Catholic Health Association of the United States

*A Passionate Voice for Compassionate Care*

October 3, 2022

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

**Attention: 1557 NPRM (RIN 0945-AA17)**

**RE: Nondiscrimination in Health Programs and Activities: Proposed Rule, 87 Fed. Reg. 47824, August 4, 2022**

Dear Sir or Madam:

I am writing on behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of more than 2,200 Catholic health care systems, hospitals, long-term care facilities, sponsors, and related organizations. Our ministry is represented in all 50 states and the District of Columbia, and one in every seven patients in the United States is cared for in a Catholic hospital each year. CHA appreciates the opportunity to comment on the referenced proposal to amend regulations implementing Section 1557 of the Patient Protection and Affordable Care Act ("ACA").

Section 1557 of the ACA provides that an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity receiving Federal financial assistance, or administered by an Executive Agency or entity created by Title I (e.g., state-based Marketplaces and federally-facilitated Marketplaces), on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (race, color, national origin) ("Title VI"); Title IX of the Education Amendments of 1972 (sex) ("Title IX"); the Age Discrimination Act of 1975 (age) ("the ADA"); or § 504 of the Rehabilitation Act of 1973 (disability) ("§ 504").

As a Catholic health ministry, our mission and our ethical standards in health care are rooted in and inseparable from the Catholic Church's teachings about the dignity of each and every human person, created in the image of God. Access to health care is essential to promote and protect the inherent and inalienable worth and dignity of every individual. These values form the basis for our steadfast commitment to the compelling moral implications of our health care ministry and

for CHA's long history of insisting on and working for the right of everyone to affordable, accessible health care. Our members are committed to the provision of quality health care services to any person in need of care, without regard to race, color, national origin, sex, age, or disability, or any other category, including gender identity, sexual orientation, financial means or immigration status.

CHA therefore strongly supports the principle of nondiscrimination in health programs and activities established by the ACA and the promulgation of regulations to ensure that principle is implemented robustly.

As HHS persuasively lays out in the preamble, nondiscrimination in health care is an essential element in addressing health disparities and inequities. The Catholic health ministry is committed to achieving health equity, eliminating racial and ethnic disparities in health outcomes and improving access to quality health care for all, a commitment that is deeply rooted in our mission. In 2020 CHA and our members launched our Confronting Racism by Achieving Health Equity pledge/We Are Called initiative to recommit to ending health disparities across our country and to dismantling the systemic racism that remains ever-present in our society. The initiative is our shared effort to achieve equity in our own health systems and facilities and to advocate for change in the wider health care sector and our society. Almost 90% of our members have signed on to the four pillars of the pledge: working to achieve equity in covid-19 testing, treatment and vaccination; putting our own houses in order; building just and right relationships with our communities; and advocating for change at the federal, state and local levels to end health disparities and systemic racism. We applaud HHS for its commitment to integrating health equity into all its programs and initiatives.

While we welcome and remain committed to this shared goal of ensuring health equity, we also believe that allowing faith-based health care providers to participate in accordance with their faith and beliefs creates a more pluralistic and robust health care system. During prior Section 1557 rulemaking, CHA raised its concern that declining to provide abortion and certain services directly related to gender transition could be treated as a form of discrimination, which would present a conflict for some faith-based health care providers. We therefore would like to take this opportunity to reiterate our concerns and to share with the Office of Civil Rights' ("OCR") additional comments on the proposed amendment of the Section 1557 regulations.

- **Discrimination on the Basis of Sex**

Regulations implementing Section 1557 were first finalized on May 18, 2016 (the 2016 rule). The final rule defined "on the basis of sex" to include discrimination based on "pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping or gender identity." On June 19, 2020 a final rule was published amending the regulations by, among other changes, deleting that definition (the 2020 rule). In the current proposal, prohibited discrimination on the basis of sex would include, but not be

limited to, "discrimination on the basis of sex stereotypes; sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; and gender identity." (§ 92.101(a)(2)). CHA supports protecting patients against discrimination in health care on these bases. But if HHS finalizes its proposal, we ask the agency to make clear that it will not be considered prohibited discrimination when faith-based health care providers are unable to provide certain services that are in conflict with deeply held religious beliefs.

*Abortion*

HHS does not propose to specify "termination of pregnancy" as an example of discrimination on the basis of sex. However, it is considering whether to include a provision to address discrimination on the basis of "pregnancy-related conditions," which the preamble discussion implies would include termination of pregnancy and invites comments on whether it should do so.

CHA fully supports protecting pregnant women against discrimination related to their pregnancy or pregnancy-related conditions and considers care for women a central part of our mission. The history of Catholic health care in the United States began by providing care for women and children, particularly in communities with high immigrant populations that lacked access to medical care. Today, Catholic health providers continue that tradition by providing a wide range of high-quality prenatal, obstetric, and postnatal services for women and infants. Establishing 12-month Medicaid postpartum coverage and passage of the Black Maternal Health Momnibus Act to address maternal morbidity and mortality are top advocacy priorities in our work with Congress.

In Catholic health care, we do not perform elective abortions as it is counter to our mission, our values, and our faith. CHA opposes including "termination of pregnancy" among the prohibited bases of sex discrimination, either explicitly or implicitly as a "pregnancy-related condition," because of our concern that doing so could result in requiring providers and health plans to provide, cover or refer for abortions. We also are concerned that the language as currently proposed could be so interpreted, as it states that discrimination on the basis of sex includes "but is not limited to" pregnancy or related conditions, which could include abortion.

Such an interpretation of Section 1557 of the ACA would be in clear conflict with other provisions of federal law, including the ACA itself. Section 1303 of the ACA establishes a very clear policy *against* requiring abortion coverage to be included in health plans, affirmatively stating that the ACA does not require abortion to be included as an essential health benefit in a qualified health plan and that the decision whether to include abortion services in a plan shall be determined by the insurer.

Section 1303 also protects providers who refuse to perform abortions, prohibiting qualified health plans offered on the Exchanges from discriminating against a health care provider or facility because of an unwillingness to provide, pay for, cover or refer for abortions.

Federal law forbids mandating involvement with abortion in other ways as well. The Weldon Amendment, attached to the annual Labor/HHS/Education appropriations law every year since 2004, forbids funding under that law to a federal agency or program that discriminates against an institutional or individual health care entity because of a refusal to provide, pay for, provide coverage of, or refer for abortion. The Church Amendment (42 USC §300a-7) prohibits public authorities from requiring as a condition of certain forms of HHS funding that health facilities be willing to provide abortions contrary to moral or religious convictions.

While HHS notes it will apply such provisions as consistent with the law, it declines to include in the proposed rule Title IX's provision on abortion neutrality. Congress established Section 1557's prohibition against sex discrimination by reference to discrimination prohibited by Title IX. Title IX makes clear that declining to provide or pay for any service related to abortion is not to be treated as prohibited sex discrimination. (20 USC § 1688). HHS gives no substantive explanation for its decision not to incorporate Title IX's neutrality language.

CHA urges HHS to eliminate any uncertainty on this issue by including in the final rule a provision clearly stating that Section 1557 does not require the provision of, referral for, or coverage of abortion.

*Gender Identity/Gender Transition*

The 2016 rule included gender identity as a basis for wrongful discrimination "on the basis of sex." We expressed our concern that this would mandate the provision of certain services directly related to gender transition, which could present a potential conflict for some faith-based health care providers, and requested that HHS include in the final rule a religious exemption from the proposed requirements. The final rule did not include a religious exemption.

The 2020 rule eliminated any regulatory requirement that faith-based organizations perform gender transition related services if to do so would be contrary to their any religious tenets. In that rule HHS also amended several health regulations unrelated to either Section 1557 or a requirement to provide gender-transition services, removing the terms "gender identity" and/or "sexual orientation" from several regulations. CHA expressed its concern that these changes could make it more difficult for people in the LGBTQ community to have access to health insurance or needed medical care. As a November 2017 survey conducted by the Robert Wood Johnson Foundation, NPR, and the Harvard T.H. Chan School of Public Health found, many LGBTQ people avoided medical care because of fears about how they would be treated, and we were concerned the overall effect of the changes would be exacerbate that problem.

The proposed rule would return to and expand the scope of the 2016 rule by including sex stereotypes, sex characteristics, intersex traits, sexual orientation and gender identity as bases for wrongful sex discrimination. Denial or limitation of health services related to gender transition or gender affirming care would be discriminatory, unless the covered entity does not otherwise provide those services or in a specific case the covered entity has a legitimate, non-discriminatory reason for denying or limiting the service such as a reasonable determination that it would not be clinically appropriate for that patient. (§ 92.206).

CHA is committed to the principle that health care must be available to any person in need of care, without regard to race, color, national origin, sex, age, or disability, or any other category or status. CHA believes strongly that individuals should not be denied access to needed health care merely because of their gender identity. Refusing to provide medical assistance or health care services because of discomfort with or animus against an individual on the basis of how that person understands or expresses gender is unacceptable. CHA firmly supports steps to prevent discriminatory treatment of members of the LGBTQ community seeking health care services.

However, the provision of certain health services directly related to gender transition may present a potential conflict with the equally important principle of the free exercise of religion. Mandating the provision or coverage of these services would substantially burden faith-based organizations, such as Catholic health care facilities, which have sincerely held religious beliefs precluding them from providing or covering these services.

For example, Catholic hospitals do not perform procedures on healthy, functioning reproductive organs that would result in sterilization. We do not perform these procedures for any reason, because of our religious beliefs. Declining to perform a specific procedure because it conflicts with religious values or beliefs is not a form of sex discrimination. We are very concerned that the proposed § 92.206 as written could give rise to claims that declining to perform a hysterectomy or other sterilizing procedures sought for the purpose of gender transition could be deemed discriminatory.

As HHS notes in the preamble, federal law currently includes protections with respect to religious beliefs, including conscience laws that protect providers with religious concerns over providing certain services such as abortion and sterilization. These laws demonstrate the federal government's commitment to finding a balance between the free exercise rights of health care providers and others with moral or religious objections to providing certain health care services, and the ability of those who seek such services to receive them. However, we are concerned that these laws may not adequately protect those with moral or religious objections to certain medical or surgical gender transition services if the rule is finalized as written. We therefore urge HHS to include in the final rule language making clear that provisions on gender transition and gender affirming care do not apply to health providers that hold themselves out as religious organizations to the extent that applying the requirements with respect to certain procedures would be inconsistent with their religious tenets.

- **Application of Federal Conscience and Religious Freedom Laws**

CHA appreciates that in numerous places in both the preamble and the proposed text HHS acknowledges that federal law currently includes protections with respect to religious beliefs, including conscience laws that protect health care providers with religious concerns over providing certain services. While we are grateful that HHS has reaffirmed its commitment to respecting conscience and religious freedom laws when applying this rule, we urge HHS to make the following changes in the final rule.

The proposed rule directly addresses Federal conscience and religious freedom laws in two places. Proposed § 92.3 provides that the rule is not to be construed to limit rights under such laws. At § 92.302 HHS proposes a procedure by which a health care providers can inform HHS that certain the application of provisions of the regulation would violate Federal conscience and religious freedom laws.

*Proposed § 92.3*

Proposed § 92.3(c) provides that

> Nothing in this part shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals under Federal conscience or religious freedom laws.

We offer two comments on this language. First, as written it refers to the rights of "individuals" under federal laws. The term "individuals" is not defined in the regulation and when used it appears most often to refer to individual persons. If this section is finalized, the phrase "covered entities" should be added to be clear that the provision refers to the rights of both individuals and covered entities.

Second, the 2016 rule included similar but not identical language in § 92.2 (b)(2).

> Insofar as the application of any requirement under this part would violate applicable Federal statutory protections for religious freedom and conscience, such application shall not be required.

CHA urges HHS to adopt this language in place of the proposed § 92.3(c). It is preferable because it makes clear that when provisions of the regulation are in conflict with federal religious liberty and conscience laws, those laws take preference and the Section 1557 provision does not apply.

*Proposed § 92.302*

HHS proposes to create a process by which a recipient may notify the Office of Civil Rights (OCR) of its view that under Federal conscience or religious freedom laws it is exempt from certain provisions of the Section 1557 requirements. OCR would then consider such views when responding to complaints or proceeding with investigations. It would halt any such proceeding until it had determined the merits of the recipient's claim. Should OCR determine the recipient is exempt, that determination would not apply to other contexts, procedures or health care services. In the preamble HHS indicates it plans to take a case-by-case approach to such determinations.

While CHA appreciates that in proposing this process HHS is attempting to address potential conflicts between provisions of Section 1557 and laws protecting religious freedom and conscience rights, we have several concerns with the proposal and believe a better approach would be to include in the regulation explicit language protecting those rights.

The proposal appears to invite recipients to preemptively appeal to OCR with their claim of exemption, but the language only requires OCR to consider such claims when responding to complaints or proceeding with investigations or enforcement activities. OCR has no affirmative obligation to respond promptly to the claim itself. Because a recipient would be left in uncertainty until and unless action was taken by a complainant or OCR, there is no incentive for recipients to approach OCR with their claim of exemption.

HHS' stated intention to treat these claims on a case-by-case basis also undermines the usefulness of the proposed process. The proposed rule invites recipients to claim exemption from *provisions* of the regulation, but OCR will only make an exemption determination with regard to specific *case*s which by necessity would involve past or current actions. Thus, the process is actually not inviting recipients to seek an exemption from provisions of the regulation upon which they can rely with respect to future actions. It is merely allowing them to assert a defense against a specific claim of discrimination – which they can and will do without the creation of a new process.

Treating each claim separately is also problematic for health care systems with multiple hospitals. Systems would be deprived of the clarity and certainty needed to establish and require compliance with policies that would apply to all member hospitals and would ensure that claimed exemptions were being appropriately and narrowly applied.

Another area of uncertainty is the interaction between the proposed exemption process and private rights of action. The process would apply to OCR investigations and enforcement but does not address a situation in which a lawsuit has been filed as there is no requirement that an OCR administrative process be exhausted before going to court. Faith-based hospitals likely will be forced to litigate claims in the courts without the ability to stay proceedings pending OCR's consideration of its exemption claim, another factor undermining the usefulness of the proposal.

Accordingly, we strongly urge HHS to include in the final rule a religious exemption with respect to the application of sex discrimination to specific services for organizations that hold themselves out as religious organizations to the extent that applying the requirements would be inconsistent with their religious tenets. Title IX, which Congress used as the model for the Section 1557 prohibition on sex discrimination, includes a similar exemption.

Including a religious exemption also makes sense given that, without one, the final regulations are certain to be challenged under the Religious Freedom Restoration Act ("RFRA") as have previous versions of the rule. Based on recent U.S. Supreme Court jurisprudence the challenging plaintiffs are likely to win. Having protracted and costly litigation to determine on a case-by-case basis the breadth of protection for faith-based organizations is not a desirable or workable solution.

- **Access for Individuals with Limited-English Proficiency**

CHA and the Catholic health ministry are committed to welcoming each patient as an individual with inherent dignity, which includes respecting the cultural backgrounds, preferred languages and styles of communication of every person seeking care. Language barriers can keep individuals who do not speak English or have limited English proficiency from seeking and receiving the high-quality health care they need and deserve. Effective communication between health care providers and patients is essential to facilitating access to care, reducing health disparities and medical errors, and supporting patients' adherence to treatment plans.

CHA supports HHS' attention to access to language assistance services in the proposed rule. In particular, we agree that relying on children to provide translation or interpretation is inappropriate, except in an emergency. We urge HHS to work with stakeholders to ensure that adequate resources are available for the training and funding of qualified healthcare interpreters and translators.

- **Nondiscrimination in Telehealth Services**

The COVID-19 pandemic has highlighted the changing nature of providing care and support to patients and families across the country. At a time when hospitals and other providers were forced to limit outside visitors or halt elective procedures, telehealth became a critical means for allowing patients to receive health care services while staying safe. The temporary flexibilities provided by federal and state policy makers during COVID-19 have played a critical role in meeting health care needs during the pandemic. These flexibilities allowed health care workers and patients to stay safe while still having access to real-time health care and support. As the urgency of the pandemic wanes, telehealth will continue to play an important role in ensuring patients receive the care they need, when they need it, while providing greater access to specialists, especially for rural communities, low-income communities and patients with limited access to health care providers. Telehealth is therefore a critical tool in promoting greater health

access and equity. We must ensure that telehealth resources are provided in an equitable manner and CHA supports the proposed provision on non-discrimination in the delivery of health programs and activities through telehealth services.

As HHS notes in the preamble, studies have indicated there were racial and disability-based disparities in access to telehealth during the pandemic. Certainly, we must ensure that such disparities are not caused or exacerbated by discriminatory practices and that services are accessible to individuals with disabilities and those with limited English proficiency. CHA is also advocating for additional policies to ensure that telehealth is broadly available, including extending the COVID-19 flexibilities, eliminating the geographic and originating site restrictions, expanding the types of providers eligible to deliver telehealth services, and expanding access to broadband services. All of these policies will help to ensure that more people have affordable and quality care through telehealth and to achieve equity in access to those services

- **Nondiscrimination in the Use of Clinical Algorithms**

The proposed rule provides, for the first time, that covered entities may not discriminate on the basis of race, color, national origin, sex, age or disability through the use of clinical algorithms. While they would not be held responsible for algorithms they did not develop, the preamble makes clear that covered entities would be accountable for discrimination that results from decisions based on their use of such tools. HHS cautions providers against over-relying on algorithms in a way that replaces or substitutes for their own clinical judgment based on the needs and medical histories of their patients.

Artificial intelligence (AI) technologies, including the use of algorithms, hold great promise to enhance the quality of care and achieve better patient outcomes – but they are not without risk. Biases that exist in the underlying data or the people that create algorithms can be "baked into" systems that rely on AI and influence the outcomes produced. Health inequity is a persistent and lingering legacy of the systemic racism and social prejudices that have far too often been prevailing characteristics in our nation's history. AI tools, if developed properly, could play a powerful role in improving health outcomes and ending disparities in health care delivery and outcomes on the basis of race, ethnicity, geography, income or other factors unrelated to health. But we must ensure that such tools are not built on data or assumptions that reflect and perpetuate existing biases or structures of systemic racism.

As HHS details in the preamble, studies have identified specific algorithms used by doctors to make clinical decisions about treating patients that incorporated assumptions based on race or ethnicity. HHS also cites the work of federal agencies taking steps to address discrimination in clinical algorithms and other AI technologies. CHA fully supports efforts to ensure that algorithms and other forms of AI do not exacerbate health disparities or contribute to discrimination. As we harness the power of artificial intelligence, we must be vigilant in

ensuring it does not deepen and further entrench racial and ethnic biases that harm the health of the patients we serve.

However, CHA urges HHS to reconsider including this provision in the final rule. We have several concerns with its implementation. The development and use of AI and algorithms is a relatively new and evolving field and, as HHS acknowledges in the preamble, covered entities will find it challenging to identify potential violations of Section 1557. If covered entities cannot anticipate potential violations, how can they prevent them? Establishing causation will be another problem. When disparate outcomes occur, it may not always be possible to attribute them to the use of the algorithm or to other factors. CHA firmly agrees with HHS that overreliance on algorithms alone must be avoided. Physicians must use, and be empowered to use, their own clinical judgment when they make treatment decisions. But how are covered entities to know how much reliance on an algorithm is too much and what standard HHS will use in making that determination?

CHA suggests that it is premature to address this problem through a nondiscrimination policy targeting outcomes. We should first focus on the development of algorithms and how to ensure they do not incorporate biased assumptions. It must be pointed out that this does not necessarily mean banning the use of information related to race, ethnicity, age or disability as an input to health care algorithms but proceeding with utmost caution. It is possible that properly designed algorithms could be used, for example, to identity or mitigate the existence of racial or ethnic health disparities. And human decision making is of course also subject to bias and algorithms could be a tool to counter provider bias. Artificial intelligence technologies are rapidly transforming health care and how it is delivered. Applying a nondiscrimination framework to the use of algorithms may be appropriate in the future but making sure that the development and use of clinical algorithm do not contribute to disparate or discriminatory outcomes is an urgent matter better addressed by other means at this time. CHA suggests HHS work with stakeholders to identify other policy levers to help those who create algorithms as well as covered entities identify and eliminate potential disparities in outcomes due to the use of algorithms before adding clinical algorithms to the Section 1557 regulations.

- **Operational Policies and Procedures**

The proposed rule includes many requirements related to policy and procedures such as notice, training and the designation of a Section 1557 coordinator. While each of them may have merit in principle and contribute to the implementation of Section 1557 protections, CHA urges HHS to consider the cumulative burden this can create for hospitals and health care providers and to take steps to avoid imposing undue burdens. We offer a few specific suggestions.

The proposal would reinstate the 2016 rule's requirement to provide notices of nondiscrimination and taglines in the 15 most common languages spoken in a state. We appreciate that HHS has taken steps to alleviate some of the burdens of the 2016 requirement by specifying the materials

in which the notice must be provided and allowing individuals to "opt out" of the requirements. HHS has committed to providing a sample notice in the 15 most common languages in each state. HHS should stipulate that it will not begin to enforce the requirement until after it has produced these materials and given covered entities time to operationalize them. CHA also requests that HHS consider allowing multi-state health systems to aggregate 1557 taglines across states to streamline compliance, as was the case in the 2016 rule.

HHS proposes a new requirement that covered entities train relevant employees in the implementation of Section 1557. Initial training of all such employees would have to be completed within one year of the effective date, with additional training within a reasonable time for new employees or after significant changes to Section 1557's requirements. While we appreciate that HHS is not prescribing specific training methods, we urge HHS to work with stakeholders to develop appropriate training materials that covered entities could use to comply with the requirement. For example, providing a web-based training platform would be very helpful. We also believe it would be appropriate to give covered entities more time to complete staff training, by extending the one-year deadline or making clear that HHS will not begin enforcement actions if a covered entity has in place a reasonable training schedule it is implementing in good faith.

The 2016 rule required that each covered entity with 15 or more employees designate a Section 1557 compliance coordinator and HHS proposes to reinstate that requirement. CHA suggests that HHS make clear that the designation of system-level Section 1557 coordinator, responsible for ensuring compliance at all system facilities, would satisfy the requirement.

In closing, thank you for the opportunity to provide comments to the proposed rule implementing the ACA's non-discrimination provision. If you have any questions about these comments or need more information, please do not hesitate to contact Kathy Curran, Senior Director, Public Policy at 202-296-3993.

Sincerely,

Sr. Mary Haddad, RSM
President and CEO