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

Re: Nondiscrimination in Health Programs and Activities (“1557 NPRM,” RIN 0945-AA17)

Submitted electronically via <http://www.regulations.gov>

UnidosUS (formerly the National Council of La Raza) respectfully submits these comments on the Office for Civil Rights’ (OCR) proposed rule, “Nondiscrimination in Health Programs and Activities.”

UnidosUS is the nation’s largest Hispanic civil rights and advocacy organization. Through its unique combination of expert research, advocacy, programs, and an Affiliate Network of nearly 300 community-based organizations across the United States and Puerto Rico, UnidosUS simultaneously challenges the social, economic, and political barriers to the success and well-being of Latinos at the national and local levels. For more than 50 years, UnidosUS has united communities and different groups seeking common ground through collaboration and that share a desire to make our country stronger.

For more than 12 years, UnidosUS has helped shape, implement, and defend the Affordable Care Act (ACA). Our work includes advancing policies and programs that give more people the tools they need to be healthy and economically secure, including access to affordable, quality health coverage and care. In 2019, when the previous administration proposed a revised Section 1557 rule, we opposed its efforts to weaken the law’s protections, including its repeal of the nondiscrimination notice and tagline requirements involving language access.

Health care is a civil rights issue. We appreciate OCR’s efforts to strengthen and improve existing civil rights protections and to ensure that everyone can access care. We support the proposed rule overall, but we focus our comments on three specific issues: requiring all covered entities to employ a Section 1557 coordinator; preventing discrimination against people with limited English proficiency in the operation of federally funded health programs; and clarifying

that discrimination based on pregnancy-related conditions, including termination of pregnancy, is discrimination based on sex, which violates Section 1557.

Require all covered entities to appoint Section 1557 coordinators (§92.7)

We support the proposal to require entities with more than 15 employees to designate a Section 1557 coordinator to carry out the responsibilities necessary for complying with the law and protecting patients' civil rights. OCR has requested whether this requirement should apply to entities with fewer than 15 employees. **We urge OCR to require all covered entities, regardless of their size, to designate a coordinator.** Having each entity designate a coordinator will help ensure greater compliance with the law's requirements for all patients. Covered entities must follow the law, regardless of the entity's size. Part of the rationale for requiring a coordinator is that, without a specific allocation of responsibility for compliance, violations are more likely. Studies [show](#) that, in a variety of contexts, assigning responsibilities to particular individuals makes a significant difference in improving performance, including in organizations or organizational units with fewer than 15 employees.

The proposed rule's regulatory preamble cites 45 CFR §86.8(a)'s requirement that each recipient of federal funding must "designate at least one employee to coordinate its efforts" to comply with Title IX of the Education Amendments of 1972. Notably, that regulation applies to "each recipient," which 45 CFR §82.2(i)(4)(i) defines to include any "entity, or any person, to whom Federal financial assistance is extended." This obligation is not limited to entities with at least 15 employees. Congress's [intent](#) in passing Section 1557 was to incorporate the highest levels of protection pursuant to prior civil rights statutes, including Title IX. To effectuate that intent, it is essential that the final rule eliminate the restriction of coordinator obligations to entities with 15 or more employees.

Prohibit discrimination against people with limited English proficiency

Robust civil rights protections are essential for people with limited English proficiency (LEP)

Linguistic access has long received legal protection. Since 1964, Title VI of the Civil Rights Act has guaranteed that no one may be discriminated against in federal programs based on their race, color, or national origin. More recently, additional civil rights protections have been implemented, including Executive Order 13166, which aimed to improve access to federal programs and federally assisted activities for persons who, because of national origin, have limited English proficiency. Section 1557 extends earlier civil rights protections to any health program or activity receiving federal financial assistance or any program or activity administered by an Executive Agency, or any entity established under the ACA.

More than 25 million Americans speak English less than “very well,” including over 16 million Spanish-speakers. Language access in health care will only grow more important over time. Between 1990 and 2013, the LEP population grew 80%.

If people with LEP are limited in their ability to benefit from federally funded health programs, the effect is to discriminate based on national origin, in violation of Section 1557. In 2019, 16.1% of Latinos and 13.4% of Asian Americans and Pacific Islanders spoke little or no English, compared to 0.6% of non-Hispanic Whites.¹

Inadequate language services contribute to poorer care and outcomes for patients with LEP. While it can vary by condition or reason for admission, individuals with LEP often experience longer hospital stays and are more likely to be readmitted than English-speaking patients. In fact, one study found that patients with LEP who do not receive professional interpretation services at admission spent as many as 1.5 days longer in the hospital, on average, than patients with LEP who do receive these services. Individuals with LEP who have an emergency department (ED) visit are significantly more likely to need a return visit within 72 hours—a costly failure for a common measure of ED quality of care.

Language barriers can often contribute to and exacerbate health conditions that Latinos disproportionately suffer from. Latinos have higher rates of hypertension than non-Hispanic Whites, but LEP is also a demonstrated driver of poorer health outcomes for patients with hypertension. LEP Latinos with diabetes also experience better health outcomes when they are treated by bilingual or Spanish-speaking primary care providers, and LEP patients with diabetes more frequently report dissatisfaction with their provider-patient interactions.

Individuals with LEP often face numerous intersecting barriers to health care, including uninsured status, limited health literacy, and racial discrimination and bias within the health system. Even after controlling for various demographic factors such as lack of insurance, income, and education level, individuals with LEP are more likely to struggle with medical comprehension. As a result, patients with LEP face challenges adhering to a prescribed course of treatment, partly driven by lack of language-concordant providers and discharge instructions.

LEP is associated with health care underuse among Latinos, whether measured by spending, episodes of care, or prescriptions. This is likely the result of a combination of factors that disproportionately impact Latinos, including lower health literacy, familiarity with what one’s health plan covers, and obstacles presented by the digital language divide. Gaps in spending and use raise concerns that language barriers are obstructing access to care, resulting in underuse of medical services by LEP Latinos. Strong civil rights protections are one essential tool to help guarantee that LEP individuals can access quality care.

We strongly support many of the changes in the proposed rule and have also provided additional recommendations to strengthen these efforts. In brief, we make the following comments, and address each in turn below:

- Policies and procedures standards should require the development of a language access plan.
- The notices of availability of language access services and auxiliary aids and services should require covered entities to conspicuously display this information on the first page of all relevant correspondence and should recognize the differences among the communications to which this requirement applies.
- A language access plan should be considered a tool for evaluating compliance with the meaningful access requirements.

Policies and Procedures (§92.8)

We support the proposal that all covered entities facilitate compliance with the requirements of the law by implementing written policies and procedures, including how an employee identifies whether an individual is limited English proficient, obtains the services of qualified interpreters and translators, and effectively communicates with individuals.

From the elements described in the proposed rule, it is unclear to what degree covered entities will be required to engage in the advanced planning and needs assessment that is part of developing a language access plan, which is an invaluable tool for meeting the needs of patients with LEP and attaining the goals articulated by civil rights laws such as Section 1557. The U.S. Department of Health and Human Services (HHS) 2003 Limited English Proficient Guidance describes several elements important for an effective LEP plan, including how to respond to callers with LEP; how to respond to written communications from persons with LEP; how to respond to individuals with LEP who have in-person contact with recipient staff; and how to ensure competency of interpreters and translation services. In addition to increasing covered entities' compliance, such a plan can help OCR see whether a particular entity is certain to violate the law, even if it fully implements its plan.

We thus request that OCR explicitly require covered entities to develop a language access plan. The degree of advanced planning and the scope of the needs assessment can vary based on the resources and reach of a particular covered entity, but all covered entities must develop such a plan.

Notice of Nondiscrimination (§92.10)

We support the restoration of the nondiscrimination notice requirements which were removed from the previous Section 1557 rule in 2019. Lack of awareness of one's language access rights

has [long posed](#) an obstacle for many patients, and restoring the requirement for these notices is an essential step toward addressing this long-standing issue.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (§92.11)

We strongly support the requirement to provide notices of availability for language access services. In addition to the requirements described within the rule, we urge OCR to make improvements involving the notice's content and placement, the range of documents covered by the requirement, and the languages encompassed by the notice.

In terms of notice content and placement, we urge OCR to require that these notices be made available on the first page of each of the documents described. We routinely hear from our community-based Affiliates about challenges that individuals with LEP face navigating through English-language portals or reading through English-language paperwork to locate critical information in Spanish.

We also urge **OCR to require tailored notices, depending on the type of document, to make clear when failing to respond to the communication could cause serious harm.** For example, among the written communications required to provide notices are those "related to a person's rights, eligibility, benefits, or services that require or request a response" from an individual. OCR should develop model notices for different types of written communications and make these available to covered entities.

In terms of the range of documents covered by the requirement, we believe the list of written communications to which this particular notice applies is comprehensive, and we are pleased to see the proposed rule's specificity. People with LEP will not receive the full benefits of any communication if it does not contain this notice, so it is important not to leave "loopholes" allowing important communications to skip this notice.

However, we urge OCR to expand the list of covered communications by making clear that **provider directories must contain these notices.** Otherwise, LEP consumers who are selecting a plan may not be able to absorb the information they require to choose a plan that meets their needs.

The likely inadvertent failure of the proposed rule to add provider directories to the list of covered documents illustrates a broader problem. **The final rule should add a catch-all category requiring that every document that a covered entity is legally required to provide should include this notice,** prominently displayed on the document's first page. Otherwise, people with LEP will be denied equal access to the benefits that policymakers sought to provide when they promulgated the requirement.

Lastly, in terms of languages encompassed by this requirement, instead of requiring the notices be made available in the top 15 languages "in a state or states," **we urge OCR to require**

covered entities to provide notice in the top 15 languages in a state, rather than allowing aggregation across multiple states served by an entity, which would potentially jeopardize access for speakers of smaller languages.

Meaningful Access for Limited English Proficient Individuals (§92.201)

We support the proposed changes to the meaningful access requirements for individuals with LEP, including the new requirements related to video and audio remote interpreting services. We also support the proposed revision providing that the meaningful access requirements encompass people “likely to be directly affected” rather than only “encountered.”

Regarding the proposed “Evaluation of compliance,” as mentioned above we urge OCR to require covered entities to develop a language access plan. While we appreciate that measuring compliance with the meaningful access requirements may take into consideration an entity’s written language access procedures, **we urge OCR to revise this section to reflect any new requirement for a language access plan.** The 2016 Final Rule acknowledged the importance of access plans as a tool for measuring compliance when it described this as another factor that can be taken into account by the OCR Director.

We are pleased to see the proposed rule’s language regarding restricted use of certain individuals to act as interpreters. Ordinarily, relying on minor children or accompanying adults to interpret for an individual in the health care setting should only be a last resort in extreme circumstances and when the patient with LEP requests and agrees to this measure. We support the clarification as included in the proposed rule that this arrangement should only be a temporary measure in emergency situations.

The proposed rule requires covered entities to take appropriate steps to ensure that communications with individuals with disabilities, and *companions with disabilities*, are as effective as communications with individuals without disabilities in its health programs and activities. **We urge OCR to extend this requirement to companions of individuals with LEP.** Many individuals will be accompanied by their family members, a child, or another close friend who may help with decision-making for a patient. Requiring provision of meaningful access to the companion of an individual with LEP can help facilitate this and ensure effective communication for all involved.

Finally, we strongly support the proposed language requiring that a covered entity which uses machine translation must also have the translation reviewed by a qualified human translator for any text critical to the rights, benefits, or meaningful access of an LEP individual, when accuracy is essential, or when the source documents or materials contain complex, nonliteral, or technical language.

Prohibit discrimination based on pregnancy-related conditions, including termination of pregnancy (§ 92.101(a)(2))

In response to the Department’s request for comment,² we strongly encourage OCR to specify in the final rule that sex-based discrimination includes discrimination based on “pregnancy-related conditions, including childbirth, false pregnancy, termination of pregnancy, and recovery therefrom.” As drafted, the proposed rule does not consistently define sex discrimination to include pregnancy-related conditions. We noted that sex discrimination includes “pregnancy or related conditions” at § 92.101(a)(2), but only “pregnancy” under § 92.101 and § 92.10.

In light of the Supreme Court’s decision in *Dobbs v. Jackson Women’s Health Organization*, 142 S. Ct. 2228 (2022), it is critical that HHS ensure that termination of pregnancy and pregnancy-related conditions are protected throughout the regulation. Before *Dobbs*, Latinas already faced significant barriers to receiving reproductive health care, including limitations on linguistic access,³ a lack of culturally competent care,⁴ and much [higher rates of uninsurance](#), compared to non-Hispanic White women.⁵ The additional barrier of legal restrictions to abortion access, post-*Dobbs*, further exacerbates preexisting disparities based on national origin in many states.

Today, Latinas make up 18% of the total number of women in the U.S., a percentage that is projected to rise to 27% by 2060. Examining the population of three states, we can see how the growing number of Latinas can be disproportionately affected by abortion restrictions.⁶

- In Arizona, Latinas comprise 37.4% of all women and girls of reproductive age (15–49), compared to 31.4% of women and girls of all ages.
- In Florida, Latinas make up 30.5% of women and girls ages 15–49, compared to 26.1% of women and girls of all ages.
- In Texas, 42.2% of women and girls ages 15–49 are Latina, compared to 39.2% of women and girls of all ages.

The proposed rule notes that Title IX regulations classify discrimination based on pregnancy-related conditions as sex-based discrimination. We respectfully submit that incorporating Title IX standards via cross-reference places Latinas at heightened risk. If those Title IX regulations are successfully challenged, such a challenge could implicate Section 1557 as well. Moreover, many other provisions of the proposed rule explicitly restate provisions that are already found in other regulations, including those implementing Title IX. Singling out this particular policy for incorporation by reference, rather than restatement, is an invitation to mischief. A court or later administration could infer from this difference in regulatory treatment an intent to apply less stringent prohibitions—or indeed, no prohibitions at all—compared to other prohibitions that 1557 regulations explicitly state.

Without clear and explicit protection in the final rule, state restrictions on abortion will add a chilling effect that deters Latinas and other women from accessing necessary reproductive health services for fear that pregnancy and potential complications could lead to discrimination while seeking health care. Patients seeking life-threatening emergency care for pregnancy or related conditions may find themselves subject to criminal prosecution or be turned away by providers refusing to provide care. The final rule must make it explicitly clear, wherever sex-based discrimination is discussed, that such discrimination includes discrimination based on “pregnancy or related conditions,” which includes termination of pregnancy.

Conclusion

We appreciate HHS and OCR’s efforts to improve access to quality health care and prevent discrimination in our health system. Should you have any questions or need further information, please contact Stan Dorn, Director of Health Policy at sdorn@unidosus.org.

¹ UnidosUS analysis of 2019 American Community Survey data, accessed through IPUMS USA, University of Minnesota, www.ipums.org.

² See 87 Federal Register 47824, 47879 (August 4, 2022).

³ José Pares-Avila, Mary Sobralske, and Janet Kats, “No Comprendo: Practice Considerations When Caring for Latinos with Limited English Proficiency in the United States Health Care System,” *Hispanic Health Care International*, December 2011; 9(4): 159–167.

⁴ Lisa Ross DeCamp et al., “The Voices of Limited English Proficiency Latina Mothers on Pediatric Primary Care: Lessons for the Medical Home,” *Maternal and Child Health Journal*, January 2013; 17(1): 95–109.

⁵ In 2019, 17.5% of Latina women were uninsured, compared to 5.5% of non-Hispanic White women, 8.6% of non-Hispanic Black women, 6.5% of Asian American and Pacific Islander women, 17.5% of Native American women, and 7.2% of other women. UnidosUS analysis of American Community Survey (ACS) data for 2019, accessed through IPUMS USA, University of Minnesota, www.ipums.org (IPUMS). In 2020, 10.0% of Latinas reported delaying medical care because of cost, compared to 7.1% of non-Hispanic White women, 7.5% of non-Hispanic Black women, 9.2% of Native American women, 2.8% of Asian American and Pacific Islander women, and 2.8% of other women. UnidosUS analysis of National Health Interview Survey (NHIS) data for 2020, accessed through IPUMS. According to that same data source, 9.2% of Latina women reported having no usual source of health care, compared to 5.3% of non-Hispanic White women, 6.5% of non-Hispanic Black women, 6.6% of non-Hispanic Native American women, 7.1% of Asian American and Pacific Islander women, and 3.3% of other women.

⁶ UnidosUS analysis of 2019 ACS data, accessed through IPUMS.