Health Care in Motion
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Trump Administration Discrimination - Deep Dive

Chapter One – Who and What is Covered?

Our *May 24 Health Care in Motion* alerted readers to a regulatory proposal from the Trump Administration threatening to erase transgender protections in health care by issuing a new interpretation of Section 1557 of the Affordable Care Act (otherwise referred to as the Health Care Rights Law). The headline news from that edition remains most important – advocates and others affected by this proposal should connect with the national community fighting against this change, and prepare to submit regulatory comments explaining the many harmful effects that such a rule will have on their lives and those they care for.[1]

At that time, we also promised a deep dive into each important aspect of the proposed rule written by the U.S. Department of Health & Human Services (HHS). This is the first of several *Health Care in Motion* editions to follow through on that promise. Below we will analyze the changes the Trump Administration is making to the scope of who and what is covered by the requirements imposed by Section 1557. In a series of weekly follow-ups, we will offer in-depth analysis on many more significant aspects of the proposed rule, including:

- A new interpretation of what constitutes discrimination "on the basis of sex" – including the weaponizing of antidiscrimination law against the people it is supposed to protect;
- The Trump Administration's purported rationale for why the new rule is necessary in the first place – including the state of legitimizing discrimination via "religious refusal;"
- The Trump Administration's outrageous characterization of the impact the new rule is expected to have;
- How the proposed rule undermines efforts to enforce antidiscrimination law;
- The effects of the new rules on abortion rights and language access in health care settings.

Look out for those editions of *Health Care in Motion* in the coming weeks. For now, we describe a fundamental change proposed to who and what is covered under Section 1557 in the first place.

[1] The official period to submit comments has not yet opened, but it will start soon. We at *Health Care in Motion* are in the process of developing a template comment that can be used by others as a starting point to let HHS know how they will be impacted by these changes. Please stay tuned to *Health Care in Motion* for updates. You can also visit www.protecttranshealth.org to submit comments that will later be sent to HHS on your behalf.

The Status Quo

Under the 2016 rule now in place, the scope of who/what is subject to Section 1557's prohibition on discrimination is interpreted quite broadly by HHS. Because rules merely represent the interpretation of a particular law by a federal agency, we should look first to the underlying statute itself. In this case, Section 1557 of the ACA applies to:

> [a]ny health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance or under any program or activity that is administered by an Executive Agency or any entity established under this title 1 (or amendments). 42 U.S.C. § 18116(a).

This language plainly encompasses many of the individuals and entities with whom health care consumers most commonly interact. Hospitals, nursing homes, skilled nursing facilities, and home health agencies that use federal money are all generally agreed to be within this definition. Federally qualified health centers and most community health clinics and centers are covered as well, given that they constitute "health programs or activities" that receive federal money. None of that will change going forward.

The term "health program or activity" is also interpreted broadly in the 2016 rule to include "the provision or administration of health-related services *or health-related insurance coverage* and the provision of assistance in obtaining health-related services or health-related insurance coverage." Until now, health insurers have been understood to be within the scope of the Section 1557's requirements. This interpretation is consistent with other federal antidiscrimination rules, which are historically given broad application in order to effect their remedial aims.

Further, HHS has, until now, viewed a large entity that receives federal financial assistance in one of its multiple lines of business or products to be subject to Section 1557 across the board. Where a large insurance company has a single company under its corporate umbrella that receives federal money and is therefore subject to Section 1557, so too does the 2016 rule apply to all of the corporation's affiliated entities, subsidiaries and products be held to the same standard. This includes all of the insurers' health insurance plans, whether supported by federal assistance or not, including insurance plans sponsored by employers in the group market, and even extending to plans for which that insurer acts as a "third-party administrator."

Also included within the sweep of the 2016 rule are all manner of public health insurance and related programs, including state Medicaid and public health agencies, insurance companies that participate in Medicaid or Medicare, and doctors receiving Medicaid payments or other payments from HHS.

Last, the 2016 rule included an interpretation of the term "federal financial assistance" to extend beyond money that was directly administered by HHS itself to include health-related funds that are expended by other federal administrative agencies. For example, tax credits play an important role in the architecture of the Affordable Care Act, but are administered by the Internal Revenue Service, rather than HHS. In keeping with the broad sweep of Section 1557 itself, the 2016 rule uses a definition of "federal financial assistance" that includes dollars "[HHS] plays a role in providing or administering, including all tax credits under Title I of the ACA." This yet another measure to extend the reach of Section 1557's protections.

In short, there are few corners of our massive health care system that are not encompassed by the 2016 rule's scope of coverage. The new proposed rule would change that significantly.

The Proposed Changes

The changes to who and what is covered by Section 1557 proposed on May 24 may not appear like much at first glance. But a careful reading reveals that the Trump Administration is proposing a set of drastic changes with far-reaching implications.

First, the new proposed rule does away with the "Definitions" section altogether. This change is justified with an explanation that "some terms are clear enough to obviate the need for further definition given the context of the proposed rule." Left unstated is the overall effect of eliminating this section as facilitating targeted changes to the 2016 rule. For example, by omitting a "Definitions" section, the new rule silently repeals the 2016 interpretation of the term "on the basis of sex" to encompass gender identity. (The substance of this change will be the subject of our next edition of *Health Care in Motion*.) For now, we recognize that this method of effectuating change allows significant shifts in policy without substantial, meaningful justification.

Second, the proposed rule seeks to exclude a slew of federal government activity from Section 1557's protections. For example, the proposed rule would limit the definition of "federal financial assistance" to money that HHS directly administers. In doing so, some health-related federal assistance, such as tax credits used to buy health insurance, would no longer be an avenue for the federal government to subject private entities to antidiscrimination protection. Despite the explicit coverage in Section 1557 itself as applying to "any program or activity that is administered by an Executive Agency," the new proposed rule restricts the rule's reach to financial assistance administered by a single agency – HHS.

Third, the new rule limits the HHS programs subject to Section 1557 as those that are administered under Title I of the ACA. Title I is the part of the ACA that creates health insurance Marketplaces – either by the states themselves or in cooperation with the federal government. By limiting application to Title I, the new proposed rule would exclude other health programs administered by HHS, such as the Food and Drug Administration, the Health Resources and Services Administration, the Centers for Disease Control, the Substance Abuse and Mental Health Services Administration, the National Institutes of Health, and the Indian Health Service, among others.

Last, and perhaps most importantly, the new proposed rule draws a line between entities that provide health care and entities that provide health insurance. The new proposal would repeal the 2016 rule's broad definition of "health program or activity" that extended the reach of Section 1557 to entities that receive federal funds when they are "principally engaged in providing or administering health services or health insurance coverage or other health coverage." Under the proposed rule, insurance companies that accept federal financial assistance in one of multiple insurance plans are no longer automatically subject to Section 1557 across the board. Instead, the new rule would have limited application to only the insurance plan involving federal financial assistance. Whereas under the 2016 rule, an insurance company offering both a plan on the ACA Marketplace and private group health plans would be subject to Section 1557 across all its plans, now the rule would have limited applicability to just the company's Marketplace plan. The proposed rule accomplishes this change with a cramped, narrow understanding of the statute by differentiating between health care and health insurance. It does so with a semantic manipulation that health insurance companies are not engaged in the "business of providing health care."

The proposed rule's distinction between *health care* and *health insurance* prompts at least three principal objections. First, imposing such a limited interpretation runs counter to the underlying broad remedial purpose of the statute.

Indeed, with respect to federal civil rights laws governing sex-based discrimination, the Supreme Court has found it appropriate to accord it meaning with "a sweep as broad as its language." And the statute that HHS cites in support of its restricted interpretation – the Civil Rights Restoration Act of 1987 – was enacted to "restore the broad scope of coverage and to clarify the application of" disability-based discrimination law. To turn this law into a weapon used against protected minorities twists its meaning beyond recognition.

Second, the proposed rule's distinction represents the kind of serpentine wordplay that recalls less auspicious examples of legalized interpretation of our language at the expense of common sense. Of course it is true that health care and health insurance are distinct from one another. It remains just as true that health insurers exist for the purposes of "the business of providing health care." What other reason would one purchase health insurance other than facilitation of access to affordable health care services? The degree of strain apparent in the new HHS interpretation betrays the agency's political agenda more than it represents a fair reading of the statute.

Moreover, a close reading of the Affordable Care Act itself undermines the HHS position that health insurance lies outside the reach of Section 1557 generally. Within the same statutory section as Section 1557 is a provision adopting the definitions of the Public Health Service Act, 42 U.S.C. § 300gg-91. Those definitions, in turn, describe a wide array of health insurance plans, even using the word "program" as synonymous with "group health plan." 42 U.S.C. § 300gg-91(a)(3). With this context, it is quite strange for HHS to draw a line that excludes health insurance plans from what constitutes a "health program" under the ACA.

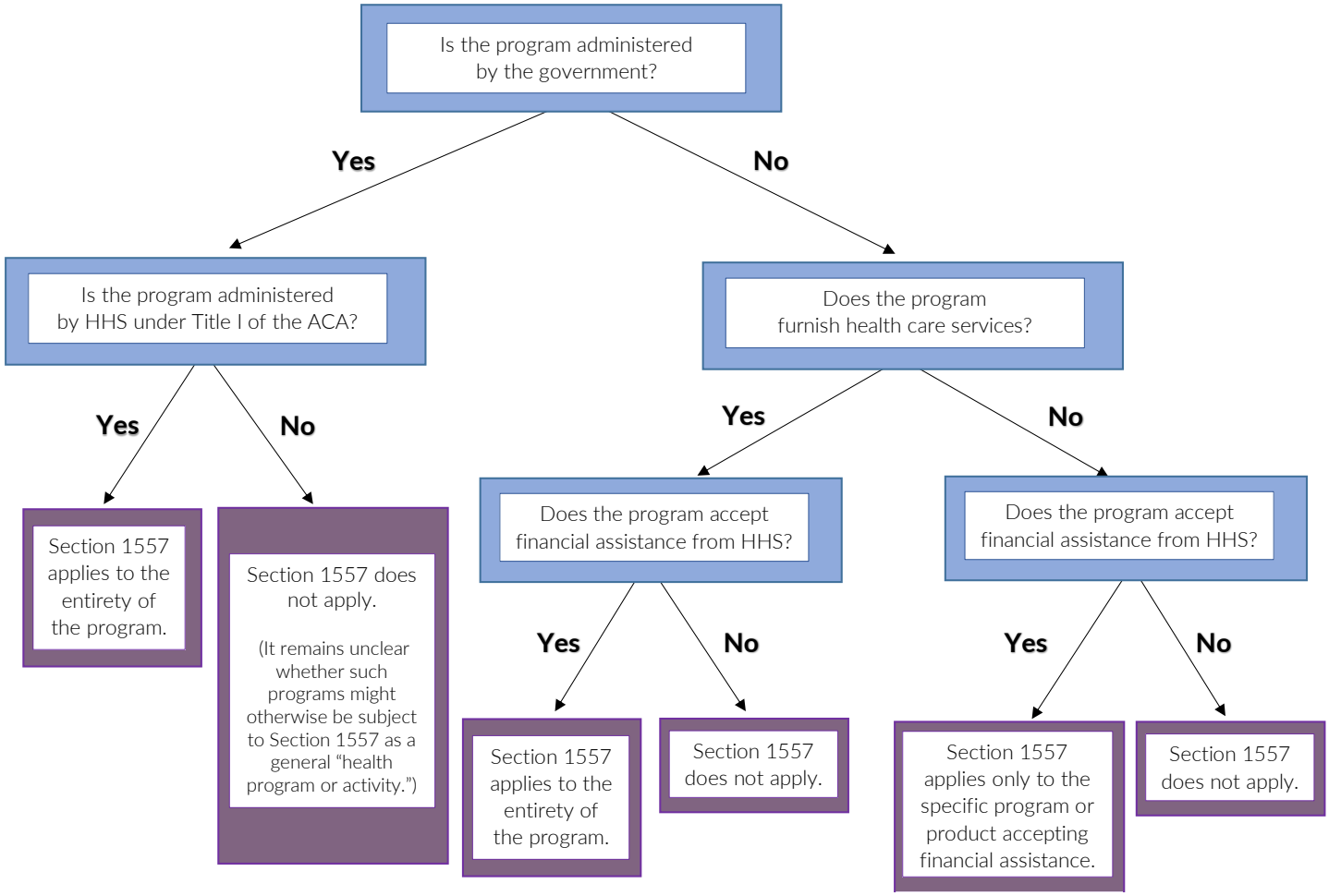
There are other minor changes in the new proposed language around scope. For example, the new proposed language replaces "every" with "any" in referring to health programs and activities. While it is true that those two words have slightly different meanings, it is doubtful that such a change will have meaningful effect.

The Impact on Who and What is Covered

At the risk of stating the obvious, the changes reflected in the proposed rule's scope of who and what is covered by Section 1557 are complicated and nuanced. It takes significant investment to see the forest for the trees in order to understand the impact. To assist in that effort, Figure 1 below illustrates the changes visually. Readers should understand that this visualization may be oversimplified; it should not be taken as exhaustive, especially given that the proposed rule is subject to change in its final form. Readers with specific questions about impact should contact *Health Care in Motion* directly. With that said, the impact on who and what is covered is described below.

The most significant set of effects that will occur if the proposed rule is adopted as written involves the exclusion of certain health insurance plans. It is important to note that where an entity is engaged in what HHS deems to be "the business of providing health care," e.g. hospitals, nursing homes and health clinics, Section 1557 will continue to apply across the entity's business operations. But *health insurance* companies are a different story. Based on the new distinction described above, the revised rule would not subject insurers to Section 1557's requirements in programs or products that do not directly receive federal assistance. This includes, among other things, employer-sponsored group health insurance plans, products in which the insurer acts as third-party administrator, and so-called "short-term limited duration" products. Under the new proposed rule, Section 1557 will no longer constrain health insurance products of this sort, even if the insurance company is otherwise subject to the rules in its Marketplace plans. HHS also believes that Medicare Part B, self-funded group health plans, and Federal Employees Health Benefits Program are likewise excluded from Section 1557's requirements.

FIGURE 1: Who/What is Covered Under Section 1557 Proposed Rule



These are significant changes. There are about 11 million Americans enrolled in Marketplace plans under the ACA. But the number of individuals enrolled in group health insurance plans is far greater. Because of overlapping legal rules, it is not clear what proportion of these private group plans will deem themselves completely free to discriminate. As with any big health care policy change, the proof will be in the pudding. As for the exemption of Short-Term Limited Duration plans from Section 1557, *Health Care in Motion* has previously warned its readers about these products, designed specifically to avoid the strictures of the ACA. Research has already proven these plans to categorically discriminate against those living with HIV and other preexisting conditions. Marketing investigations have further shown that insurers are using unfair and deceptive techniques to mislead consumers about these plans. It is these types of practices that have earned Short-Term Limited Duration plans the label of "junk insurance."

What Can I Do?

The proposed changes to the scope of who and what is covered under Section 1557 is an important, but nuanced change that deserves the focus of advocates across the many constituencies that work on access to health care. The official period to submit comments has not yet opened, but it will start soon. We at *Health Care in Motion* are in the process of developing a template comment that can be used by others as a starting point to let HHS know how they will be impacted by these changes. Please stay tuned to *Health Care in Motion* for updates or visit www.protecttranshealth.org to submit comments that will later be sent to HHS on your behalf.

In the meantime, it is also important to keep the scale of this proposed change in perspective. Without diminishing the significance of this backward step by the Trump Administration, it remains just one aspect of the multilayered legal protections for LGBTQ health care consumers. A full exploration of the constellation of these protections is beyond the scope of this *Health Care in Motion*. Nevertheless, it remains possible in certain circumstances and in certain states, that the entities, plans and programs removed from Section 1557's scope by the proposed rule remain subject to other, overlapping antidiscrimination rules such as state public accommodation laws. Advocates should not give up hope that the long march toward full recognition of every person under the laws governing health care remains a guiding star that we can and will achieve.

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