section 1557 is nothing less than an end run around the ACA's statutory protections against discrimination.

Below, we offer comments on some of the proposed changes that will harm individuals with disabilities. Specifically, the NPRM:

1. Impermissibly limits the scope of application of Section 1557;
2. Deletes or substantially weakens sections of the rule designed to prohibit discrimination against people with disabilities, including provisions related to the notice and grievance process, the availability of auxiliary aids and services, the general prohibition on discrimination, specific prohibitions on discriminatory benefit designs and discrimination on the basis of association, and 1557's enforcement mechanisms; and
3. Asks for information on other provisions important for people with disabilities, including whether entities with fewer than 15 employees should even have to provide auxiliary aids and services to people, and whether some multistory entities should have to provide elevators—changes that would invariably harm access to health care for people with disabilities.

I. Proposed "Scope of Application" (Proposed § 92.3)

The proposed rule erroneously interprets Section 1557 to restrict its application to many health insurers. The Civil Rights Restoration Act (CRRA), by its terms and those of Section 1557, does not limit the application of Section 1557. Moreover, the proposed rule incorrectly incorporates the Civil Rights Restoration Act (CRRA) into Section 1557 to limit the scope of Section 1557's coverage of health insurers. We also object to proposed changes that narrow the scope of the rule as it applies directly to HHS

[6] 78 Fed. Reg. 46558 (Aug. 1, 2013); 80 Fed. Reg. 54172 (Sept. 8, 2015); 81 Fed. Reg. 31376 (May 18, 2016).
[7] 81 Fed. Reg. 31376 (May 18, 2016).
[8] See C. Stephen Redhead & Janet Kinzer, *Legislative Actions in the 112th, 113th, and 114th Congresses to Repeal, Defund, or Delay the Affordable Care Act*, CONG. RES. SERVICE (Feb. 7, 2017), available at: https://fas.org/sgp/crs/misc/R43289.pdf.

programs and health programs that receive federal financial assistance (FFA) from HHS.

A. A "Health Program or Activity" Includes Providing Health Insurance Coverage

The proposed rule misreads the clear statutory language and purpose of Section 1557 by applying the CRRA, a prior-enacted law that does not by its terms limit the scope or application of Section 1557, to severely limit Section 1557's application to health insurers.[9] Section 1557 prohibits disability-based discrimination in "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title [of the Affordable Care Act]."[10]

HHS's 2016 interpretation of "health program or activity" to include health insurers (and, in accordance with the statutory language, to cover all of these insurers' activities if any part of their operations receives FFA) was not only appropriate but required by the law. The statutory language that Congress used in Section 1557 is extremely broad, covering "*any* health program or activity." Health insurers clearly have a significant role in the provision of health care, including controlling access to health care services through benefit design, utilization management, and other means. Moreover, the *primary purpose* of the Affordable Care Act was to expand the availability and scope of health insurance and assist individuals in securing and enrolling in health insurance coverage. Further, the debate about the non-discrimination provisions during passage of the Affordable Care Act was about discrimination in insurance. If Congress meant to exclude health insurance from the term "health program or activity"—particularly in a law that is *about* health insurance—certainly Congress would have said so. Thus, the 2016 final rule's definition of "health program or activity" to mean "the provision or administration of health-related services, health-related insurance coverage, or other health-related coverage, and the provision of assistance to individuals in obtaining

[9] 84 Fed. Reg. 27846, 27850 (June 14, 2019) (applying the CRRA's definition of a "program or activity" receiving federal financial assistance for purposes of Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, and the Age Discrimination in Employment Act, which defined "program or activity" to cover "all operations of . . . an entire corporation, partnership, or other private organization, or an entire sole proprietorship (I) if assistance is extended to such corporation, partnership, private organization, or sole proprietorship as a whole; or (II) which is principally engaged in the business of providing . . . health care. . . ." to conclude that a "health program or activity" under Section 1557 cannot cover health insurers unless they receive federal financial assistance as a whole).

[10] 42 U.S.C. § 18116(a).

health-related services or health-related coverage"[11] reflects the clear language and intent of the law.[12]

HHS newly re-interprets "health program or activity," concluding 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 health care."[13] It further states that federal financial assistance to *any part* of such an entity is not sufficient to trigger coverage of the entity under Section 1557, a conclusion entirely inconsistent with the statutory language of Section 1557.

The only justification that HHS offers for reading health insurance out of "health care" is a reference to another federal statute with an entirely different purpose (5 U.S.C. § 5371) that defines "health care" for purposes of that law as "direct patient-care services or services incident to direct patient care-services."[14] That law, however, concerns pay rates and personnel practices for federal employees, and 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 largely out of the non-discrimination provisions of a law that is *about health insurance* is without foundation and inconsistent with the statute that HHS is interpreting.

B. Section 1557 Does Not Incorporate the CRRA

The proposed rule incorrectly attempts to incorporate the CRRA directly into Section 1557. Nothing in the text of the CRRA or that of Section 1557 supports such an incorporation. Moreover, the way that HHS proposes to incorporate the CRRA is inconsistent with the statutory language of Section 1557. The proposed rule incorporates language from the CRRA indicating that a program or activity of a private entity receiving federal financial assistance is covered by relevant laws (Section 504, Title VI, and Title IX) if the program or activity receives federal financial assistance "as a

[11] 45 C.F.R. § 92.4 (2016). The final rule further specified that for an entity "principally engaged in providing or administering health services or health insurance coverage or other health coverage" (including group health plans and health insurance issuers), all of its operations are considered part of the health program or activity except as otherwise specified in the rule. *Id*.
[12] HHS acknowledged in the final rule that there are concerns about excluding Medicare Part B from the definition of FFA. 81 Fed. Reg. 31384 (May 18, 2016). However, because HHS determined in final rule that the 1557 regulation was not the appropriate place for the government to change its position on this issue, we do not raise those concerns here.
[13] 84 Fed. Reg. 27846, 27891 (June 14, 2019).
[14] *Id. at* 27863.

whole" or if it is "principally engaged in the business of providing . . . health care . . ."). [15] Having defined health insurance out of "the business of providing health care," the proposed rule applies the CRRA to conclude that health insurers are covered by Section 1557 only to the extent that a particular operation receives federal financial assistance.

But Congress already *answered* the question of whether coverage under Section 1557 requires FFA for part of a program or activity or for its operations as a whole: it specifically stated in the statute that any health program or activity is covered if "any part" of it receives FFA. [16] The proposed rule ignores that language, which cannot be squared with HHS' new interpretation of the law. There is no logical way to read Section 1557's statutory language consistently with the language that HHS reads into Section 1557.

C. *HHS seeks to exempt itself and other federal programs and agencies from Section 1557's nondiscrimination requirements*

We have serious concerns about proposed changes that narrow the scope of the rule. The standards established under Section 1557 should apply to HHS health programs, as well as to health programs that receive FFA from HHS. This includes a range of important HHS activities, including, for example, programs administered by the Health Resources and Services Administration (HRSA) to improve health care for people who are geographically isolated, economically or medically vulnerable, and to support the health care workforce. The proposed rule, as formulated, including the scope of application in the new § 92.3(a), unnecessarily narrows and limits the departmental entities that are covered. This theory stands contrary to the statutory text, design, and intent of Section 1557 and the ACA as a whole.

As HHS stated when it originally proposed the rule in 2015, "a fundamental purpose of the ACA is to ensure that vital health care services are broadly and nondiscriminatorily available to individuals throughout the country." [17] Particularly given the context that people with disabilities have been and continue to be systemically disadvantaged by a health system with fragmented funding and delivery, an institutional bias in the 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, to name just a few troubling

[15] *Id. at* 27862 (Proposed § 92.3).
[16] 42 U.S.C. § 18116(a).
[17] 80 Fed. Reg. 54172 (Sept. 8, 2015).

issues in a history of unequal treatment, the interpretation of the application the rule to HHS programs must not be narrowed.

The plain language of Section 1557, as well as the 2016 Final Rule, establishes that any health "program or activity" administered by an Executive agency is subject to the law's provisions.[18] HHS' new interpretation of Section 1557 in effect changes the word "or" to "and," specifying that the law applies to health programs or activities administered by an Executive agency "and" created under Title I.[19] This reading is inconsistent with the statute, which includes the word "or", thereby plainly prohibiting discrimination by both programs or activities "administered by an Executive Agency" as well as those entities "established under" Title I of the ACA. If Congress had intended to limit Section 1557 only to those entities created under Title I, it would not have included the clause pertaining to executive agencies.

Moreover, if implemented, the new definition would lead to a situation whereby recipients of FFA would be subject to non-discrimination requirements of Section 1557, but agencies administering them would be exempt. For example, under HHS new interpretation, state Medicaid programs would be subject to Section 1557 as recipients of FFA, but the Centers for Medicare & Medicaid Services, which administers these programs, would be exempt. Such an interpretation is not only inconsistent with the plain meaning of Section 1557, but it is also inconsistent with Section 504, and therefore likely to cause significant confusion. HHS and all its components, including CMS, HRSA, CDC, SAMHSA, are subject to Section 504's prohibition on discrimination.[20]

RECOMMENDATION: HHS should retain the current regulations addressing the applicability of Section 1557 and not finalize the proposed 45 C.F.R. § 92.2 and 92.3.

II. The NPRM Deletes or Substantially Weakens Sections of the Regulations Prohibiting Discrimination against People with Disabilities.

The NPRM deletes several sections of the 2016 Final Regulation that are integral to implementing Section 1557's prohibition on discrimination against people with disabilities. CCD opposes HHS' proposal to repeal the current regulations, including:

- Definitions (§ 92.4);

[18] 42 U.S.C. § 18116(a); 45 C.F.R. §§ 92.1, 92.2, 92.4 (2016).
[19] 84 Fed. Reg. 27862 (June 14, 2019).
[20] 29 U.S.C. § 794; 45 C.F.R. Part 85.

- Designation of responsible employee and adoption of grievance procedures (§ 92.7);
- Notice Requirement (§ 92.8);
- Discrimination Prohibited (45 C.F.R. § 92.101);
- Nondiscrimination in Health Related Insurance and Other Health-Related Coverage (§ 92.207); and
- Nondiscrimination on the Basis of Association (§92.209);

We also object to HHS' proposal to delete the section entitled "Enforcement Mechanisms" (§ 92.301) and replace it with proposed § 92.5, as the proposed provision fails to recognize a private right of action and the availability of compensatory damages.

A. Proposed Repeal of "Definitions" (§ 92.4)

HHS proposed to delete the entire section of the Final Regulations that contains definitions for the regulation. We strongly oppose these changes. HHS contends that the "proposed rule retains most of the disability-rights related definitions from the current rule either explicitly . . . by using the definition to describing the requirements or characteristics of the entity; or by referencing underlying regulations or statutes, such as for technical accessibility standards and definitions."[21] As we note in Section III(A) below, the text of the NPRM demonstrates that HHS has altered crucial definitions related to effective communication, without any explanation or even acknowledgement that it is doing so. We urge HHS to retain all current definitions in § 92.4

RECOMMENDATION: HHS should retain the full definitions as articulated in 45 C.F.R. § 92.4.

B. Proposed Repeal of "Designation of Responsible Employee and Adoption of Grievance Procedures" (§ 92.7)

We oppose the deletion of requirements related to designation of a responsible employee and adoption of grievance procedures. The requirements for a responsible employee and adoption of a grievance procedure are very important to holding covered entities responsible for the protections provided by Section 1557. Without a designated employee and defined grievance procedure, many individuals protected by Section 1557 may not receive the information needed to prevent discrimination or seek redress for discrimination faced. Other federal civil rights laws require designation of a responsible employee and creation of grievance procedures; retaining the regulatory

[21] 84 Fed. Reg. 27860 (June 14, 2019).

grievance procedure for Section 1557 should not create a significant burden on covered entities.

RECOMMENDATION: HHS should retain § 92.7 in its entirety.

C. Proposed Repeal of "Notice Requirement" (§ 92.8)

We strongly support the notice and tagline requirements in current regulations that ensure covered entities inform beneficiaries, enrollees, applicants, and members of the public of the availability of language services and auxiliary aids and services, and that the entity does not discriminate on the basis of race, color, national origin, sex, age or disability. The proposed changes are inconsistent with Section 1557 and should not be finalized.

The 2016 Final Rule requires notice of the following:

(1) The covered entity does not discriminate on the basis covered by Section 1557;
(2) The covered entity provides auxiliary aids and services for people with disabilities;
(3) The covered entity provides language assistance services for individuals with LEP;
(4) How to obtain auxiliary aids and services;
(5) How to obtain language services;
(6) The availability of the grievance procedure; and
(7) How to file a discrimination complaint with OCR.[22]

First, the proposed elimination of notices compromises and diminishes the primacy of the non-discrimination message of Section 1557. To clearly communicate a covered entity's non-discrimination obligations and individuals' right to access services, a notice must be posted in physical locations, on websites, and sent with significant documents as the current regulations provide. If an individual enters an emergency department, for example, he or she needs to know immediately how to obtain auxiliary aids and services, or his or her medical care, health, and even life may be compromised. Similarly, if an individual cannot communicate with their insurance provider to obtain information regarding how to access covered services or benefits, they may suffer serious harm and be forced to forgo necessary care.

Second, the notice requirements under Section 1557 are not duplicative of any other requirements, especially Section 504 or Title VI. The notice requirements in the current

[22] 45 C.F.R. § 92.8 (2016).

regulations are explicit and designed to adequately inform individuals of the scope of their rights under Section 1557. By not fully explaining why repeal of the notices is necessary, HHS fails to justify the repeal. Further, HHS recognizes that eliminating the notice requirement will result in some individuals not knowing of their rights and how to enforce them. As HHS noted, "repealing the notice of nondiscrimination requirement may result in additional societal costs, such as decreased utilization of auxiliary aids and services by individuals with disabilities."[23] Any burdens of wall space and use of information technology staff and resources to post the notice and include it on a website are greatly outweighed by the benefit of having the notice visible and conspicuous so that individuals may access the services promised by Section 1557 as outlined in the notice.

While we recognize that some covered entities have raised concern about how often they have to send this notice with significant documents, the wholesale elimination of the notice is not justified by these concerns. Rather, HHS could consider a variety of options including an explanation of what constitutes significant documents or how often a covered entity has to send a notice if the covered entity sends multiple significant documents to individuals over the course of a year. Indeed, in comments submitted by insurers and medical associations in response to the original NPRM, the overriding question was about the frequency of sending notices or taglines rather than the need to send them at all.

HHS also fails to calculate the specific costs related to posting notices, and focuses almost entirely on the cost associated with mailings. Similarly, HHS's analysis does not separate out costs for providing notice of nondiscrimination versus the costs related to taglines in other languages, thereby making it impossible to appropriately understand which costs are related to providing notice in English, and which costs are related to taglines. Further, HHS failed to explain why completely eliminating notice requirements is justified given the prior analysis HHS has already undertaken in adopting these requirements just a few short years ago. We thus oppose the repeal of requirements related to notices.

RECOMMENDATION: HHS should retain § 92.8 in its entirety.

D. Proposed Repeal of "Discrimination Prohibited" (§ 92.101)

HHS proposes to delete § 92.101 of the current rule, claiming it will be replaced by "provisions addressing Section 1557's purpose, nondiscrimination requirements, scope of application, enforcement mechanisms, relationship to other laws, and meaningful

[23] 84 Fed. Reg. 27846, 27883 (June 14, 2019).

access for LEP individuals."[24] However, § 92.101 contains important prohibitions on discrimination that the recent NPRM fails to incorporate.

By deleting 92.101(b)(2), HHS deletes references to important regulatory definitions of disability discrimination. For example, the current regulation states that "Each recipient and State-based Marketplace[SM] must comply with the regulation implementing Section 504, at §§ 84.4(b), 84.21 through 84.23(b), 84.31, 84.34, 84.37, 84.38, and 84.41 through 84.52(c) and 84.53 through 84.55 of this subchapter."[25] It also states that "[t]he Department, including the Federally-facilitated Marketplaces, must comply with the regulation implementing Section 504, at §§ 85.21(b), 85.41 through 85.42, and 85.44 through 85.51 of this subchapter."[26] These cross-references clarify that covered entities have an affirmative obligation to ensure that their health care is accessible to individuals with disabilities in myriad ways not captured in other sections of the NPRM.

For example, §§ 84.4(b) and 85.21(b) prohibit discrimination by:

- denying individuals with disabilities the opportunity to participate;
- affording unequal opportunity to participate;
- providing a less effective aid, benefit or service;
- providing different or separate aids, benefits, or services; or
- otherwise limiting a person with a disability in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service.

The regulations also prohibit recipients from:

> utiliz[ing] criteria or methods of administration (i) that have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap, (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program or activity with respect to handicapped persons, or (iii) that perpetuate the discrimination of another recipient if both recipients are subject to common administrative control or are agencies of the same State."[27]

[24] *Id.* at 27860.
[25] 45 C.F.R. § 92.101(b)(2)(i) (2016).
[26] 45 C.F.R. § 92.101(b)(2)(ii) (2016).
[27] 45 C.F.R. § 84.4(b) (2010); 45 C.F.R. § 85.21(b) (2003).

In short, without the inclusion of § 92.101, the NPRM's description of prohibited discrimination under Section 504, and thereby Section 1557, is incomplete.

RECOMMENDATION: HHS should retain § 92.101 in its entirety.

E. Proposed Repeal of "Nondiscrimination in Health-Related Insurance and Other Health-Related Coverage (§ 92.207)

CCD strongly opposes HHS' proposal to eliminate 45 C.F.R. § 92.207, a regulation that specifies that Section 1557 prohibits covered entities from discriminating in the issuance or renewal of a health insurance policy, the coverage of a health insurance claim, cost-sharing and other coverage limitations, marketing practices, and the design of the health benefit plan. HHS' proposal to repeal this entire regulation is contrary to the text and purposes of the ACA; it would disproportionately harm people with disabilities; and it is inadequately justified in the NPRM.

In enacting the ACA, Congress intended to prohibit health insurance practices, including plan benefit designs, that discriminate on the basis of race, color, national origin, sex, age, or disability. The ACA significantly changed the health insurance industry by not only expanding access to health coverage, but also explicitly prohibiting many of the methods historically used by health insurers to minimize costs and risks. Before the ACA, the business model of health care incentivized insurers to avoid covering individuals who had high health needs or who would otherwise be costly to the plan. While there was some federal and state regulation of restrictive coverage policies, insurers still had a large array of mechanisms at their disposal to deny enrollment, limit benefits, and impose high premiums and cost-sharing on enrollees with disabilities and pre-existing conditions.[28] The ACA ushered in a new era for health care equity—implementing reforms to expand coverage; create protections in enrollment, cost-sharing, and benefit coverage; and improve the scope and quality of health insurance.

As an integral component of these reforms, Congress mandated comprehensive health benefit coverage and explicitly prohibited discriminatory practices in the content of those plan designs. Most pertinent, it prohibited limitations or exclusions of benefits based on pre-existing conditions; it mandated coverage, on a nondiscriminatory basis, of ten

[28] *See, e.g.*, Valarie K. Blake, *An Opening for Civil Rights in Health Insurance After the Affordable Care Act*, 36 B.C. J. L. & SOC. JUST. 235 (2016) (describing pre-ACA health insurance discrimination and how the ACA addressed those issues); Sara Rosenbaum et al., *Crossing the Rubicon: The Impact of the Affordable Care Act on the Content of Insurance Coverage for Persons with Disabilities*, 25 NOTRE DAME J. L. ETHICS & PUB. POL'Y 235 (2014) (describing ACA nondiscrimination provisions and focusing on the function of essential health benefits).

categories of essential health benefits (EHBs); and it prohibited qualified health plan (QHP) "marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs," among other protections.[29]

Section 1557 of the ACA is the key to enforcing these statutory mandates. Section 1557 prohibits discrimination, including discrimination in the design of a benefit package, in health programs or activities receiving federal financial assistance, under any program or activity that is administered by an Executive Agency, or by any entity established under Title I of the ACA.[30] By statute, it creates a private right of action for individuals to enforce their civil rights in the health care context.[31] The scope of actionable discrimination under Section 1557 logically covers discrimination in enrollment, equal access to benefits, and benefit design.[32]

Recognizing this statutory requirement, HHS promulgated regulations in 2016 reiterating that Section 1557 prohibits "marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age, or disability in a health-related insurance plan or policy."[33] In guidance, it provided examples of practices that would contravene Section 1557 and this regulation. Plans that, for example, "cover bariatric surgery in adults but exclude such coverage for adults with particular developmental disabilities;"[34] "plac[e] most or all drugs that treat a specific condition on the highest cost tiers;"[35] or "exclude bone marrow transplants regardless of medical necessity"[36] would run afoul of Section 1557, it explained.

HHS' 2016 regulation logically follows the letter and intent of the ACA. Explicit acknowledgement of, and a resulting prohibition on, discriminatory benefit design is critical to the effectiveness of Section 1557's nondiscrimination protections. If Section 1557 did not clearly reach the structure of a benefit package, a health insurer could

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[29] 42 U.S.C. § 300gg-3(b)(1); 42 U.S.C. § 18022; 42 U.S.C. § 18031(c)(1)(A).
[30] *See* 42 U.S.C. § 18116(a).
[31] *See, e.g.*, *Rumble v. Fairview Health Servs.*, No. 14-cv-2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (finding that Section 1557 creates a private right of action).
[32] *See, e.g.*, The AIDS Inst. & Nat'l Health Law Program, *Administrative Complaint RE: Discriminatory Pharmacy Benefits Design in Select Qualified Health Plans Offered in Florida* (May 28, 2014), https://healthlaw.org/resource/nhelp-and-the-aids-institute-complaint-to-hhs-re-hiv-aids-discrimination-by-fl/ (HHS OCR complaint alleging that placing all HIV/AIDS medications in the highest cost-sharing tier violates Section 1557).
[33] 45 C.F.R. § 92.207 (2016).
[34] 81 Fed. Reg. 31376, 31429 (May 18, 2016).
[35] 80 Fed. Reg. 10750, 10822 (Feb. 17, 2015).
[36] *See* CMS CCIIO, *QHP Master Review Tools for 2015, Non-Discrimination in Benefit Design* (2015), http://insurance.ohio.gov/Company/Documents/2015_Non-Discriminatory_Benefit_Design_QHP_Standards.pdf.

always manipulate their benefit design to elude discrimination law, despite maintaining the same discriminatory effects. For illustration, consider cancer benefits. If discrimination in benefit designs were permitted, a health insurer could exclude from its coverage all cancer-related surgery, chemotherapy, radiation, and post-treatment drugs, even if it could not deny an individual with cancer enrollment in a QHP or equal access to the treatments, services, and prescription drugs the plan chooses to cover. It could also limit beneficiaries to provider networks that fail to include key oncology specialists, thus avoiding coverage of the expensive treatments they may prescribe. For a person with cancer, access to a health plan would be deemed virtually meaningless in the absence of cancer-related coverage. The effect of these exclusions would be the same as an outright denial of enrollment. Elimination of the benefit design regulation perversely encourages this result. It incentivizes insurers to find roundabout ways to deter people with pre-existing conditions from their plans. This is impermissible under Section 1557 of the ACA as well as Section 504 of the Rehabilitation Act.[37]

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 already experience significant disparities in health outcomes and access to health care.[38] For example, adults with disabilities are 58% more likely to experience obesity, three times more likely to be diagnosed with diabetes, and nearly four times more likely to have early-onset cardiovascular disease.[39] Moreover, they are nearly three times more likely to have not accessed needed health care because of cost and twice as likely to have unmet mental health needs.[40] The ACA's reforms worked to reduce some of these disparities by, for example, reducing the uninsurance rate and increasing the likelihood of a person with a disability having a regular health care provider.[41] However, there are still large gaps in health access and persistent attitudinal and programmatic barriers to care are ongoing.[42] Section 1557 provides an avenue through which people

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[37] See 29 U.S.C. § 794; 42 U.S.C. §§ 18116(a), 18031(c)(1)(A); 45 C.F.R. § 92.207(b)(2) (2016).

[38] *See, e.g.*, Silvia Yee et al., *Compounded Disparities: Health Equity at the Intersection of Disability, Race, and Ethnicity*, NAT'L ACADS. SCI., ENG'G, & MED. 1 (2017), *available at:* http://nationalacademies.org/hmd/Activities/SelectPops/HealthDisparities/Commissioned-Papers/Compounded-Disparities.

[39] *Id.* at 32.

[40] *Id.* at 31.

[41] *See* H. Stephen Kaye, *Disability-Related Disparities in Access to Health Care Before (2008–2010) and After (2015–2017) the Affordable Care Act*, 109:7 AM. J. PUB. HEALTH 1015–21 (2019); Gloria L. Krahn, *Drilling Deeper on the Impact of the Affordable Care Act on Disability-Related Health Care Access Disparities*, 109:7 AM. J. PUB. HEALTH 956–58 (2019).

[42] *See* Kaye, *supra* note 41, at 1019–21 (for example, across the population of people with disabilities, there has been "much greater delayed or forgone care" post-ACA); Yee, et al., *supra* note 38, at 31–32; 39–44.

with disabilities can identify and challenge discriminatory policies—including those that manifest in the design of a health plan's benefit package. Elimination of the benefit design protections will allow health insurers to perpetuate coverage policies that exclude people with certain disabilities from benefit coverage or target the health care services, devices, and prescription drugs that people with disabilities disproportionately rely on. As a group of individuals already facing significant external barriers in the health care context, such a regression of their civil rights should not be realized.

Finally, HHS has not provided sufficient explanation on *why* it proposes to eliminate the benefit design regulation in the NPRM. The only reference to the current regulation is in Footnote 147, wherein the referenced text states that a handful of the current Section 1557 regulations are "duplicative of, inconsistent with, or confusing in relation to" pre-existing Section 504, Title VI, Title IX, and Age Act regulations.[43] It is unclear which of these three factors HHS is relying on with respect to the benefit design regulation. Regardless, concerns of duplication, inconsistency, or confusion in this context are unfounded. First, the benefit design regulation does not duplicate existing regulations. Section 1557 practically applies longstanding civil rights principles to the unique context of health care. Because pre-existing statutes such as Section 504 are more generally applicable and have not historically been applied to private health insurers,[44] their regulations do not explain how the content of a health benefit package can discriminate.[45] Thus, it was necessary to explain this concept in the Section 1557 regulations. Second, the benefit design regulation is also not inconsistent with or confusing in relation to pre-existing civil rights regulations. Its provisions do not contradict currently-existing regulations. Instead—in recognition that the ACA significantly reformed the health insurance market, increased administrative oversight of health plans, and applied nondiscrimination principles to private health insurers for the first time—the Section 1557 benefit design regulation served to explain one form of health insurer discrimination that was previously difficult to challenge.[46] The regulation should not be repealed on these erroneous grounds.

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[43] 84 Fed. Reg. 27846, 27869 (June 14, 2019).

[44] Prior to the ACA, most private health insurance plans that did not receive federal financial assistance, and thus Section 1557 and Title VI did not typically apply to them. The ACA's creation of, e.g., premium tax credits and federal- and state-run exchanges, changed this.

[45] *See, e.g.*, 28 C.F.R. § 41 (2019) (HHS Section 504 regulations).

[46] Prior to the ACA, private health insurers were generally not subject to disability nondiscrimination laws. Additionally, some lower courts misinterpreted the U.S. Supreme Court's decision in *Alexander v. Choate*, 469 U.S. 287 (1985) to stand for the proposition that Section 504 does not reach the "content" of a health benefit policy, but rather only the ability to "access" the benefit. *See, e.g.*, Doe v. Mutual of Omaha Ins. Co., 179 F.3d 557 (7th Cir. 1999). These erroneous interpretations of *Choate* critically misunderstood the Supreme Court's holding, which made clear that people with disabilities must have "meaningful access" to health care benefits. 469 U.S. at 296–99, 301. The benefit, it explained, could not be defined in a way

RECOMMENDATION: HHS should retain 45 C.F.R. § 92.207 in its entirety.

F. Proposed Repeal of "Nondiscrimination on the Basis of Association" (§ 92.209)

Current regulations expressly prohibit discrimination on the basis of association with a protected class. Without explanation, the NPRM eliminates this provision. Congress intended Section 1557 to protect against discrimination by association, and these provisions should be retained.

In the 2016 Final Rule, HHS explains that the statute does not restrict

> the prohibition to discrimination based on the individual's own race, color, national origin, age, disability or sex. Further, we noted that a prohibition on associational discrimination is consistent with longstanding interpretations of existing antidiscrimination laws, whether the basis of discrimination is a characteristic of the harmed individual or an individual who is associated with the harmed individual.[47]

The current regulation's language tracks statutory language of Title I and Title III of the ADA, and the regulatory language of Title II of the ADA, which protect against discrimination based on association or relationship with a person with a disability.[48] Congress intended that Section 1557 provide at least the same protections for patients and provider entities. In accord with the ADA, the current regulation recognizes this protection extends to providers and caregivers, who are at risk of associational discrimination due to their professional relationships with patients, including those patient classes protected under Section 1557. For example, a dentist may not refuse to treat an HIV-positive individual based on unfounded fears of transmission. Similarly, the individual's HIV-negative partner would also be protected under Section 1557, if the dentist refused to treat her based on her relationship with an HIV-positive individual.

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that disparately harms people with disabilities. *Id.* For further analysis of the meaning of *Alexander v. Choate* in the context of ACA-regulated health plans, *see* Brief of Disability Rights Education and Defense Fund, Disability Rights Advocates, Disability Rights California, Disability Rights Legal Center, The National Health Law Program, and The American Civil Liberties Union as *Amici Curiae* in Support of Neither Party, *Doe One v. CVS Pharmacy, Inc.*, No. 19-15074 (9th Cir. appeal filed Jan. 1, 2019), https://dredf.org/2019/07/02/doe-v-cvs-pharmacy-inc/.

[47] 81 Fed. Reg. 31376, 31439 (May 18, 2016).

[48] 42 U.S.C. 12112(b)(4)(Title I); 42 U.S.C. 12182(b)(1)(E)(Title III); 28 C.F.R. 35.130(g)(Title II) (2010).

By eliminating regulatory provisions expressly prohibiting discrimination on the basis of association, HHS will create uncertainty and confusion regarding the responsibilities of providers and the rights of persons who experience discrimination. However, because HHS provides no explanation of its reasons for removing 45 C.F.R. § 92.209, we cannot adequately comment, and urge HHS to retain the current regulatory protections.

RECOMMENDATION: HHS should retain 45 C.F.R. § 92.209 in its entirety.

G. Proposed Modification of "Enforcement Mechanisms" (§ 92.301; Proposed § 92.5)

We oppose the proposed changes to § 92.301 as newly designated § 92.5. HHS's NPRM incorrectly attempts to limit the remedies available under Section 1557. Congress intentionally designed Section 1557 to build and expand on prior civil rights laws such that individuals seeking to enforce their rights would have access to the full range of available civil rights remedies and not be limited to only the remedies provided to a particular protected group under prior civil rights laws. Section 1557 expressly provides individuals access to any and all of the "rights, remedies, procedures, or legal standards available" under the cited civil rights statutes, regardless of the type of discrimination. Rather than recognizing that the statute creates a single standard for addressing health care discrimination, HHS's interpretation of the statute in these regulations as amended and re-designated would instead attempt to create multiple piecemeal legal standards and burdens of proof derived from different statutory contexts. HHS's interpretation is contrary to the statutory language and Congress's intent.

The proposed language is not a valid interpretation of Section 1557. While the statute expressly sets out the grounds for discrimination by reference to the cited civil rights statutes, it does not set forth separate remedies, legal standards, and burdens of proof applicable to each prohibited basis of discrimination based on the statutes that are referenced.[49] To the contrary, Congress specified that "[t]he enforcement mechanisms provided for and available under such Title VI, Title IX, Section 504, *or* such Age Discrimination Act shall apply for purposes of violations of this subsection."[50] The use of the disjunctive "or" indicates that any of the enforcement mechanisms applicable under any of the incorporated statutes are available to every claim of discrimination under Section 1557, regardless of the particular type of discrimination triggering the claim.

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[49] *See* Sarah G. Steege, *Finding A Cure in the Courts: A Private Right of Action for Disparate Impact in Health Care*, 16 MICH. J. RACE & L. 439, 462 (2011) ("[T]here is no indication in § 1557 that each listed statute's enforcement mechanisms apply only to its own protected classes.").
[50] 42 U.S.C. § 18116(a) (emphasis added).

Applying standard rules of construction, all the enforcement mechanisms provided for and available under each of the generally incorporated statutes in Section 1557 are available to every claim of discrimination under Section 1557.

It is also necessary to read Section 1557 as establishing a single standard for addressing health care discrimination to avoid "patently absurd consequences."[51] HHS's reading of Section 1557 in this proposed section "would lead to an illogical result, as different enforcement mechanisms and standards would apply to a Section 1557 plaintiff depending on whether the plaintiff's claim is based on her race, sex, age, or disability."[52] Moreover, courts would be left without guidance on how to address intersectional claims—should a person who alleges discrimination on the basis of both race and age be subject to the standards and enforcement mechanisms under a Title VI analysis or the Age Discrimination Act? Congress explicitly adopted one provision to prohibit all discrimination in health care. It strains the imagination to read that one provision would require agencies and courts to apply a hodgepodge of standards and enforcement mechanisms.

Further, the proposed changes to the regulation do not comport with congressional intent. Congress did not intend that the enforcement mechanisms and standards available under 1557 be tethered to the nature of the claim. Rather, in enacting 1557, Congress sought to "create a new right and remedy in a new context without altering existing laws."[53] Congress has repeatedly expressed that it intends civil rights laws to be broadly interpreted in order to effectuate their remedial purposes.[54] By trying to narrowly limit the legal standards and burdens of proof that apply to those who have experienced health care discrimination, HHS's interpretation in the NPRM would ignore Congress's intent to provide broad remedies to address discrimination. HHS should not finalize the proposed language in § 92.5.

As HHS notes, some courts have interpreted Section 1557 to apply different enforcement mechanisms and standards depending on whether someone's claim is based on race/ethnicity/national origin, sex, age, or disability. These courts rely on the fact that Congress incorporated the enforcement mechanisms from the four cited civil rights statutes to then incorrectly conclude that Section 1557 limits the standards and enforcement mechanisms available based on the statute that defines the grounds for

[51] *United States v. Brown*, 333 U.S. 18, 27 (1948).
[52] *Rumble*, 2015 WL 1197415, at *11 (D. Minn. Mar. 16, 2015).
[53] *See id.* at *11, note 6.
[54] *See Kang v. U. Lim Am., Inc.*, 296 F.3d 810, 816 (9th Cir. 2002); *see also* H.R. Rep. No. 102–40(I), at 88, U.S. Code Cong. & Admin. News at 626 (stating that "remedial statutes, such as civil rights law[s], are to be broadly construed").

discrimination.[55] But the courts in these cases miscomprehend the statutory language and context. As discussed above, Section 1557 expressly provides for broad and uniform enforcement, consistent with Congress's intent that civil rights laws provide broad remedies. While Congress could perhaps have more clearly articulated its intent to establish a single statutory standard for determining discrimination and enforcing Section 1557, its failure to perfectly articulate such a standard does not necessitate the narrow reading of the statute articulated in the NPRM and the cases it cites.[56] These cases overly rely on interpretations of the underlying statutes without recognizing the inherent shifts that ACA made in the health care realm.[57]

We particularly oppose HHS's proposal to replace current § 92.301(b) with proposed § 92.5(b). Every court that has ruled on the question has found that the statutory language of Section 1557 confers a private right of action for monetary damages. The existence of such a right is clear from the statutory language in Section 1557, which explicitly references and incorporates the "enforcement mechanisms" of the four civil rights laws listed—all of which contain a private right of action. Once again, this understanding is also consistent with Congress's intent that civil rights laws be broadly interpreted to effectuate the remedial purposes of those laws. Removing the regulatory language that makes clear that private right of action and monetary damages are available to redress violations of Section 1557 will serve only to confuse. HHS should not finalize proposed § 92.5(b).

RECOMMENDATION: HHS should retain § 92.301 in its entirety.

III. Requests for Comment

Throughout the NPRM, HHS requests comments on numerous provisions, many of which would be more appropriate to inform agency decisions prior to issuing an NPRM,

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[55] *See, e.g., Southeastern Pennsylvania v. Gilead*, 102 F. Supp. 3d 688, 699 n.3 (E.D. Pa. 2015); *Briscoe v. Health Care Serv. Corp*., 281 F. Supp. 3d 725, 738 (N.D. Ill. 2017); *see also, e.g., Doe v. BlueCross BlueShield of Tennessee, Inc*., 926 F.3d 235, 241 (6th Cir. 2019).

[56] *See King v. Burwell*, 135 S. Ct. 2480, 2492 (2015) (noting that the ACA "contains more than a few examples of inartful drafting" and thus emphasizing the importance of considering the broader context of the statute).

[57] The Supreme Court has recognized that the broader purpose of the ACA is to "expand insurance coverage…[and] ensure that anyone can buy insurance." *King*, 135 S. Ct. at 2493. An expansive prohibition on discrimination in health care is key to ensuring that *anyone* can buy insurance. Thus other courts have properly concluded that a single standard and burden of proof apply under Section 1557: "looking at Section 1557 and the Affordable Care Act as a whole, it appears that Congress intended to create a new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff's protected class status." *Rumble*, 2015 WL 1197415, at *10.

such as through a Request for Information, than in response to an NPRM. However, where HHS proposes specific disability-related questions, we have responded below.

A. "Effective Communication for Individuals with Disabilities" (§ 92.202; Proposed § 92.102)

CCD supports HHS' proposal to retain the provisions of 45 C.F.R. § 92.202 (redesignated § 92.102), regarding effective communication for individuals with disabilities. Effective communication is a critical component of accessing and receiving quality health care. We often hear about entities refusing to provide effective communication or relying on communication methods that are the preference of the entity rather than the choice of the individual. Therefore, we commend HHS for holding all covered entities to the higher ADA Title II standards found at 28 C.F.R. §§ 35.160–35.164. Giving primary consideration to the choice of aid or service requested by the individual with a disability helps to ensure actual effective communication and thus equal opportunity in the health care setting.

We are, however, concerned with HHS' proposed changes to the definitions relating to the effective communication regulation. First, we object generally to the deletion of the definitions section at 45 C.F.R. § 92.4. The elimination of this section will cause confusion for covered entities and risk inconsistency among the various Section 1557 regulations. It also makes it more difficult to amend definitions as needed, which is especially important in the context of effective communication, as auxiliary aid technologies are constantly evolving. Second, while we appreciate HHS' efforts to incorporate many of the current ADA definitions, including the definitions of disability, auxiliary aids and services, qualified interpreter, and video remote interpreting, we note that HHS has erred in tracking the language of these longstanding definitions. The problems we have identified are as follows:

- The definition of auxiliary aids and services at proposed § 92.102(b)(1) excludes "acquisition or modification of equipment and devices" and "[o]ther similar services and actions," despite these two items being found in the ADA definition at 28 C.F.R. § 35.104 and the current Section 1557 definition at 45 C.F.R. § 92.4. HHS states in its NPRM that "[t]he list of auxiliary aids and services from 28 CFR 35.104 is incorporated into the proposed rule at § 92.102(b)(1)" and in general that "[t]hese provisions are drawn from regulations implementing Title II of the Americans with Disabilities."[58] This list is incomplete and HHS' statements are misleading. Parts of 28 C.F.R. § 35.104 are incorporated into the NPRM, but the above-quoted language regarding the "acquisition or modification of equipment

[58] 84 Fed. Reg. 27846, 27867, n. 123 (June 14, 2019).

and devices" and "other similar services and actions" is missing. This deletion alters what was an open-ended functional definition, and takes what is clearly a list of examples of auxiliary aids and services in the current regulations and turns it into an exhaustive list in the proposed regulation. Moreover, to the extent that HHS claims it seeks to eliminate inconsistent applications of the law, such change is neither prudent nor consistent with the law. We strongly oppose these deletions.

- The definition of auxiliary aids and services at proposed § 92.102(b)(1) also excludes the term "Qualified" before "Interpreters" in subsection (i) and before "Readers" in subsection (ii), despite this critical adjective being found in the ADA definition at 28 C.F.R. § 35.104 and the current Section 1557 definition at 45 C.F.R. § 92.4. While we appreciate that HHS does track the content of the ADA definition of *qualified* interpreters at proposed § 92.102(b)(2)–(3), we believe it will enable greater clarity and consistency with the ADA regulations to keep the term "Qualified interpreters" in the auxiliary aids definition at proposed § 92.102(b)(1)(i). Moreover, the word "Qualified" has also been deleted from "readers" in proposed § 92.102(b)(1)(ii), yet the proposal fails to incorporate the ADA definition of qualified readers. We strongly encourage HHS to both include the word "Qualified" in proposed § 92.102(b)(1)(ii), and incorporate the ADA definition of this term, *see* 28 C.F.R. § 351.04 ("Qualified reader means a person who is able to read effectively, accurately, and impartially using any necessary specialized vocabulary."). The change here is not merely theoretical. Covered entities should not, for example, be free to assign the task of reading personal information about health care status, medical procedures, and bills to a high school student hired to help with receptionist duties over the summer. The requirement for a defined "qualified reader" helps to ensure effective communication and health care for people with disabilities.

CCD is also concerned with the narrowing of the "free of charge" and "timely manner" provision at proposed § 92.102(b)(2). The current Section 1557 regulations provide that a covered entity must provide appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner . . ."[59] This language echoes the ADA Title II regulations, which provide that covered entities "may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility . . . "[60] In proposed § 92.102(b)(2), HHS significantly narrows this provision by only stating that

[59] 45 C.F.R. § 92.8 (2016).
[60] 28 C.F.R. § 35.130(f) (2010).

"*interpreting service* shall be provided to individuals free of charge and in a timely manner" (emphasis added).[61] We strongly oppose this change and encourage HHS to replace the words "interpreting service" with "auxiliary aids and services" to be consistent with the ADA and prevent unnecessary confusion over the requirement. Covered health care entities may not legally charge for *any* auxiliary aid provided; this pre-existing legal requirement should be made clear.

Finally, HHS requests comment on whether it should add an exemption from the effective communication requirements for covered entities with fewer than 15 employees.[62] CCD strongly opposes this exemption. HHS has not applied such an exemption in nearly 20 years and to apply it now would roll back the clock on the enforcement of effective communication for people with disabilities. To be clear, effective communication requirements profoundly impact threshold access to and the quality of health care that a person with a disability receives. Breakdowns in communication between a health care provider and a patient with a disability are reported across all types of disabilities,[63] and the lack of accurate and effective communication can lead to misdiagnosis, erroneous treatment, and ultimately a negative impact on the health of the patient.[64] The lack of positive health care communication experiences can also lead to a loss of trust or fear of health care providers, leading some people with disabilities to feel as if they have no choice but to rely upon self-diagnosis and treatment.[65] The provision of appropriate auxiliary aids and services can help remedy some of these health care disparities. For example, the provision of ASL interpreters to Deaf patients preferring this type of communication accommodation has been linked with significantly higher utilization rates of preventative care, including cholesterol screens, colonoscopy, and influenza vaccines.[66] While there are still many improvements to be made, requiring all covered entities to provide effective communication is a vital first step towards ensuring health care equity.

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[61] 84 Fed. Reg. 27846, 27893 (June 14, 2019)
[62] *Id.* at 27867.
[63] *See, e.g.*, Thilo Kroll et al., *Primary Care Satisfaction Among Adults with Physical Disabilities: The Role of Patient-Provider Communication*, 11:1 MANAGED CARE Q. 11–19 (2003); Melinda Neri & Thilo Kroll, *Understanding the Consequences of Access Barriers to Health Care: Experiences of Adults with Disabilities*, 25:2 DISABILITY & REHAB. 85–96 (2003); Sara Bachman et al., *Provider Perceptions of Their Capacity to Offer Accessible Health Care For People With Disabilities,* 17:3 J. DISABILITY POL'Y STUD. 130–36 (2006); Elizabeth H. Morrison et al., *Primary Care for Adults with Physical Disabilities: Perceptions from Consumer and Provider Focus Groups*, 40:9 FAM MED. 645–51 (2008).
[64] *See* Yee, et al., *supra* note 38, at 43–44 (summarizing and analyzing the abundance of research on this point).
[65] *Id.*
[66] Michael M. McKee et al., *Impact of Communication on Preventive Services Among Deaf American Sign Language Users*, 41 AM. J. PREVENTATIVE MED., no. 1, 75–79 (2011).

Provider offices with fewer than 15 employees should not be exempted from this basic civil rights requirement. People with disabilities often obtain their health care from local providers or specialists with only a few employees. This is especially true in rural areas, where providers are more likely to have smaller practices, and there may only be one appropriate specialist within a reasonable distance. This exemption could thus function to exclude many people with disabilities from accessing the health care they need. The American Medical Association's (AMA's) Physician Practice Benchmark Survey in the period from 2012-16 found that a majority of physicians still work in small practices, with 57.8% in practices of 10 or fewer physicians, and 37.9% working in practices with fewer than 5 physicians in 2016.[67] Physicians in single specialty practices were even more likely to be in smaller practices. A practice with 10 physicians may or may not have 15 or fewer employees, but a practice with 5 physicians is very likely to have fewer than 15 employees. Exempting these small practices means that people with disabilities will have significantly more difficulty obtaining effective communication from both general and specialty physicians, and sends the message that HHS's latest health care-specific civil rights regulations make it harder for people with communication disabilities to obtain needed health care. Congress surely did not intend such a result in enacting the ACA and Section 1557.

Moreover, in practice, this exemption would make little sense because public accommodations (including hospitals and provider offices) of any size are already required to provide effective communication under Title III of the ADA. Even HHS, when it originally announced that the 15-employee exemption does not apply to entities receiving HHS funds, recognized this reality:

> This is not a new requirement; Title III of the Americans with Disabilities Act (ADA) already requires public accommodations of all sizes to provide auxiliary aids and services to persons with disabilities where necessary to ensure effective communication and Title II of the ADA extends the same requirement to state and local government entities. The vast majority of entities that receive federal financial assistance from HHS thus are already required to provide auxiliary aids and services to persons with disabilities where necessary to ensure effective communication.[68]

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[67] *See* Carol K. Cane, *Updated Data on Physician Practice Arrangements: Physician Ownership Drops Below 50 Percent*, J. AM. MED. POLICY RESEARCH PERSPECTIVES (2017), *available at: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/health-policy/PRP-2016-physician-benchmark-survey.pdf.* The Benchmark surveys are of practicing physicians who provide a minimum of 20 hours of patient care/week in one of the 50 states or the District of Columbia, and who are not employed by the federal government.

[68] 65 Fed. Reg. 79368 (Dec. 19, 2000).

If HHS intends to protect small entities from costs, then the appropriate mechanisms to do so is already in 45 C.F.R. § 92.202, which incorporates the ADA Title II exemptions found in 28 C.F.R. § 35.164 by explicit reference.[69] Adding an exemption for small entities will harm people with disabilities and is not the proper solution.

RECOMMENDATIONS:

- **HHS should clarify that the list of auxiliary aids and services in proposed § 92.102(b)(1) is not exhaustive by adding the following after subsection (ii):**

  "(iii) Acquisition or modification of equipment and devices; and

  (iv) Other similar services and actions."

- **HHS should restore the term "Qualified" before "Interpreters" in proposed § 92.102(b)(1)(i) and before "Readers" in proposed § 92.102(b)(1)(ii), and it should incorporate the definition of "Qualified readers" found at 28 C.F.R. § 35.104.**

- **The requirement to provide services "free of charge and in a timely manner" in proposed § 92.102(b)(2) should be applied to all "auxiliary aids and services," not just "interpreter services."**

- **No exemption should be added for covered entities with fewer than 15 employees.**

B. "Accessibility Standards for Buildings and Facilities" (§ 92.203, Proposed § 92.103)

CCD supports HHS' proposal to retain the provisions of 45 C.F.R. § 92.203 (redesignated § 92.103), regarding accessibility standards for buildings and facilities. We support HHS' position that the 2010 ADA Standards for Accessible Design ("2010

[69] 28 C.F.R. § 35.164 (2009) ("This subpart does not require a public entity to take any action that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens. In those circumstances where personnel of the public entity believe that the proposed action would fundamentally alter the service, program, or activity or would result in undue financial and administrative burdens, a public entity has the burden of proving that compliance with this subpart would result in such alteration or burdens.").

Standards") are the appropriate architectural standards for any facility or part of a facility in which health programs or activities are conducted that is constructed or altered by or on behalf of, or for the use of, a recipient or State Exchange. We appreciate HHS' continued commitment to ensuring that health care facilities and provider offices are physically accessible for people with disabilities.

HHS requests comment on the appropriateness of applying the 2010 ADA Standards' definition of "public building or facility" (i.e., the ADA Title II standards) to all entities covered under Section 1557, specifically with respect to multistory building elevators and text telephone ("TTY") requirements.[70] CCD believes that it is indeed appropriate and *necessary* to hold all health programs and activities that receive federal financial assistance to these higher Title II standards, and we strongly oppose importing the private multistory building exception found at Section 206.2.3 of the 2010 Standards and the private entity TTY standard found at Section 217.4.3 of the 2010 Standards into Section 1557.

First, by virtue of accepting federal financial assistance from HHS, it is entirely appropriate to hold <u>all</u> covered health programs and activities, including private entities, to the Title II standards. If we look at the ADA in a vacuum, a private entity that operates as a place of public accommodation would only be subject to the lower Title III architectural standards. However, here, the ADA standards function in relation to Section 1557, which notably references and incorporates the grounds of discrimination of Section 504, not the ADA. Section 504 covers programs and activities receiving federal financial assistance. So, in this context, some private health care practices, for example, would be on the hook for not only being a public accommodation under Title III, but also an entity that avails itself to nondiscrimination law (Section 504 and Section 1557) by virtue of choosing to accept federal financial assistance from HHS. This distinction justifies holding private health care entities to a higher standard, which even HHS itself recognized in its 2015 NPRM:

> [The] entities covered under the proposed rule are health programs and activities that either receive Federal financial assistance from HHS or are conducted directly by HHS. Although OCR could apply Title II standards to States and local entities and Title III standards to private entities, we believe it is appropriate to hold all recipients of Federal financial assistance from HHS to the higher Title II standards as a condition of their receipt of that assistance.[71]

[70] *See* 84 Fed. Reg. 27846, 27867 (June 14, 2019).
[71] 80 Fed. Reg. 54172, 54186 (Sept. 8, 2015).

Additionally, it is important to consider the context of the buildings and facilities at issue under Section 1557. While we affirm that architectural access is essential in all contexts, we note that it is particularly crucial for people with disabilities to have equal access to health programs and activities. People with disabilities already face significant barriers in accessing needed health care, and exempting a health insurance enrollment center or plan benefit counselor from having an elevator or a small health care practice from providing TTY, for example, will only serve to widen the disparities in health access.[72] By choosing to operate a business that is critical to an individual's health and life, and then by choosing to accept HHS funds, private health entities have also assumed a duty to ensure that their buildings and facilities are accessible for all. These are also obligations that are inevitably included in the contracts that health entities enter when they agree to function as a plan or provider with Medicaid, Medicare, or through an Exchange. Watering down this responsibility is unacceptable and unlawful. It will function to reward those few construction or alteration projects that did not have the foresight to take account of the needs of health care consumers with disabilities.

As to the two exemptions that HHS specifically requests comment on, CCD strongly opposes them both. The 2010 Standards provide, in relevant part, that:

> [i]n private buildings or facilities that are less than three stories or that have less than 3000 square feet (279 m^2) per story, an accessible route shall not be required to connect stories provided that the building or facility is not . . . the professional office of a health care provider . . . or another type of facility as determined by the Attorney General.[73]

This private elevator exemption dates back to the 1991 ADA Standards for Accessible Design, a time period in which the concept of widespread architectural accessibility was still relatively recent and wherein the construction or addition of accessible elevators was still considered extremely burdensome and costly. Today, private entities have had over 50 years to adjust their architectural designs and consider the needs of people with disabilities.[74] No longer is requiring a multi-story building or facility to have an elevator the foreign concept or perceived burden it once was. Instead, it is required by the law. Rolling back the standards for having an elevator in private health buildings will only serve to erect a new, additional barrier for individuals with disabilities to access needed health programs.

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[72] *See, e.g.*, Yee, et al., *supra* note 38; Kaye, *supra* note 41.
[73] Section 206.2.3.
[74] The Architectural Barriers Act, the first federal law requiring that facilities designed, constructed, altered, or leased with certain federal funds be accessible for people with disabilities, was signed into law in 1968. *See* 42 U.S.C. §§ 4151–57.

CCD also opposes lowering the private entity TTY standard. Section 217.4.3 of the 2010 Standards provides, in relevant part, that "[w]here at least one public pay telephone is provided in a *public building*, at least one public TTY shall be provided in the building" and "[w]here four or more public pay telephones are provided in a *private building*, at least one public TTY shall be provided in the building."[75] The lower 4:1 TTY standard for private entities, which originated 15 years ago,[76] is now outdated given the current widespread availability and affordability of the technology. It takes little effort or cost for covered entities to provide 1:1 TTY, yet the benefits offered to people who are Deaf or have hearing impairments are significant.

Although TTY is not as commonly used as it once was, there are certain populations that still rely on TTY, including people who are DeafBlind, people living in rural areas, and senior citizens. For these individuals, TTY critically enables communication with their health care providers, their insurance companies, and other similar entities. Accordingly, HHS should not lower the 1:1 TTY standard for private health care entities.

We also encourage HHS to explicitly incorporate standards that require covered entities to accommodate newer communication technologies that are being used by people with disabilities. Since the establishment of the TTY standards, new innovations such as real-time text ("RTT") have emerged. We urge HHS to codify language that both retains the existing TTY ratios and also adopts similar RTT ratios, in order to be inclusive of modern technologies. Like TTY, all health care entities should be held to more stringent public entity RTT ratios.[77] This addition will help ensure that the Section 1557 regulations stay up-to-date with technological developments.

RECOMMENDATIONS:

- **HHS should continue to apply the 2010 ADA Standards' definition of "public building or facility" to all entities covered under Section 1557.**
- **HHS should not incorporate the private multistory building elevator exemption into Section 1557 regulations.**

[75] Section 217.4.3.1; Section 217.4.3.2.
[76] The 4:1 private TTY standard was first adopted in the 2004 ADA Accessibility Guidelines ("ADAAG").
[77] The Federal Communications Commission has adopted rules to facilitate a transition from TTY technology to RTT technology, which HHS could look to for guidance. *See* 47 C.F.R. Part 67.

- **HHS should not lower the 1:1 TTY ratio for private entities under Section 1557. It should retain the existing TTY ratios and also adopt stringent RTT ratios.**

C. Medical Diagnostic Equipment Standards

CCD further recommends that HHS reference and incorporate the U.S. Access Board's Standards for Accessible Medical Diagnostic Equipment, published at 36 C.F.R. Part 1195, into 45 C.F.R. § 92.203 (as redesignated § 92.103).

In its 2016 Final Rule, HHS considered but ultimately declined to adopt specific language regarding accessibility standards for medical diagnostic equipment into Section 1557.[78] It explained that "the United States Access Board is currently developing standards for accessible medical diagnostic equipment and, therefore, we are deferring proposing specific accessibility standards for medical equipment."[79] HHS OCR has further made clear that "[o]nce the United States Access Board standards are promulgated, OCR intends to issue regulations or policies that require covered entities to conform to those standards."[80]

On January 9, 2017, the U.S. Access Board finalized and published its comprehensive Standards for Accessible Medical Diagnostic Equipment.[81] Thus, it is now appropriate and necessary to incorporate these standards into the Section 1557 regulations. Specifically, we recommend that 45 C.F.R. § 92.203 (redesignated § 92.103) incorporate a subsection as follows:

(a) If a facility or part of a facility in which health programs or activities are conducted purchases or replaces medical diagnostic equipment on or after [30 DAYS FROM DATE OF PUBLICATION OF FINAL RULE], then such newly-acquired equipment shall comply with the 2017 Standards for Accessible Medical Diagnostic Equipment at 36 CFR part 1195.

(b) Each facility or part of a facility in which health programs or activities are conducted shall fully comply with the 2017 Standards for Accessible Medical Diagnostic Equipment at 36 CFR part 1195 by or before [24 MONTHS FROM DATE OF PUBLICATION OF FINAL RULE].

[78] *See* 81 Fed. Reg. at 31422.
[79] *Id.*
[80] 80 Fed. Reg. at 54187 (Sept. 8, 2015).
[81] ATBCB, *Standards for Accessible Medical Diagnostic Equipment: Final Rule*, 82 Fed. Reg. 2810 (Jan. 9, 2017) (codified at 36 C.F.R. Part 1195).

While we recognize that HHS must still develop scoping requirements for these standards and that this process will take time, we emphasize that this development process should begin now and, while the Section 1557 regulations are being otherwise amended, the U.S. Access Board standards should be codified. CCD is deeply aware of the degree to which the common lack of accessible medical equipment presents grave barriers to effective health care for people with mobility, strength, and other disabilities.[82] Now that we have comprehensive standards to combat these widespread access barriers, HHS should take steps to require health care facilities to follow them.

RECOMMENDATION: At 45 C.F.R. § 92.203 (redesignated § 92.103), HHS should incorporate the follow subsection:

(c) If a facility or part of a facility in which health programs or activities are conducted purchases or replaces medical diagnostic equipment on or after [30 DAYS FROM DATE OF PUBLICATION OF FINAL RULE], then such newly acquired equipment shall comply with the 2017 Standards for Accessible Medical Diagnostic Equipment at 36 CFR part 1195.

(d) Each facility or part of a facility in which health programs or activities are conducted shall fully comply with the 2017 Standards for Accessible Medical Diagnostic Equipment at 36 CFR part 1195 by or before [24 MONTHS FROM DATE OF PUBLICATION OF FINAL RULE].

D. "Accessibility of Electronic and Information Technology" (§ 92.204; Proposed § 92.104)

CCD supports HHS' proposal to retain the provisions of 45 C.F.R. § 92.204 (redesignated § 92.104), regarding information and communication technology ("ICT") for individuals with disabilities. Like effective communication, access to information, communication, and electronic technologies is important to guaranteeing people with disabilities equal access to health care services—and this fact is even more true as U.S. society increasingly relies on digital and web-based communications. Health care providers and health insurance plans are rapidly developing interactive websites, moving their medical recordkeeping online, and communicating with patients through

[82] *See, e.g.*, Nancy M. Mudrick, Mary Lou Breslin, et al., *Physical Accessibility in Primary Health Care Settings: Results from California On—Site Reviews*, 5 DISABILITY & HEALTH J. 159–67 (2012); Tara Lagu, et al., *Access to Subspecialty Care for Patients with Mobility Disabilities: A Survey*, 158 ANN. INTERN. MED., no. 6, 441–46 (2013).

electronic means. We commend HHS' efforts to ensure that people with disabilities are not left behind as technologies evolve.

We are, however, concerned with HHS' proposed change to the definition of "information and communication technology" in proposed § 92.104(c). While we generally object to the elimination of the definitions section at 45 C.F.R. § 92.4, we do appreciate that HHS has incorporated the definition of ICT from the U.S. Access Board regulations implementing Section 508 of the Rehabilitation Act. We note, however, that a critical phrase was removed from the U.S. Access Board's definition. The second sentence of the U.S. Access Board's definition reads: "Examples of ICT include, *but are not limited to*: . . ." (emphasis added).[83] HHS has removed the phrase "but are not limited to" in its NPRM. We strongly encourage HHS to keep this phrase. Information and communication technologies are constantly evolving; it is difficult to predict what technologies will be in place in 5, let alone 10 or 20, years. In order to maintain flexibility and ensure that the regulations keep pace with emerging technologies, HHS should make it absolutely clear that its list of examples of ICT is not exclusive.

Finally, HHS requests comment on whether it should cross-reference Section 508 and its applicable implementing regulations in proposed § 92.104.[84] CCD supports this proposal. Cross-referencing Section 508 and its regulations will help ensure that the Section 1557 regulations stay up-to-date as the Section 508 regulations are amended, and it will ensure consistency across the civil rights laws.

RECOMMENDATIONS:

- **HHS should amend the second sentence of proposed § 92.104(c) to read "Examples of ICT include, <u>but are not limited to</u>: . . .".**

- **HHS should cross-reference Section 508 and its applicable implementing regulations in proposed § 92.104.**

E. "Requirement to Make Reasonable Modifications" (§ 92.205; Proposed § 92.105)

The proposed text of 45 C.F.R. § 92.105 mirrors the current text of 45 C.F.R. § 92.205 and retains the requirement to make reasonable modifications to policies, practices, or procedures. We support this language. This language of "reasonable modification" conforms to other non-discrimination regulations that apply to state and local

[83] 36 C.F.R. app. A § 1194 (2011).
[84] *See* 84 Fed. Reg. 27846, 27867–68 (June 14, 2019).

government, and therefore is consistent with other regulatory schemes applicable to entities subject to 1557.[85] The 2016 Final Rule specifically applies the definition of "reasonable modification" from Title II of the ADA (state and local governments), which we believe continues to be the appropriate standard for recipients of federal financial assistance, programs established under Title I of the ACA, and programs administered by HHS. The concept of "reasonable modification" is not burdensome. The concept has long applied to a broad swath of entities, whether public or private, and therefore it is clear and familiar to most entities covered by Section 1557.[86] There is no reason to make any changes to this language, nor to import unrelated concepts from other regulatory schemes.

HHS has requested comment on whether the following language should be substituted for the proposed 45 C.F.R. § 92.105: covered entities shall make "reasonable accommodation to known physical or mental limits of an otherwise qualified" individual with a disability. HHS also asks whether an exemption for "undue hardship" should be imported from 45 C.F.R. § 84.12 and 28 C.F.R. § 92.205 into proposed 45 C.F.R. § 92.105. The substitute language is from regulations related to employment, and is unnecessary, ill-fitting, and inappropriate for a health care context. The answer to both questions is no. HHS should not make any changes to the language at current § 92.205.

As a preliminary matter, in asking about the imported language, HHS states that the language is taken from HHS Section 504 regulations and the "Department of Justice's Section 504 coordinating regulation."[87] However, the citations to the DOJ Section 504 coordinating regulations are to a non-existent portion of the Code of Federal Regulations.[88] These incorrect citations makes it impossible for the public to know with certainty what HHS is proposing, nor does it allow the public to analyze the context of

[85] *See* 45 C.F.R. § 92.205 (2016).
[86] *See, e.g.,* 28 C.F.R. § 35.130(b)(7) (2010) ("A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.")(Title II of the ADA). Title III also incorporates a requirement that covered entities make "reasonable modifications in policies, practices, or procedures, when the modifications are necessary to afford goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the public accommodation can demonstrate that making the modifications would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations." 28 C.F.R. § 36.302(a) (2010).
[87] 84 Fed. Reg. 27846, 27868 (June 14, 2019).
[88] *Id.* (citing to 28 C.F.R. § 92.205 two separate times: 28 C.F.R. Part 92 contains regulations regarding the "Office of Community Oriented Policing Services (COPS)," and does not contain a section 92.205).

the proposed imported language, or any case law interpreting such language.[89] Public comment requires transparency, and the source of any imported language is an integral part of transparency.

Furthermore, new exemptions are unnecessary and contrary to Section 1557. The concept of a "reasonable modification" is not boundless—it is already well-defined by regulation and decades of case law. In fact, the definition of "reasonable modification" is so clear that HHS declined to provide additional explanation of the term in the 2016 Final Rules.[90] The 2016 final regulations track Title II of the ADA, requiring covered entities to make a reasonable modification "unless the covered entity can demonstrate that making the modifications would fundamentally alter the nature of the health program or activity."[91] Continuing to apply the "reasonable modification" analysis to Section 1557 promotes consistency with pre-existing civil rights statutes, one of HHS' stated goals of their NPRMs.[92] Neither Section 504 nor Title II of the ADA would permit an exemption for "undue hardship" in this context, and it is inappropriate to import such an exemption into Section 1557 where none exists in the statute itself.

The suggested imported language of "reasonable accommodation," "known physical or mental limitation," and "undue hardship" stems directly from employment-related regulations. Such concepts are ill-fitting in the health care context and cannot be applied under Section 1557. For example, the definition of "undue hardship" makes little sense when divorced from the employment context, as it requires consideration of factors often irrelevant to the health care context, such as "(1) The overall size of the recipient's program or activity with respect to number of employees, number and type of facilities, and size of budget; (2) The type of the recipient's operation, including the composition and structure of the recipient's workforce; and (3) The nature and cost of the accommodation needed."[93] These factors make sense in an employment context; they do not when applied to health care. For example, the composition and structure of a

[89] It appears that HHS seeks to import DOJ's rules for the implementation of Executive Order 12250. *See* 28 C.F.R. § 41.53 (2002). It is also possible that HHS intends to refer to DOJ's rules for reasonable accommodation in employment in federally assisted programs pursuant to Section 504. *See* 28 C.F.R. § 42.511 (2000). Either way, it is incumbent on HHS to accurately explain the source of any regulations it seeks to substitute.
[90] *See* 81 Fed. Reg. 31375, 31382 (May 18, 2016) ("OCR believes that defining the terms ''reasonable modification'' and ''accessibility'' in this rule is unnecessary, given the meaning that these terms have acquired in the long history of enforcement of Section 504 and the ADA in the courts and administratively. We intend to interpret both terms consistent with the way that we have interpreted these terms in our enforcement of Section 504 and the ADA and so decline to add these definitions to the final rule").
[91] 45 C.F.R. § 92.205 (2016).
[92] 84 Fed. Reg. 27848 (June 14, 2019).
[93] 45 C.F.R. § 84.12 (2010).

workforce and the number of employees is relevant to common employment-related accommodations, such as changes in job duties or schedules. These factors are much less likely to have bearing on common health care modifications, which may more commonly include requests for alternative evacuation plans for individuals who cannot use stairs, additional training for health care staff on how to provide services to certain individuals, ensuring lab referrals are made to accessible entities when necessary, or altering a policy to allow an individual to remain in a wheelchair and avoid unnecessary transferring while receiving some treatments such as dental care. Because the factors used to analyze “undue hardship” are more appropriate for the employment context, we believe that the appropriate approach is to retain the “reasonable modification” language, which is taken from Title II of the ADA, already applies to many entities subject to Section 1557, and has a clear definition that is flexible enough to provide guidance to health care entities.

We specifically object to the importation of the concept of “known physical or mental limitation” because it could introduce confusion, suggest that covered entities' obligations are limited, and unduly focuses on measures entities must take in response to requests for modifications. Disability discrimination encompasses not just inappropriate responses to requests for modifications, but also a failure of covered entities to take affirmative steps to prevent discrimination. Taken in conjunction with the proposed deletion of § 92.101 which defines discriminatory actions prohibited (discussed *supra,* Section II(D)), importing the language regarding "known physical or mental limitation" could be read to limit covered entities' obligations. Nothing in Section 1557 permits such limitations, and such a reading would be contrary to the language of Section 1557 and the larger Act within which it sits. Nor has HHS provided an explanation of how this concept, which heretofore has been largely limited to the employment context, would be applied in the health care context. Such an application would undermine HHS’ stated purpose of the proposed rule, which is to promote consistency in the application of rules and to adhere to the enforcement mechanisms available in the underlying statutes.[94]

Furthermore, while we disagree with HHS’ statement that Congress only intended to permit disparate impact claims if such claims were permissible prior to 1557, HHS admits that many courts have permitted disparate impact claims under Section 504.[95] Importing language regarding “known” limitations could be interpreted as limiting plaintiffs’ ability to bring systemic disparate impact claims, or other substantive claims. If HHS intends to create such a limitations, it must be explicit about its intent, and do so

[94] 84 Fed. Reg. 27848, 27849-51 (June 14, 2019).
[95] *See, e.g., McWright v. Alexander,* 982 F.2d 222, 229 (7th Cir. 1992); *Smith v. Barton*, 914 F.2d 1330, 1340 (9th Cir. 1990).

via a transparent rulemaking process. If HHS does not intend to create such a limitation, we request that HHS retain the language in proposed 45 C.F.R. § 92.105.

For the reasons stated above, we urge HHS to retain the language proposed in § 92.105 as drafted, and not to import any new exemptions or language regarding "reasonable accommodations to known physical and mental impairments."

RECOMMEDNATIONS:

- **HHS should not import an "undue hardship" exemption into the regulations related to reasonable modification.**
- **HHS should retain the current language of "reasonable modification."**

F. Comments on Proposed §§ 92.102 through 92.105

HHS has asked broadly whether it has struck the "appropriate balance" in proposed §§ 92.102 through 92.105 with respect to Section 504 rights and obligations imposed on the "regulated community." We agree generally that to the extent that HHS has retained protections from the 2016 Final Regulations, such protections are appropriate. More broadly, however, the question should not be "whether the benefits of these provisions exceeds the burdens imposed by them." Such a balancing exercise is not called for by the statute, and inserts an inappropriate regulatory finesse on a remedial scheme created by Congress and intended to be interpreted broadly to correct decades of harm.[96] The task of the agency is to interpret and implement the statute. The proposed balancing of interests may be an appropriate role for Congress, but not for the administrative branch. Although we disagree with the premise of the question, we do note that the harm that people with disabilities would suffer if Section 1557 and the current regulatory scheme were not upheld is immense.[97]

HHS also asks generally whether regulations for Section 1557 are consistent with the regulatory scheme for entities that are not covered by Section 1557 regulations, such as human services grantees, or whether underlying regulations for other civil rights statutes need to be modified. In general, we have commented on contexts where it is inappropriate to import regulations created for the employment into Section 1557's regulatory scheme. While there are clearly other areas of nondiscrimination law where

[96] *See, e.g.* 42 U.S.C. § 12101 (1990) (ADA findings and purposes). The ADA built upon Section 504, and Section 1557 follows in their footsteps. *See also Kang v. U. Lim Am., Inc.*, 296 F.3d 810, 816 (9th Cir. 2002); citing H.R. Rep. No. 102–40(I), at 88, U.S. Code Cong. & Admin. News at 626 ("remedial statutes, such as civil rights law[s], are to be broadly construed").
[97] *Supra*, notes 38-42 and accompanying text.

importing or exporting other regulatory regimes would be inappropriate, HHS has not provided sufficient clarity in both the questions and the context to allow us to provide additional meaningful comment outside of the comments raised above.

To propose changes in existing regulations, HHS must provide its own justification for the changes. Given that the public must be provided an opportunity to comment on HHS' alleged explanations and rationale for these proposed changes, HHS' attempt to solicit feedback on unspecified underlying regulations that it may then use to promulgate unanticipated changes in a final rule violates requirements of public notice and comment as required by the Administrative Procedures Act. These issues would be more appropriate to inform agency decisions prior to issuing an NPRM, such as through a Request for Information, than in response to an NPRM. We thus decline to provide feedback additional feedback on the question of whether Section 1557 is generally aligned with underlying but unspecified regulations, but have provided our explanations, justifications and evidence supporting our comments in the sections above.

V. Conclusion

People with disabilities, like all people, have intersectional identities, and the anti-discrimination mandate in Section 1557 is designed to prohibit discrimination based on a single identity as well as the intersection of two or more identities such as race and disability, age and disability, or sex and disability. We therefore strongly oppose the NPRM provisions which seek to eliminate and limit protections for limited English proficient individuals, LGBTQ+ persons, women *and* persons with disabilities and chronic conditions. Section 1557 addresses not only protections for each protected class covered, but the intersection of those protections. As such, an attack on the civil rights of one group in the NPRM is an attack on the civil rights of all. We stand in solidarity with other marginalized groups in objecting to this NPRM.

We strongly recommend that HHS not finalize any part of the proposed changes to the Section 1557 regulations as well as the other conforming provisions. HHS should instead leave the 2016 final Section 1557 regulations in place in their entirety.

Thank you for the opportunity to provide comments on the NPRM. We urge HHS not to finalize these changes. If you have questions about our comments, please contact Jennifer Lav at lav@healthlaw.org.

Sincerely,

Allies for Independence

ALS Association
American Academy of Physical Medicine & Rehabilitation
American Association on Intellectual and Developmental Disabilities (AAIDD)
American Association on Health & Disability
American Association of People with Disabilities (AAPD)
American Council of the Blind
American Dance Therapy Association
American Foundation for the Blind
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association (AOTA)
American Physical Therapy Association
American Therapeutic Recreation Association
Amputee Coalition
Autism Society of America
American Speech-Language-Hearing Association
Autistic Self Advocacy Network
Bazelon Center for Mental Health Law
Center for Medicare Advocacy
Center for Public Representation
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Christopher & Dana Reeve Foundation
Disability Rights Education & Defense Fund
Easterseals
Epilepsy Foundation
Family Voices
Institute for Educational Leadership (IEL)
Justice in Aging
Lutheran Services in America-Disability Network
National Academy of Elder Law Attorneys
National Association for the Advancement of Orthotics and Prosthetics
National Association of Councils on Developmental Disabilities
National Association of State Head Injury Administrators
National Center for Parent Leadership, Advocacy, and Community Empowerment (National PLACE)
National Council on Independent Living
National Disability Institute
National Disability Rights Network
National Down Syndrome Congress
National Health Law Program

National Multiple Sclerosis Society
Paralyzed Veterans of America
Partnership for Inclusive Disaster Strategies
The Arc of the United States