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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

STATE OF WASHINGTON,

Plaintiff,

v.

UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES; ALEX M. AZAR, in
his official capacity as the Secretary of the
United States Department of Health and
Human Services;

Defendants.

NO. 2:20-cv-01105

BRIEF OF AMICI NATIONAL
HEALTH LAW PROGRAM ET
AL., IN SUPPORT OF
PLAINTIFF'S MOTION FOR
PRELIMINARY INJUNCTION

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1 Care, and SAGE are health and disability advocacy organizations dedicated to
2 eliminating disparities in health care.¹ Proposed amici have a strong interest in
3 ensuring that the regulations adhere to the statute and that people receive the full
4 protection of Section 1557. *See* 5 U.S.C. § 702. While Washington’s Preliminary
5 Injunction motion is based on the changes to the definition of discrimination on the
6 basis of sex, its complaint recognizes that the changes are far more expansive and will
7 harm a range of individuals, including those represented by amici as described below.
8

9 The initial rulemaking process for Section 1557 spanned three years and resulted
10 in 25,000 comments reflecting the importance of eliminating longstanding
11 discrimination in health care. This process culminated in the U.S. Department of Health
12 and Human Services (“HHS”) issuing a final rule in 2016. Nondiscrimination in Health
13 Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) (formerly codified at 45
14 C.F.R. pt. 92), <https://perma.cc/47EC-4NZL> (“2016 Final Rule”). Then, just four years
15 later, the Trump Administration issued a revised rule. Nondiscrimination in Health
16 and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg.
17 37,160 (June 19, 2020), <https://perma.cc/P2TJ-AN54> (“2020 Revised Rule”). As
18 Washington has shown, the 2020 Revised Rule threw away important protections
19 against sex discrimination that will harm Lesbian, Gay, Bisexual, Transgender, Queer
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25 ¹ None of the proposed Amici is a subsidiary of any other corporation and no publicly held corporation
26 owns 10% or more of any proposed Amici’s stock.

1 Plus (“LGBTQ+”) individuals and women. *See* Memo. in Support of Mtn. for
2 Preliminary Inj., ECF No. 4, at 8. As amici discuss below, it also added a host of
3 exemptions contrary to the ACA. It eliminated important notice and effective
4 communication protections for people with limited English proficiency (LEP) and
5 disabilities. And it erased whole categories of entities from coverage by Section 1557.
6

7 The 2020 Revised Rule was one of multiple attempts to undermine the ACA and
8 its non-discrimination protections. Previously, the Administration issued a memo to
9 discourage staff from systemic investigations of discrimination. *See* Candice Jackson,
10 OCR Acting Assistant Sec’y Civil Rights, *OCR Instructions to Field Re: Scope of*
11 *Complaints* (Jun. 8, 2017), <https://perma.cc/45L6-8Q5T>. It also filed briefs in litigation
12 that challenged the non-discrimination protections.²
13

14 Caught in the midst of all of these attempted rollbacks are the people whom
15 Congress intended to protect under the ACA. Prior to the ACA, Congress heard
16 testimony about the impact of discrimination on women, people with disabilities,
17 LGBTQ+ individuals, people with limited English proficiency (“LEP”), older adults,
18 and other protected classes. In passing the ACA, Senator Tom Harkin said:
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20 [U]ntil now, it has been perfectly legal to discriminate against our fellow
21 Americans because of illness-because of illness-and to exclude tens of
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24 ²*Defendants’ Memorandum in Response to Plaintiffs’ Mtn. for Summary Judgment, Franciscan Alliance v. Price*,
25 No. 7:16-cv-00108 (N.D. Tex., Apr. 5, 2019), <https://perma.cc/48ZU-GAHU> (informing court that HHS
26 no longer interpreted “sex” to include gender identity); *c.f. Federal Defendants’ Memorandum in Response to*
Plaintiffs’ Application for Preliminary Injunction, Texas v. U.S., No. 4:18-cv-00167-O (N.D. Tex., Jun. 7, 2018),
<https://perma.cc/FU5G-HASZ> (arguing ACA’s pre-existing condition protection is unconstitutional).

1 millions of our citizens from decent health care simply because they could
2 not afford insurance or afford health care-blattant discrimination.

3 156 Cong. Rec. S1983 (daily ed. Mar. 24, 2010). To ensure that such discrimination
4 remains illegal, proposed amici support Washington's motion.

5 **I. Allowing Exemptions Will Cause Significant Harm to Women,
6 LGBTQ+ People, People with Disabilities, and Older Adults.**

7 The 2020 Revised Rule illegally incorporates harmful exemptions from other laws,
8 including Title IX of the Education Amendments Act of 1972 ("Title IX") and the
9 Americans with Disabilities Act ("ADA"). 20 U.S.C. § 1681 et seq.; 42 U.S.C. § 12101 et
10 seq. These exemptions are contrary to the language of Section 1557, which creates a
11 baseline protection of rights, remedies, and procedures that other non-discrimination
12 provisions may add to, but not take away from. The language of Section 1557(b) protects
13 individual rights. *See* 42 U.S.C. § 18116(b) ("Nothing in this title ... shall be construed to
14 invalidate or limit the rights, remedies, procedures, or legal standards" available under
15 the cited non-discrimination statutes or supersede more protective State law). The 2016
16 Rule appropriately reflected this language. *See* 81 Fed. Reg. at 31,466 (codified at 45
17 C.F.R. § 92.3(b)). By contrast, the 2020 Revised Rule uses language that cabins Section
18 1557 and incorporates exemptions from nine statutes never referenced in Section 1557.
19 *See* Exhibit 1 (providing a side-by-side comparison of the language).

20 Including these exemptions is not only contrary to the statute, but also ignores the
21 ample evidence in the record that the exemptions would cause significant harm,
22 especially to women, LGBTQ+ people, people with disabilities, and older adults. The
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1 question of including exemptions to Section 1557 was thoroughly commented on and
2 reviewed in the 2016 rulemaking process. Nothing significant has changed in the interim,
3 and HHS has not provided a reasoned justification for its changes.

4 HHS first solicited comment on whether it should incorporate any religious
5 exemptions to compliance with the sex discrimination component of Section 1557 in
6 2013, in a “Request for Information Regarding Nondiscrimination in Certain Health
7 Programs or Activities.” 78 Fed. Reg. 46,558 (Aug. 1, 2013), [https://perma.cc/NJ8P-
8 2VKJ](https://perma.cc/NJ8P-2VKJ) (“RFI”) (referencing Title IX).³ RFI Commenters gave examples of how allowing
9 exemptions from Section 1557’s protections would result in real-world discrimination
10 and harm. *See, e.g.*, Lambda Legal, Comment ID HHS-OCR-2013-0007-0161, at 2; Nat’l
11 Latina Inst. Repro. Health, Comment ID HHS-OCR-2013-0007-0101, at 6; Whitman-
12 Walker Health, Comment ID HHS-OCR-2013-0007-0063, at 11. HHS later noted:

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15 Nearly all commenters who provided a response to this inquiry indicated
16 that Section 1557 includes only one exception—that the statute applies
17 except as otherwise provided in Title I of the ACA. To this end,
18 commenters noted that nothing in the language or legislative history of
19 Section 1557 allows for any other limitations or exceptions regarding its
20 application, highlighting that exceptions to general rules like Section
21 1557’s antidiscrimination provision must be read strictly and narrowly.

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24 ³ All comments received by HHS in response to the 2013 RFI can be found at [https://perma.cc/T719-
25 YALK](https://perma.cc/T719-YALK). In this brief, individual comments have been identified by their comment ID number the first time
26 they are cited and then by the organization’s name thereafter.

1 Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,173
2 (proposed Sept. 8, 2015), <https://perma.cc/LTK9-5YET>.⁴

3 HHS solicited comment on the question again in 2015 in its first Notice of
4 Proposed Rulemaking on Section 1557, asking “whether the regulation should include
5 any specific exemptions . . . with respect to requirements of the proposed rule related to
6 sex discrimination” and whether “existing protections . . . provide sufficient safeguards
7 for religious concerns in the context of the proposed rule.” *Id.* at 54,173. HHS stated that
8 its goal was to “ensure that the rule has the proper scope and appropriately protects
9 sincerely held religious beliefs to the extent that those beliefs conflict with provisions of
10 the regulation,” while noting that “protections already exist with respect to religious
11 beliefs, . . . [and] this proposed rule would not displace the protections afforded by
12 provider conscience laws, the Religious Freedom Restoration Act, provisions in the ACA
13 related to abortion services, or regulations issued under the ACA related to preventive
14 health services.” *Id.* (citations omitted). Those existing statutes that allow individuals
15 and entities to refuse to provide certain services based on moral and religious objections
16 are more than sufficient to accommodate any religious objections.
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20 In response to HHS’s inquiry, “[m]ost of the organizations that commented on
21 this issue, including professional medical associations and civil rights organizations, and
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25 ⁴ All comments received by HHS in response to the 2015 NPRM can be found at
26 <https://perma.cc/X267-26UZ>. In this brief, individual comments have been identified by their comment ID number the first time they are cited and then by the organization’s name thereafter.

1 the overwhelming majority of individual commenters—many of whom identified
2 themselves as religious—opposed any religious exemption on the basis that it would
3 potentially allow for discrimination on the bases prohibited by Section 1557 or for the
4 denial of health services. . . .” 81 Fed. Reg. at 31,379. In addition, as HHS noted, “mergers
5 of religiously-affiliated hospitals with other hospitals have deepened concerns that
6 would be raised by providing a religious exemption, as the mergers may leave
7 individuals in many communities with fewer health care options. . . .” *Id.* Many
8 commenters also discussed the harm that a religious exemption would have on LGBTQ+
9 individuals. *See Nat’l Women’s Law Ctr., Comment ID HHS-OCR-2015-0006-0837, at 8-*
10 *9 (citing ACLU & Merger Watch, Miscarriage of Medicine: The Growth of Catholic Hospitals*
11 *and the Threat to Reproductive Health Care (2013), <https://perma.cc/SV62-NDCQ>); Nat’l*
12 *Ctr. Lesbian Rights, Comment ID HHS-OCR-2015-0006-1829, at 10-13 (citing numerous*
13 *studies on the negative impact of the growth in religiously affiliated hospitals on access*
14 *to care for women seeking reproductive health services and rape survivors). This impact*
15 *was reiterated by hundreds of individual commenters, including over one hundred*
16 *individuals from Washington State. See, e.g., Leslie Gray of Olympia, WA, Comment ID*
17 *HHS-OCR-2015-0006-2159, at 524-25 (describing experience of a transgender woman*
18 *whose urological medical condition was not treated due to her transgender identity,*
19 *which caused blood clots to form in her heart, resulting in permanent cardiac damage).*

20 Thus, in promulgating the 2016 Final Rule, HHS stated that while “some
21 commenters urged us also to incorporate Title IX’s blanket religious exemption into this
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1 final rule, we believe that applying the protections in [existing] laws . . . offers the best
2 and most appropriate approach for resolving any conflicts between religious beliefs and
3 Section 1557 requirements.” 81 Fed. Reg. at 31,380. With respect to Title IX’s exemptions,
4 HHS emphasized that these exemptions are limited to educational institutions and noted
5 key differences between the educational and health care contexts, concluding, “[t]hus, it
6 is appropriate to adopt a more nuanced approach in the health care context, rather than
7 the blanket religious exemption applied for educational institutions under Title IX.” *Id.*
8 HHS recognized that in health care, people often have little choice as to where an
9 ambulance takes them or may have few choices of providers in rural areas heavily
10 populated with religious providers. *See id.*

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13 Nevertheless, the 2020 Revised Rule adds Title IX’s blanket exemption for
14 religiously affiliated entities along with a range of other religious exemptions. *See*
15 *Nondiscrimination in Health and Health Education Programs or Activities*, 84 Fed. Reg.
16 27,846, 27,892 (proposed June 14, 2019), <https://perma.cc/FY4Z-ZUBA> (to be codified
17 at § 92.6).⁵ This 180 degree turn is all the more significant given the growing percentage
18 of the health care market that is occupied by religiously affiliated hospitals and health
19 systems. *See* ACLU of Illinois, Comment ID HHS-OCR-2019-0007-138982, at 7-8 (citing
20 Louis Uttley & Christine Khaikin, *Growth of Catholic Hospitals and Health Systems: 2016*
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25 ⁵ All comments received by HHS in response to the 2019 NPRM can be found at
26 <https://perma.cc/4VCN-Y2DK>. In this brief, individual comments have been identified by their comment
ID number the first time they are cited and then by the organization’s name thereafter.

1 *Update of the Miscarriage of Medicine Report*, MergerWatch, (2016),
2 <https://perma.cc/A9TW-Y6P5>); Amelia Thomson-DeVeaux and Anna Maria Barry-
3 Jester, *Insurers Can Send Patients to Religious Hospitals that Restrict Reproductive Care*,
4 *FiveThirtyEight* (Aug. 1, 2018), <https://perma.cc/3V2Z-CYGV>); *see also* ACLU Finds.
5 of Cal., Comment ID HHS-OCR-2019-0007-149859, at 8-10 (the growing size and scope
6 of Catholic hospitals will increase the likelihood of harm to women and LGBTQ+
7 individuals). This issue is particularly acute in Washington as it has the second highest
8 proportion of short-term acute-care beds in hospitals under Catholic restrictions at
9 40.9%. Legal Voice, Comment ID HHS-OCR-2019-0007-151507, at 8.

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12 The inclusion of sweeping religious exemptions to Section 1557's protections will
13 result in serious harm. As commenters noted these exemptions will disproportionately
14 harm women, especially Black, Indigenous, and women of color, who are often denied
15 reproductive health care due to the proliferation of entities that discriminate by refusing
16 to provide such care based on religious beliefs. *See* Ass'n Am. Med. Colls., Comment ID
17 HHS-OCR-2019-0007-115960, at 3-4 (religious exemptions will exacerbate race-based
18 discrimination in family planning care); Nat'l Hisp. Leadership Agenda, Comment ID
19 HHS-OCR-2019-0007-149018, at 11 (citing study finding that 4 in 10 Latina/o voters
20 under age 45 (41 percent) have gone without the birth control method they wanted in
21 the past two years because of access issues); *see also* Legal Voice at 8; *In Our Own Voice*:
22 Nat'l Black Women's Reproductive Justice, Comment ID HHS-OCR-2019-0007-140963,
23 at 7; Nat'l Women's Law Ctr., Comment ID HHS-OCR-2019-0007-149018, at 5-11.

1 The 2020 Revised Rule’s religious exemptions also disproportionately harm
2 LGBTQ+ people. According to a study published in 2018, 8% of LGBQ people were
3 refused health care because of their sexual orientation, and 29% of transgender people
4 were denied care because of their gender identity. *See* NHeLP, Comment ID HHS-OCR-
5 2019-0007-127004, at 51 (citing Shabab Ahmed Mirza & Caitlin Rooney, *Ctr. Am.*
6 *Progress, Discrimination Prevents LGBTQ People From Accessing Health Care* (2018),
7 <https://perma.cc/ZG7E-7WK8>); Justice in Aging, Comment ID HHS-OCR-2019-0007-
8 149354, at 7 (“Many [LGBTQ+] older adults report having to go back ‘in the closet’
9 because of stigma and fear when transitioning to a long-term care facility. . . .”).
10

11 HHS also acted contrary to the ACA and Section 1557 by incorporating the
12 exemptions set forth in the ADA. The ADA includes religious exemptions, private club
13 exclusions, and exclusions related to drug use that are not found in Section 1557. NHeLP
14 at 24. The ADA also includes a safe harbor provision that exempts insurers, hospitals,
15 managed care entities, benefit administrators, and other organizations “underwriting
16 risks, classifying risks, or administering such risks” from the disability discrimination
17 protections in Titles I through III of the ADA. 42 U.S.C. § 12201(c). Under the safe harbor
18 provision of the ADA, insurers and others have been allowed to discriminate against
19 people with disabilities. *See, e.g.,* Samuel R. Bagenstos, *The Future of Disability Law*, 114
20 *Yale L.J.* 1, 41 nn.168-70 (2004) (collecting cases that did not analyze whether content of
21 benefits was discriminatory when they upheld exclusions on the basis of treatment or
22 diagnosis). Although disability discrimination claims under Section 504 of the
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1 Rehabilitation Act are allowed, courts have narrowly construed certain types of claims.

2 *Id.* The ACA contains many examples of corrections to exemptions and definitions that
3 courts had upheld in disability discrimination challenges under the ADA and Section
4 504, including prohibitions against discriminatory benefit design. *See, e.g.*, 42 U.S.C. §
5 300gg-6; 42 U.S.C. § 18022; Consortium for Citizens with Disabilities (“CCD”), Comment
6 ID HHS-OCR-2019-0007-146162, at 2-7; *see generally* Sara Rosenbaum et al., *Crossing the*
7 *Rubicon: The Impact of the Affordable Care Act on the Content of Insurance Coverage for Persons*
8 *with Disabilities*, 25 Notre Dame J. L. Ethics & Pub. Pol’y 235 (2014).

9
10 The 2020 Revised Rule purports to recreate some of the very gaps that Section
11 1557 was intended to fill. Under the 2020 Revised Rule individuals with disabilities who
12 are facing discriminatory benefit designs outside of the qualified health plan context may
13 have limited, if any, options for challenging such harmful discrimination. *See* Coalition
14 to Preserve Rehabilitation, Comment ID HHS-OCR-0007-146075, at 2 (noting that Section
15 1557 “acted as a capstone to the ADA expanding disability protections in the provision
16 of health insurance.”).

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19 The ACA reformed disability discrimination in health care. Many of the
20 discriminatory practices that had been allowed are now prohibited. Section 1557 was
21 included as the mechanism to enforce this seismic shift. The 2020 Revised Rule turns this
22 mechanism on its head by incorporating all of the exemptions, exclusions, definitions,
23 and defenses of statutes not even mentioned in Section 1557. HHS lacks the authority to
24 promulgate regulations interpreting Section 1557 that “create[] any unreasonable
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1 barriers to the ability of individuals to obtain appropriate medical care.” 42 U.S.C. §
2 18114. Yet HHS’s action will do just that. For these reasons, the 2020 Revised Rule’s
3 addition of exemptions and exclusions untethered to the text of Section 1557 is contrary
4 to law and is arbitrary and capricious.

5 **II. Removal of the Notice, Tagline, and Effective Communication**
6 **Requirements Will Harm Individuals with Limited English**
7 **Proficiency (“LEP”), Older Adults, and People with Disabilities.**

8 Before the ACA, individuals who needed communication assistance experienced
9 barriers to regularly receiving quality health care, leaving important information
10 uncommunicated or ineffectively communicated between providers and patients. The
11 result: preventive visits did not happen, treatment regimens were not followed, and
12 appointments were missed. 81 Fed. Reg. at 31,459. Congress passed the ACA to “help
13 uninsured and underserved populations gain access to care[.]” 81 Fed. Reg. at 31,443.
14 The 2016 Final Rule recognized the ACA and Section 1557’s purposes to “expand access
15 to care and eliminate barriers to access,” including by preventing disability
16 discrimination. *Id.* at 31,377.
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19 In the 2020 Revised Rule, HHS has removed provisions that are essential to ensure
20 that individuals with limited English proficiency (“LEP”), older adults, and people with
21 disabilities can regularly access quality health care. In particular, the Rule eliminates
22 notice requirements that are critical for people to understand their rights. *See* 85 Fed.
23 Reg. at 37,204. The 2020 Revised Rule also removes requirements for taglines—short
24 statements commonly added to documents to inform individuals in their language of
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1 their right to language assistance and how to seek such assistance – a critical language
2 access provision designed to ensure that LEP individuals can access needed care. *Id.* at
3 37,175. In addition, the Rule harms people with disabilities by limiting access to
4 necessary effective communication. *Id.* at 37,213-37,215; *see also* CCD at 20-21.

5
6 A. *Harm of Repealing the Notice and Tagline Requirements*

7 The 2016 Final Rule contained a number of provisions to ensure that patients
8 understand their rights and are able to communicate effectively with health care staff. In
9 particular, the 2016 Final Rule required covered entities to provide notice of
10 nondiscrimination policies, including notice of the availability and how to access
11 auxiliary aids and services necessary for certain patients with disabilities and language
12 assistance services for LEP patients. 81 Fed. Reg. at 31,469. The 2016 Final Rule required
13 covered entities to post this notice in physical locations, in significant communications,
14 and on its website. *Id.* The 2020 Revised Rule has entirely eliminated the notice
15 requirements. *See* 85 Fed. Reg. at 37,204.
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18 In crafting the 2016 Final Rule, HHS noted that “the use of incompetent or ad hoc
19 interpreters, such as family members, friends, and children, is not uncommon and can
20 have negative implications.” 80 Fed. Reg. at 54,184. Accordingly, the 2016 Final Rule
21 required covered entities to include taglines on all significant documents in the top 15
22 languages spoken by individuals with LEP in their state. 45 C.F.R. § 92.8(d)(1); *see* 81 Fed.
23 Reg. at 31,469. Despite commenters raising concerns about the benefits of the 2016 Final
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1 Rule and the harms of eliminating these provisions, the 2020 Revised Rule entirely
2 eliminated the tagline requirements. *See* 85 Fed. Reg. at 37,204.

3 Eliminating these critical language access provisions will result in some of these
4 individuals failing to understand or assert their rights. *See* NHeLP at 29 (“All too often,
5 individuals with limited English proficiency do not understand their rights, and will not
6 know their new rights under Section 1557[.]”); *see also* Asian Health Services, Comment
7 ID HHS-OCR-2019-0007-146378; California Pan-Ethnic Health Network, Comment ID
8 HHS-OCR-2019-0007-152828. It will also result in some people failing to receive
9 adequate care, delaying care, or not seeking care at all, because they are unaware of their
10 right to receive accommodations and language services, undermining the purpose and
11 intent of Section 1557. *See* Leadership Conference, Comment ID HHS-OCR-2019-0007-
12 138231, at 7 (“Protections for language access are also required in order to combat
13 discrimination based upon national origin.”); NHeLP at 29 (individuals often “believe
14 they have to bring their own interpreter or use a child, other patient, or unqualified
15 individual to interpret.”); Disability Law Ctr., Comment ID HHS-OCR-2019-0007-
16 127904, at 2 (“Without the notice, members of the public will have limited means of
17 knowing that auxiliary aids and services are available, how to request them, what to do
18 if they face discrimination, and their right to file a complaint.”); Justice in Aging at 2
19 (describing particular needs of LEP older adults, including the four million plus LEP
20 Medicare beneficiaries); Medicare Rights Ctr., Comment ID HHS-OCR-2019-0007-
21 145479, at 6-7 (describing importance of language access protections for older adults,
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1 including LEP older adults, people with disabilities, and older adults who are deaf, hard
2 of hearing, blind, or have low vision, to access health care, understand medical
3 instructions, and engage with providers).

4 As a result of the repeal of the notice and tagline requirements, it will be more
5 difficult for LEP patients to navigate complex documents with specialized terminology.
6 See Commonwealth of Mass., Comment ID HHS-OCR-2019-0007-136510, at 4. In
7 addition, there will be an increase in LEP patients and patients with disabilities who are
8 unable to communicate with health care workers, resulting in incorrect diagnoses or
9 inappropriate care. See Leadership Conference at 7-8 (citing The Joint Comm'n,
10 *Overcoming the Challenges of Providing Care to LEP Patients* (May 2015),
11 <https://perma.cc/BE6A-5QYP>); Wash. State Coalition for Language Access, Comment
12 ID HHS-OCR-2019-0007-127779, at 2 (“[I]nadequate language services[] have been well-
13 documented as contributing to U.S. health and healthcare disparities, including: reduced
14 access to regular care; lesser quality of care; higher rates of uninsurance; increased risk
15 of medical errors; difficulty in following post-care instructions; more frequent
16 hospitalizations and higher rates of readmissions; unnecessary tests and procedures; and
17 higher rates of mortality.”) (citing WASCLA Tools for Health, *What Does Language Access
18 Have to Do With Health?* (2014)); Justice in Aging at 4 (consistent access to professional
19 interpreters in hospital setting was associated with decreased readmission rates for LEP
20 individuals 50+ years old receiving palliative care services); Disability Law Center at 1
21 (“Persons with sensory impairments also experience challenges understanding or
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1 complying with care instructions because interpreters are more often than not
2 unavailable or materials are not offered in alternative formats.”).

3 The cost of these language and communication barriers can be deadly. A 2010
4 report found that patients lost their lives and suffered irreparable harm from medical
5 errors, worse clinical outcomes, and lower quality of care due to language barriers.
6 NHeLP at 28 (citing Kelvin Quan & Jessica Lynch, *The High Costs of Language Barriers in*
7 *Medical Malpractice*, Univ. of Cal. Berkeley and Nat’l Health Law Program (2011),
8 <https://perma.cc/59PM-4NHU>). Others may be improperly billed if their LEP status
9 prevents them from successfully navigating the healthcare system. *See Justice in Aging*
10 at 3 (“Especially for older adults with limited income and high health care needs, the
11 consequences of an erroneous bill or forgoing care can be catastrophic.”).

14 As the 2016 Final Rule recognized, studies have shown that “when reliable
15 assistance services are utilized, patients experience treatment-related benefits, such as
16 enhanced understanding of physician instruction, shared decision-making, provision of
17 informed consent, adherence with medication regimes, preventive testing, appointment
18 attendance, and follow-up compliance.” 81 Fed. Reg. at 31,459 (citing *Institute of Medicine,*
19 *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* 17 (Brian D.
20 Smedley et al. eds., 2002) (citation omitted), <https://perma.cc/RQK2-U9RA>).

23 Despite HHS’s suggestion that the notice and tagline requirements were
24 duplicative, these requirements are not met by other non-discrimination provisions. For
25 example, HHS cites the Medicare Advantage (Part C) and Prescription Drug Plans (Part
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1 D) as requiring taglines in Medicare Communications and Marketing Guidelines
2 (MCMG), but the Centers for Medicare & Medicaid Services eliminated this requirement
3 effective this year. See CMS, MCMG (2018), <https://perma.cc/2T3G-DTAR>.
4 Requirements for notices and taglines in other contexts are also not duplicative. For
5 example, HHS cites requirements in Medicaid and Medicaid managed care, but these
6 differ from the specific requirements of the 2016 rule. See Justice in Aging at 5.
7

8 The elimination of the notice and tagline requirements undermines the purpose
9 of Section 1557. Failing to provide taglines does not provide adequate notice of language
10 assistance services and thus will not ensure entities comply with the statutory
11 nondiscrimination requirements of Section 1557. As such, the 2020 Revised Rule is not
12 in accordance with the underlying law and is in excess of HHS's statutory authority.
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14 B. *The 2020 Revised Rule Discriminates by Limiting Access to Effective*
15 *Communication for People with Disabilities.*

16 The lack of effective communication has “significant adverse effects on . . . access
17 to, participation in, compliance with, and decision-making in health care.” American
18 Speech-Language-Hearing Association, Comment ID HHS-OCR-2019-0007-127462, at 3;
19 see also ANCOR, Comment ID HHS-OCR-2019-0007-104180, at 2 (“It is essential that this
20 access [to effective communication devices] is protected to ensure that [individuals with
21 disabilities] can be active in decision making for their health and to reach the best
22 outcomes.”). To address this problem, the 2016 Final Rule provided clear definitions
23 regarding auxiliary aids and services, interpreters, and other disability related
24 definitions, eliminated by the 2020 Final Rule. Compare 81 Fed. Reg. at 31,466-67 (former
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1 45 C.F.R. § 92.4, § 92.202) *with* 85 Fed. Reg. at 37,213-16 (new § 92.102). The 2016 Final
2 Rule required that all auxiliary aids and services be provided timely and free of charge
3 as is required by other disability non-discrimination laws. Yet the 2020 Final Rule only
4 requires that a subset of auxiliary aids and services—interpreters--be provided free of
5 charge and in a timely manner. 45 C.F.R. § 92.102(b)(2).
6

7 Significantly, interpreters provide effective communication for a very narrow
8 subset of people with disabilities. Auxiliary aids and devices include a broad range of
9 services such as closed captioning, qualified readers, Braille materials, telephone handset
10 amplifiers, and other similar devices. They also include using people with training, skill,
11 or experience to communicate. Further, individuals with similar disabilities may need
12 different devices or assistance. For example, a person who is hard of hearing may not
13 always know American Sign Language or be able to use closed captioning but may be
14 able to use an amplifying device compatible with their hearing aid.
15

16 The 2020 Final Rule’s distinction between type of auxiliary aids and devices that
17 will be provided free and timely discriminates against people who need other auxiliary
18 aids and devices, in direct contravention of Section 1557’s statutory prohibition on
19 disability-based discrimination. *See also* 28 C.F.R. § 36.301; 34 C.F.R. § 104.4 (entity
20 receiving Federal financial assistance is prohibited from providing an aid, benefit, or
21 service that is not as effective as that provided to others and cannot perpetuate
22 discrimination through criteria or methods of administration).
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1 **III. HHS Relies on an Inappropriate Calculation of the Cost of**
2 **Providing Notice and Taglines and Underestimates the Benefits.**

3 HHS improperly relied on an incomplete cost-benefit analysis to repeal the notice
4 and tagline requirements. HHS admits that “[r]epealing the notice and tagline
5 requirements may impose costs, such as decreasing access to, and utilization of,
6 healthcare for non-English speakers by reducing their awareness of available translation
7 services[.]” 85 Fed. Reg. at 37,232, but stated that it was unaware of “a way to quantify
8 those potential effects.” *Id.* at 37,234. HHS ignored numerous comments quantifying the
9 harm of this change and indicates that HHS failed to adequately consider the record.
10

11 HHS failed to address multiple comments on the 2019 Proposed Rule which
12 demonstrated that the costs of providing notice under the 2016 Final Rule are not
13 prohibitive. *See Ass’n of Am. Med. Colls.* (HHS’s cost estimates related to notice were
14 inflated and notice, at most, adds incremental burden given hospital operating
15 procedures); ACCESS, Comment ID HHS-OCR-2019-0007-144346, at 4 (the majority of
16 the costs estimated by HHS are associated with provision of EOBs). As many
17 commenters pointed out, HHS provided a sample notice and translated it into 64
18 languages, alleviating entities from the cost of developing their own. HHS also made
19 clear that it expected most covered entities to avoid costs by using its sample notices and
20 exhausting current publications before printing new notices. 81 Fed. Reg. 31,453.
21 Commenters also noted that any burdens of wall space and use of resources to post the
22 notice were greatly outweighed by the benefits of conspicuous notice so that people are
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1 aware of and able to access the services that the notice promises. *See Asian Americans*
2 *Advancing Justice – Los Angeles*, Comment ID HHS-OCR-2019-0007-155779, at 8-9.

3 HHS did not acknowledge these comments or provide any assessment or
4 explanation why other options to reduce the purported burden of the notice requirement
5 would not work or why eliminating the notice provision was the only option considered.
6 Moreover, in estimating costs, HHS heavily relied on studies and reports it received from
7 insurers and pharmacy benefit managers that were not provided to the public. *See, e.g.,*
8 *84 Fed. Reg. at 27,258-59*. Because HHS failed to adequately weigh the costs and burdens
9 associated with repealing the notice requirement as described in the administrative
10 record, eliminating this provision was arbitrary and capricious.
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13 Similarly, HHS failed to provide an adequate explanation or consideration of the
14 comments regarding the costs and burdens of the tagline requirements. At the outset,
15 HHS failed to provide sufficient information about the basis of its cost-benefit analysis
16 in the 2019 Proposed Rule. The information provided did not reveal information about
17 HHS's source or methodology of the data it used in its repeal of the taglines. Without
18 this information, commenters could not adequately comment on HHS's decision-
19 making. *See Leadership Conference at 8; NHeLP at 4; see also, e.g., Am. Radio Relay League,*
20 *Inc. v. FCC*, 524 F.3d 227, 236 (D.C. Cir. 2008) (requiring agency to make "critical factual
21 material" upon which it relies available for public comment); *Portland Cement Ass'n v.*
22 *Ruckelshaus*, 486 F.2d 375, 393 (D.C. Cir. 1973) ("It is not consonant with the purpose of a
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1 rule-making proceeding to promulgate rules on the basis of inadequate data, or on data
2 that, to a critical degree, is known only to the agency.”).

3 In promulgating the 2020 Revised Rule, HHS failed to adequately consider and
4 address the comments explaining the value of these provisions. *See, e.g.*, Nat’l Latina Inst.
5 Repro. Health at 1-3; California Pan-Ethnic Health Network at 1-2; Colorado Ctr. Law &
6 Pol’y, Comment ID HHS-OCR-2019-0007-147722, at 7; NHeLP at 37; Wash. State
7 Coalition for Language Access at 2; Justice in Aging at 4. HHS also failed to consider
8 alternatives suggested by the commenters that could balance the potential costs with the
9 need for individuals to be informed of their rights. *See, e.g.*, NHeLP at 68-69 (suggesting
10 clarifying the definition of “significant document” or examining whether taglines could
11 be included in fewer documents if the same document is sent multiple times a year);
12 Aimed Alliance, Comment ID HHS-OCR-2019-0007-125987, at 4 (suggesting requiring
13 more notice to be provided online rather than by mail); Viva Health, Comment ID HHS-
14 OCR-2019-0007-127421, at 1 (suggesting annual mailings).

15 Instead, HHS relied solely on data provided by insurers and pharmacy benefits
16 managers, which were not provided to the public for review before the rule was
17 finalized. *See* 84 Fed. Reg. at 27,858-59, 27,880-82. That data did not contain any
18 information about the reaction of individuals with LEP to the taglines or the impact on
19 this population. HHS acknowledged comments indicating that a hospital observed a
20 10% increase in the volume of interpreter service encounters and another saw a 28%
21 reduction on its per-member per-month claims cost with Spanish-speaking patients. 85

1 Fed. Reg. at 37,233. It then also acknowledged one plan’s minimally supported
2 comments about the inclusion of taglines not yielding an increase in interpreter requests
3 after 2016. Without providing any analysis of this data or additional reasoning, HHS
4 determined that the inclusion of taglines did not improve language access. *Id.*

5
6 Further, HHS’s cost-benefit analysis conflicts with the agency’s prior findings. In
7 the 2016 Final Rule, HHS acknowledged substantial benefits of notices and taglines to
8 patients and providers. 81 Fed. Reg. at 31,459 (citing Institute of Medicine Report). The
9 Preamble to the 2016 Final Rule additionally stated that “the burdens of taglines on
10 covered entities are outweighed by the benefits . . . for individuals with limited English
11 proficiency by making them aware, in their own languages, of the availability of
12 language assistance services.” 81 Fed. Reg. at 31,401. But in 2019 HHS determined that
13 the impact of reduced awareness would be “negligible.” 84 Fed. Reg. at 27,882 (citing a
14 two-year old assertion from a single insurer about the lack of appreciable rise in
15 translation services after the 2016 rule). HHS further reasoned that the vast majority of
16 recipients of taglines do not benefit from them. 85 Fed. Reg. at 37,211. This rationale
17 ignores the purpose of taglines in reaching those who would otherwise not know about
18 services to help them access health care. The elimination was arbitrary and capricious.
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21 **IV. HHS’s Narrowing of Section 1557 Covered Entities Contravenes**
22 **Statutory Intent.**

23 As enacted by Congress, Section 1557 protects individuals from discrimination
24 in any “health program or activity,” any part of which is receiving Federal financial
25 assistance; or any program or activity administered by the Executive, or any entity
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1 established under Title I of the ACA. 42 U.S.C. § 18116(a). Contrary to the language of
2 Section 1557, the 2020 Revised Rule only applies the non-discrimination protections to
3 health programs or activities that receive federal financial assistance from HHS;
4 programs or activities administered by HHS under ACA Title I; and entities
5 established under Title I of the ACA. 85 Fed. Reg. at 37,167-71. This definition and the
6 incorporated narrow definition of health program or activity and Federal financial
7 assistance is not supported by the plain meaning of Section 1557 or the ACA. Am. Med.
8 Ass’n., Comment ID HHS-OCR-2013-0007-137131, at 2-3; Cities of New York et al.,
9 Comment ID HHS-OCR-2013-0007-147950, at 16-18; NHeLP at 9-17.

11
12 The ACA does not define the term “health program or activity,” but uses the
13 term health program at least 30 times to reference the provision both of care and of
14 insurance. *See, e.g.*, 42 U.S.C. § 18051; *id.* § 299b-31 (cross-referencing 42 U.S.C. § 1320a-
15 7b); 25 U.S.C. § 1623. Under the ACA, health program or activity is a broad, inclusive
16 term. In the 2020 Revised Rule, HHS’s cramped interpretation carves out many entities
17 and defines health care to separate health care services from paying for those services.
18 85 Fed. Reg. at 37,172-73. Using this distinction, HHS’s conclusions about who is a
19 “health program or activity” leads to an absurd result not consistent with the ACA, as
20 it would lead to many health care programs – Federal or private – not being covered
21 entities because it is rare that any program directly provides services rather than
22 paying for services provided. Sharply reducing the types of covered entities creates
23 significant harm to individuals served by those entities who may now have very
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1 limited recourse for addressing discrimination in those programs, including many
2 Federally funded programs and private insurance plans, such as employer sponsored
3 plans. *See, e.g.,* ACLU Foundations of California at 10; NHeLP at 11-15; *see generally*
4 Brief of Northwest Health Law Advocates et al. as Amicus Curiae, ECF No. 30-1.

5 In addition, the language of Section 1557, including that regarding Federal
6 financial assistance, reflects that of similar remedial statutes such as Section 504 of the
7 Rehabilitation Act of 1973 that apply coverage broadly. *See* 29 U.S.C. § 794; *but see* 85
8 Fed. Reg. at 37,171 (HHS asserting the statute is different and ignoring the language
9 similarities). The cramped reading of Section 1557 is contrary to the statute, including
10 the provision of Section 1554 limiting HHS's rulemaking authority. 42 U.S.C. § 18114.
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13 CONCLUSION

14 The ACA reforms addressed discriminatory practices in nearly all health
15 programs, both public and private. The 2016 Final Rule reflected this broad view of
16 protecting individuals from discrimination in health programs and activities. The 2020
17 Revised Rule seeks to return to a more recessive understanding of discrimination in
18 health care. HHS's new interpretation is contrary to the ACA's approach to health care.
19

20 The 2020 Final Rule is contrary to law, arbitrary and capricious, and harmful to
21 individuals who are protected by Section 1557. For the forgoing reasons and those set
22 forth in the State's memorandum in support of this motion, this Court should grant
23 Washington's request for a preliminary injunction.
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