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

Submitted electronically at https://www.regulations.gov/commenton/HHS-OS-2022-0012-0001

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 5400 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

[1] Gruberg S, Mahowald L, Halpin J. *The state of the LGBTQ community in 2020. A national public opinion study*. Washington, DC: Center for American Progress. 2020, October 6. https://www.americanprogress.org/issues/lgbtq-rights/reports/2020/10/06/491052/state-lgbtq-community-2020/

[2] Ahmed Mirza, Shabab and Rooney, Caitlin (2018). *Discrimination Prevents LGBTQ People from Accessing Health Care*. Washington, DC: Center for American Progress.

[3] Brenick A, Romano K, Kegler C, Eaton LA. Understanding the Influence of Stigma and Medical Mistrust on Engagement in Routine Healthcare Among Black Women Who Have Sex with Women. *LGBT Health*. 2017 Feb;4(1):4-10.

[4] McConnell EA, Janulis P, Phillips G 2nd, Truong R, Birkett M. Multiple Minority Stress and LGBT Community Resilience among Sexual Minority Men. *Psychol Sex Orientat Gend Divers*. 2018 Mar;5(1):1-12

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 people[10]—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 subsquent federal agency interpretations noted in the NPRM footnote 46, nondiscrimination language be restored that to federal regulation that explicitly prohibits 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.

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[5] Quinn KG, Christenson E, Spector A, Amirkhanian Y, Kelly JA. The Influence of Peers on PrEP Perceptions and Use Among Young Black Gay, Bisexual, and Other Men Who Have Sex with Men: A Qualitative Examination. *Arch Sex Behav*. 2020 Aug;49(6):2129-2143.

[6] Cahill S, Taylor SW, Elsesser SA, Mena L, Hickson D, Mayer KH. Stigma, medical mistrust, and perceived racism may affect PrEP awareness and uptake in black compared to white gay and bisexual men in Jackson, Mississippi and Boston, Massachusetts. *AIDS Care*. 2017 Nov;29(11):1351-1358.

[7] Badget L, Choi S, Wilson B. (October 2019). *LGBT Poverty in the United States: A study of differences between sexual orientation and gender identity groups*. UCLA School of Law: The Williams Institute. Available at: https://williamsinstitute.law.ucla.edu/publications/lgbt-poverty-us/

[8] *Ibid*.

[9] Lunn MR, Cui W, Zack MM, Thompson WW, Blank MB, Yehia BR. Sociodemographic Characteristics and Health Outcomes Among Lesbian, Gay, and Bisexual U.S. Adults Using Healthy People 2020 Leading Health Indicators. *LGBT Health*. 2017 Aug;4(4):283-294. doi: 10.1089/lgbt.2016.0087. Epub 2017 Jul 20. PMID: 28727950; PMCID: PMC5564038.

[10] Artiga S, Hill L, Orgera K, Damico A. *Health coverage by race and ethnicity, 2010-2019*. Kaiser Family Foundation. July 16, 2021. https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/

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,[11,12] asthma,[13] obesity, [14,15,16] hypertension,[17,18] and cardiovascular disease.[19,20,21,22] LGBT people experience higher rates of cancer, [23]and gay and bisexual men and transgender women experience disproportionate burden of HIV and other STIs.[24,25] 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.[26] Transgender women are also disproportionately burdened by HIV.[27] Black and Latino gay and bisexual men and Black transgender women experience the most striking disparities in the domestic HIV epidemic.[28,29] Access to critical services provided by HHS grantees—including housing support, mental health

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[11] Beach LB, Elasy TA, Gonzales G. Prevalence of Self-Reported Diabetes by Sexual Orientation: Results from the 2014 Behavioral Risk Factor Surveillance System. *LGBT Health*. 2018 Feb/Mar;5(2):121-130.

[12] Caceres BA, Jackman KB, Edmondson D, Bockting WO. Assessing gender identity differences in cardiovascular disease in US adults: an analysis of data from the 2014-2017 BRFSS. *J Behav Med*. 2020 Apr;43(2):329-338.

[13] Karen I. Fredriksen-Goldsen, Hyun-Jun Kim, Chengshi Shui, and Amanda E. B. Bryan, 2017: Chronic Health Conditions and Key Health Indicators Among Lesbian, Gay, and Bisexual Older US Adults, 2013–2014. *American Journal of Public Health* 107, 1332_1338.

[14] Laska MN, VanKim NA, Erickson DJ, Lust K, Eisenberg ME, Rosser BR. Disparities in Weight and Weight Behaviors by Sexual Orientation in College Students. *Am J Public Health*. 2015 Jan;105(1):111-121.

[15] Deputy NP, Boehmer U. Weight status and sexual orientation: differences by age and within racial and ethnic subgroups. *Am J Public Health*. 2014;104(1):103-109. doi:10.2105/AJPH.2013.301391

[16] Azagba S, Shan L, Latham K. Overweight and Obesity among Sexual Minority Adults in the United States. *Int J Environ Res Public Health.* 2019 May 23;16(10):1828.

[17] Caceres BA, Brody AA, Halkitis PN, Dorsen C, Yu G, Chyun DA. Sexual Orientation Differences in Modifiable Risk Factors for Cardiovascular Disease and Cardiovascular Disease Diagnoses in Men. *LGBT Health*. 2018;5(5):284-294.

[18] Jackson CL, Agénor M, Johnson DA, Austin SB, Kawachi I. Sexual orientation identity disparities in health behaviors, outcomes, and services use among men and women in the United States: a cross-sectional study. *BMC Public Health*. 2016;16(1):807.

[19] Fredriksen-Goldsen KI, Kim H-J, Emlet CA, et al. *The Aging and Health Report: Disparities and Resilience Among Lesbian, Gay, Bisexual, and Transgender Older Adults*. Seattle: University of Washington; 2011.

[20] Caceres BA, Makarem N, Hickey KT, Hughes TL. Cardiovascular Disease Disparities in Sexual Minority Adults: An Examination of the Behavioral Risk Factor Surveillance System (2014-2016). *Am J Health Promot*. 2019 May;33(4):576-585.

[21]Caceres BA, Jackman KB, Edmondson D, Bockting WO. Assessing gender identity differences in cardiovascular disease in US adults: an analysis of data from the 2014-2017 BRFSS. *J Behav Med*. 2020 Apr;43(2):329-338.

[22] Nokoff NJ, Scarbro S, Juarez-Colunga E, Moreau KL, Kempe A. Health and Cardiometabolic Disease in Transgender Adults in the United States: Behavioral Risk Factor Surveillance System 2015. *J Endocr Soc*. 2018 Mar 5;2(4):349-360.

[23] Cahill SR. Legal and Policy Issues for LGBT Patients with Cancer or at Elevated Risk of Cancer. *Semin Oncol Nurs*. 2018 Feb;34(1):90-98.

[24] Centers for Disease Control and Prevention. *HIV and Gay and Bisexual Men*. Fact Sheet. Updated September 2021. https://www.cdc.gov/hiv/pdf/group/msm/cdc-hiv-msm.pdf

[25] Becasen JS, Denard CL, Mullins MM, Higa DH, Sipe TA. Estimating the Prevalence of HIV and Sexual Behaviors Among the US Transgender Population: A Systematic Review and Meta-Analysis, 2006-2017. *Am J Public Health*. 2019 Jan;109(1):e1-e8.

[26] Centers for Disease Control and Prevention. *HIV and Gay and Bisexual Men*. Fact Sheet. Updated September 2021. https://www.cdc.gov/hiv/pdf/group/msm/cdc-hiv-msm.pdf

[27] Becasen JS, Denard CL, Mullins MM, Higa DH, Sipe TA. Estimating the Prevalence of HIV and Sexual Behaviors Among the US Transgender Population: A Systematic Review and Meta-Analysis, 2006-2017. *Am J Public Health*. 2019 Jan;109(1):e1-e8.

[28] CDC (2018), HIV among African American Gay and Bisexual Men. https://www.cdc.gov/hiv/group/msm/bmsm.html. Accessed January 22, 2018.

[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.[30] 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.[31]

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, [32] 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.[33]

Given the plethora of anti-transgender and anti-LGBT laws and policies being adopted by states across the U.S.,[34] 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.

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[30] Ray, N. (2007). *Lesbian, Gay, Bisexual and Transgender Youth: An Epidemic of Homelessness.* National Gay and Lesbian Task Force Policy Institute, National Coalition for the Homeless. https://www.thetaskforce.org/lgbt-youth-an-epidemic-of-homelessness/

[31] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality

[32] Grasso C, Goldhammer H, Thompson J, Keuroghlian AS. Optimizing gender-affirming medical care through anatomical inventories, clinical decision support, and population health management in electronic health record systems. *J Am Med Inform Assoc*. 2021 Oct 12;28(11):2531-2535. doi: 10.1093/jamia/ocab080. PMID: 34151934; PMCID: PMC8510278.

[33] Grasso C, Goldhammer H, Brown RJ, Furness BW (2020). Using sexual orientation and gender identity data in electronic health records to assess for disparities in preventive health screening services. *International Journal of Medical Informatics* Volume 142, October 2020, 104245. https://doi.org/10.1016/j.ijmedinf.2020.104245

[34] Richgels C, Cahill S, Thompson J, Dunn M (2021). *State bills restricting access of transgender youth to health care, school facilities, and school athletics threaten health and well-being.* Boston: The Fenway Institute. https://fenwayhealth.org/wp-content/uploads/Anti-trans-legislation-policy-brief-FINAL.pdf

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 base 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

[35]Simonoff C, Wang T, Cahill S. *In its third year in office, the Trump Administration dramatically expanded discriminatory anti-LGBT policies.* The Fenway Institute. 2020. https://fenwayhealth.org/wp-content/uploads/Trump-Administration-Year-3-Brief.pdf

treatment due to discrimination; nearly three in ten transgender individuals do so.[36] 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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[36] Gruberg S, Mahowald L, Halpin J. The state of the LGBTQ community in 2020. A national public opinion study. Washington, DC: Center for American Progress. 2020, October 6. https://www.americanprogress.org/issues/lgbtq-rights/reports/2020/10/06/491052/state-lgbtq-community-2020/