October 3, 2022

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


RE: Nondiscrimination in Health Programs and Activities: Department of Health and Human Services proposed rule entitled “Nondiscrimination in Health Programs and Activities,” RIN 0945-AA17; Section 1557 of the Affordable Care Act (ACA)

Thank you for the opportunity to submit comments on the Department of Health and Human Services (HHS or the Department) proposed rule entitled “Nondiscrimination in Health Programs and Activities,” RIN 0945-AA17. This rule, to implement the groundbreaking section 1557 of the Affordable Care Act (ACA), is vitally important so that covered entities are aware of their obligations and so that those seeking health care have the ability to access the care and coverage they need. We support this proposed rule and urge its swift adoption, subject to some minor suggested changes set forth below.

We are speaking today on behalf of the Fenway Institute at Fenway Health, a federally qualified health center and Ryan White Part C HIV clinic in Boston, MA that serves 35,000 unique patients each year. Half of our patients are LGBTQIA+, and about 5,400 are transgender and nonbinary. About 2,300 of our patients are people living with HIV. Our key commitment is to address the specific health needs of sexual and gender minorities (SGM) and people affected by HIV. Honoring the intersectionality of identities and lived experience, and taking action to advance racial equity and social justice are central components of this commitment.

Discrimination based on sexual orientation and gender identity (SOGI) negatively affects the health of LGBTQIA+ people and functions as a barrier to care.\(^1\) Discrimination in health care may cause sexual and gender minority patients to have higher rates of medical mistrust, which may constitute a barrier to accessing care.\(^2\) LGBTQIA+ people of color experience intersectional stigma. Racism is a major barrier to care for Black lesbian and bisexual women.\(^3\) Anti-Black stigma is common in predominantly White LGBT settings.\(^4\) The long

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history of structural stigma and discrimination against Black people in healthcare settings contributes to medical mistrust that acts as a major barrier to accessing care for Black LGBT people.⁵,⁶

Partly as a result of widespread societal discrimination, LGBT people are more likely than cisgender, straight people to live in poverty (22% vs. 16%), with transgender people (29%), bisexual women (29%), and bisexual men (19%) experiencing the highest rates of poverty.⁷ Furthermore, LGBT people of color had significantly higher rates of poverty compared to their White counterparts.⁸

Lack of access to health insurance is also a key correlate of health disparities. Sexual minority women are less likely to have health insurance and a primary care provider than heterosexual women. An analysis of 2013-2015 National Health Interview Survey data found that lesbian and gay women were significantly less likely to have health insurance (80.7% of sexual minority women versus 85.2% of heterosexual women) and a usual primary care provider (79.6% of sexual minority women versus 84% of heterosexual women) compared to heterosexual women.⁹ Striking racial/ethnic disparities in insurance coverage—with American Indians and Alaska Natives, Hispanics, and Black people less likely to be insured than White non-Hispanic and Asian Pacific Islander people¹⁰—also affect LGBTQI+ people of color.

For these reasons, it is critically important that nondiscrimination provisions prohibit discrimination on the basis of sexual orientation or gender identity in Centers for Medicare and Medicaid Services (CMS) regulations governing Medicaid and the Children’s Health Insurance Program (CHIP); Programs of All Inclusive Care for the Elderly (PACE); health insurance issuers and their officials, employees, agents, and representatives; States and the Exchanges carrying out Exchange requirements; agents, brokers, or webbrokers that assist with or facilitate enrollment of qualified individuals, qualified employers, or qualified employees; issuers providing essential health benefits; and qualified health plan issuers. It is also critically important that, consistent with the Bostock ruling and subsequent federal agency interpretations noted in the NPRM footnote 46, nondiscrimination language be restored that to federal regulation that explicitly prohibit discrimination based on both sexual orientation and gender identity. As we have noted, such discrimination negatively impacts the health and well-being of LGBTQIA+ people, and in particular BIPOC LGBTQIA+ people, and constitutes a barrier to accessing care.

⁸ Ibid.
Access to health care is important to all people, and we believe that health care is a right. LGBT people are more likely to have chronic conditions such as diabetes, asthma, obesity, hypertension and cardiovascular disease. LGBT people experience higher rates of cancer, and gay and bisexual men and transgender women experience disproportionate burden of HIV and other STIs. Because of these disparities, LGBTQIA+ people are in need of the critical health and social support services that HHS grantee organizations provide.

The efficacy of the Ending the HIV Epidemic initiative will be heavily influenced by this nondiscrimination rule. In this country, 69% of people living with HIV and newly diagnosed with HIV each year are gay and bisexual men. Transgender women are also disproportionately burdened by HIV. Black and Latino gay and bisexual men and Black transgender women experience the most striking disparities in the domestic HIV epidemic. Access to critical services provided by HHS grantees—including housing support, mental health

29 Becasen et al., 2019.
and substance use treatment, and nutritional support—that help people living with HIV stay healthy and adhere to treatment hang in the balance. Treatment adherence is of critical importance in the Ending the HIV Epidemic initiative.

Homeless services, funding by HHS, are especially important to LGBT people, and especially for LGBT people of color. LGBT youth represent as much as 20-40% of homeless youth in some cities. Data from the 2015 National Transgender Discrimination Survey show that 30% of transgender Americans have experienced homeless at some point in their lives, and 12% in the past year.

Our comments below are organized to correspond to the sections in the Notice of Proposed Rulemaking (NPRM).

Clinical Algorithms

The proposed rule states that a covered entity must not discriminate against any individual on the basis of race, color, national origin, sex, age, or disability through the use of clinical algorithms in its decision-making. This provision is not intended to hinder the use of clinical algorithms; but to prevent discrimination given the recent increasing reliance on clinical algorithms in health care decision-making. This is an important provision, especially as more and more health care organizations collect and use sexual orientation and gender identity (SOGI) data to improve quality of care. The collection and use of SOGI data, along with anatomical inventory information, can inform clinical decision support, preventive screenings, and population health management. It can also reduce the likelihood that a transgender, nonbinary, or intersex patient will experience culturally nonresponsive or even discriminatory treatment in health care. For example, an entry in the electronic medical record of simply “male” would likely lead a provider away from screening for cervical cancer or a breast exam, when it may be relevant to a patient whose sex assigned at birth was female. The collection and use of SOGI data in a culturally responsive, affirming way can prevent discrimination from influencing decision-making related to a TGD patient.

Given the plethora of anti-transgender and anti-LGBT laws and policies being adopted by states across the U.S., it is especially important that SOGI data not be used to discriminate in health care or insurance coverage against LGBTQIA+ individuals. Fear that SOGI data will be used in discriminatory ways may cause individual patients to not answer this question, or to not disclose their sexual or gender minority status. We support this provision.

Telehealth

The proposed rule specifically addresses nondiscrimination in the provision of health programs and activities through telehealth services. This provision clarifies that covered entities have an affirmative duty to not discriminate in their delivery of such services through telehealth. We support this provision, as telehealth provides critical access to the services that Fenway Health and few other community health centers in the country are able to provide. Telehealth is especially important to TGD patients who may live a far distance from a provider who offers affirming care. Telehealth also expands access to mental and behavioral health services, which is critical to LGBTQIA+ people who may face discrimination in healthcare located closer to their home.

Religious Exemption

We strongly support the restoration of 1557’s application to all health programs or activities receiving federal funding through or administered by the Department or a Title I entity. This is consistent with the statutory language and the purpose of the ACA to ensure broad access to and coverage of health care. We also support the omission of Title IX’s religious exemption, which is harmful and has no place in a health care nondiscrimination rule. Most of the Title IX exemptions make no sense at all in the health care context. That is particularly true of Title IX’s extremely broad religious exemption, which would wreak havoc if applied to the ACA by allowing health care providers to deny essential health care services based on disapproval of a particular group or for other non-medical reasons, thereby putting the health and wellbeing of already vulnerable individuals at risk. Particularly for urgent or emergent care, a patient often has no ability to choose a particular provider in order to avoid a provider or institution that withholds care based on religious doctrine, even if the patient is aware of such restrictions (which is not typically the case).

When providers deny medical services for religious reasons, those who require the denied care are harmed. Even if patients are able to obtain the needed care from another provider, the delay in receiving care may cause irreparable harm, and the stress of being denied care and fear of facing similar denials in the future have very real negative impacts. The 2020 version of 1557 implementing regulations improperly disregarded those harms and elevated providers’ religious beliefs over the rights of individuals to receive the care they need. The strength of the protections that this final rule offers are all undermined by the ability to deny care based on a religious exemption. While the revised approach contemplates a case-by-case process, in doing so, it still grants validity to the application of religious exemption in a healthcare setting, which, by its very nature is still discrimination. Religious protections cover free exercise of worship. For example, saying a prayer before eating lunch in the workplace, wearing a hijab in an educational setting, or practicing religious traditions without persecution. It does not include denial of healthcare. “True religious freedom protects an individual’s right to worship—or not—and harms no one.”35 The application of religious exemption in a healthcare setting is harmful and damaging to the health of already vulnerable populations. We ask for the omission of Title IX’s religious exemption without any additional process for application in the healthcare setting.

As noted in the preamble to the NPRM, LGBTQI+ people face both health disparities and barriers to healthcare. More than one in three LGBTQ Americans, and more than three in five transgender people, experienced discrimination in the past year. Fifteen percent of LGBTQ Americans report postponing or avoiding medical

treatment due to discrimination; nearly three in ten transgender individuals do so. Some 69% of those who reported discrimination said it affected their psychological well-being; 44% said it affected their physical well-being.

The 2016 final rule implementing Section 1557 of the ACA explicitly prohibits discrimination based on gender identity and sex stereotyping, which includes sexual orientation discrimination, across federally-funded health care programs. This rule was implemented to address anti-LGBT discrimination in healthcare. This discrimination, as well as the fear of experiencing it, is a barrier to seeking routine, preventive care as well as emergency care. It also negatively affects people’s mental and physical health, and sense of safety and belonging in society. We thank you for restoring the original intent of Section 1557 of the ACA—to expand access to health care without fear of discrimination. Should you have any questions about our comment please contact Carl Sciortino, Vice President of External Relations, at csciortino@fenwayhealth.org.

Sincerely,

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