October 3, 2022

Melanie Fontes Rainer
Director
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, RIN Number 0945–AA17

Dear Director Fontes Rainer:

On behalf of the Association of Asian Pacific Community Health Organizations (AAPCHO), thank you for the opportunity to comment on the proposed rule on Nondiscrimination in Health Programs and Activities implementing Section 1557 of the Affordable Care Act. AAPCHO strongly supports the proposed rule and the significant improvements it makes to strengthen protections for individuals who may face discrimination in health care.

AAPCHO is a national nonprofit association of 33 community-based health care organizations, 28 of which are Federally Qualified Health Centers, that advocates for the diverse health needs of medically underserved Asian Americans (AA) and Native Hawaiians and Pacific Islander (NH/PI) communities and the community health providers that serve their needs. AAPCHO members are critical health access providers to nearly three quarters of a million vulnerable and low-income patients, providing culturally and linguistically appropriate care that is vital to supporting AA and NH/PI communities.

AAPCHO’s comments primarily focus on the proposed rule’s language access provisions to ensure meaningful access to health care. Among AAPCHO members, 47 percent are best served in a language other than English, and our member FQHCs provide care in up to 70 different languages. Every day, our member health centers see the challenges that individuals with limited English proficiency (LEP) face in accessing health care and using their insurance. Our patients who lack English literacy or have different cultural experiences with health insurance often face challenges in understanding their options or their rights as patients or their rights and responsibilities under their plans.

Section 1557 provides critical protections for individuals to access health care without discrimination including people with LEP, LGBTQ+ persons, people with disabilities and chronic conditions, and people needing reproductive health services. Regrettably, changes to Section 1557 regulations that were implemented in 2020 significantly weakened protections upon which countless individuals had relied and become accustomed to. The proposed rule restores and strengthens these critical protections including reinstating notifications, language assistance services, and legal notices that are critical in educating and informing patients about how to use health care, and the services available to them.
AAPCHO supports the direction of this proposed rule and the investments in building a strong set of civil rights protections. Our specific comments are below.

A. LANGUAGE ACCESS

1. **Designation and responsibilities of a Section 1557 Coordinator (§ 92.7)**

AAPCHO supports the proposal that covered entities have at least one designated Section 1557 coordinator. We urge OCR to extend this provision to apply to all covered entities, including those with fewer than 15 employees. Section 1557 coordinators fulfill an essential role in ensuring that covered entities are in compliance with nondiscrimination regulations and managing required systems and trainings. Even in small covered entities, it is essential that someone be responsible for coordinating implementation of Section 1557 to ensure its effective implementation.

We encourage OCR to continue to provide flexibly to community health centers and other providers and facilities to spread 1557 responsibilities across multiple staff. Many health centers are experiencing prolonged workforce challenges, including staff burnout, turnover, and pandemic-related stress. AAPCHO members also reported staff concerns with the continued high incidences of anti-Asian hate that has strained both AAPCHO health center staff and patients. Requiring all covered entities to have designated a Section 1557 coordinator(s) while continuing to provide flexibility to spread duties across multiple staff will hold all covered entities accountable for compliance with the law and these regulations.

2. **Policies and Procedures (§ 92.8)**

AAPCHO strongly supports the requirement for covered entities to adopt and implement a nondiscrimination policy, grievance procedures (for covered entities employing 15 or more persons), language access procedures, auxiliary aids and services procedures, and procedures for reasonable modifications for individuals with disabilities. Developing policies and procedures, and then requiring relevant staff to receive training, will hopefully ensure that covered entities are better able to meet the requirements of Section 1557. AAPCHO’s member health centers have expertise in providing services and care to individuals with LEP, and their experience suggests that strong internal protocols and trainings are critical to the effective implementation of services and that advance preparation across the health center is key.

However, OCR should further require covered entities to develop a language access (or more broadly a communication access that include services for people with disabilities) plan. For example, the 2022 Proposed Rule discusses the need for “language access procedures” which seems to be more the “nuts-and-bolts” of how to schedule an interpreter, how to identify whether an individual is LEP, etc., but there is no requirement that a covered entity think in advance of what types of language services it may need. We recommend OCR modify § 92.8 to clarify that covered entities have a language access plan (or a broader communication access plan) in addition to relevant policies and procedures.
We further support the requirement that a covered entity’s language access procedures must include information detailing the contact information for the Section 1557 Coordinator (if applicable); how an employee identifies whether an individual is LEP; how an employee obtains the services of qualified interpreters and translators the covered entity uses to communicate with individuals with LEP; the names of any qualified bilingual or multilingual staff members; and a list and the location of any electronic and written translated materials the covered entity has, the languages they are translated into, and the publication date. It notes that covered entities have a duty to translate that extends beyond those documents that have already been translated at the time this list is made, and the list should be updated periodically.

We recommend that OCR incorporate a number of aspects of a language access plan mentioned in HHS’ 2003 LEP Guidance but are not in the 2022 Proposed Rule 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.
- how to ensure competency of interpreters and translation services.

We also recommend a requirement to develop policies and procedures to assess the competency of bilingual/multilingual staff. These could be language proficiency assessments or other methods of ensuring that bilingual/multilingual staff are indeed qualified to provide services directly in a non-English language.

Further, the provision on policies and procedures does not mention an expectation for ongoing evaluation or updating. As OCR notes in the 2003 LEP Guidance, “effective plans set clear goals and establish management accountability.” We believe both goals and accountability are essential to ensuring effective implementation of Section 1557.

3. **Training (§ 92.9)**

AAPCHO supports the requirement for covered entities to train relevant employees on the civil rights policies and procedures. AAPCHO urges OCR to make clear that relevant staff includes not only those in “public contact” positions understand civil rights policies and procedures but also those who make decisions about and implement these policies and procedures.

In addition, all relevant staff should be trained annually on best practices for working with individuals with LEP, including how to best work with interpreters, particularly the type of interpreters the covered entity uses (e.g. in-person, telephonic, video). Relevant staff should receive training so that they understand when an interpreter should be used, how interpreter services can be accessed, what the language services options are (e.g., in-person, telephone, video, translation services) and documentation requirements for quality, utilization, billing, and internal reporting purposes.

AAPCHO health centers have significant experience in training staff on working with individuals with LEP. Their experience demonstrates that not only is this type of training desirable to ensure policies and procedures are followed but also that it makes the delivery of health care
services more efficient and improves the patient experience. Providing patients with the ability
to fully participate in their care through in-language services is key to better patient outcomes.

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

AAPCOH strongly supports the provisions for covered entities to provide notices of language assistance services and auxiliary aids and services, and the requirements for when this notice must be made available. These notices are similar to the tagline requirement contained in the 2016 Final Rule and are an efficient and cost-effective way for covered entities to inform individuals with LEP in the absence of full fully translated documents. We recommend that OCR expand on the proposed rule to require covered entities to provide notices in the top 15 languages in a single service area, instead of “relevant state or states.” Requiring notices be provided at the service area level will allow for more relevant awareness of language assistance services by individuals who may actually need them; this is especially important for providers who operate in large states like California where commonly spoken languages vary by region of the state, or in condensed metropolitan areas like New York City where commonly spoken languages may be different than the rest of the state.

OCR should also clarify that notices required by this rule are meant to be a minimum standard and do not replace other program-specific guidelines or federal, state, or local requirements that may go beyond the requirements of § 92.11.

AAPCHO further recommends that OCR develop and provide covered entities with model notices and translated information in the relevant languages that will be needed across the country. We recommend that OCR require notices to be related to the different types of publications they are on, noting that a notice would likely be different for a denial or termination of eligibility, benefits or services versus consent form versus information about a public health emergency.

We also recommend OCR specify that this notice must be provided at the beginning or on the first page of any document. Unfortunately, many documents in which this notice will be required and most helpful are lengthy and can lead to confusion about the importance of the communication when individuals with LEP are unaware, up front, that they can receive language assistance services. We view providing notices at the end of a document as similar to a provider explaining a medical condition to a patient with LEP in English and then bringing in an interpreter after the fact. Individuals with LEP should know their rights from the start, and providing notices at the beginning of documents will benefit individuals with LEP who will see information in their language and also individuals with disabilities who will see information in large print up front as well.

5. **Meaningful Access for Limited English Proficient Individuals (§ 92.201)**

AAPCHO supports the provisions related to meaningful access. It has been long recognized that the denial of adequate language services to individuals with LEP constitutes discrimination on the basis of national origin. Specifically, there are clear intersections between LEP status
and race and/or ethnicity. With many individuals with LEP, being racial/ethnic minorities, lacking adequate language services perpetuates discrimination against people of color by health care providers. This discrimination felt by patients may deter them from seeking critical health care services, leading to adverse health outcomes and decreased trust in the health care system. Therefore, improving meaningful access for individuals with LEP will be an important tool in enhancing health equity by allowing patients to access and understand health care services in a language they prefer.

Community health centers operate more than 14,000 sites across the nation, serving as the primary health home for a large patient population who speak a variety of languages. All AAPCHO member health centers provide care in multiple languages, with some providing language assistance services in up to 70 different languages. A large part of the health center program is to have translation services to serve our patients and meet community needs. In 2021, almost one-fourth of health center patients, and nearly half of AAPCHO member health center patients, preferred a language other than English. Health centers will continue to prioritize hiring more translators and interpreters to better serve individuals with LEP to ensure patients understand the care and services they receive to meet the growing need for our patient population.

AAPCHO supports the NPRM’s clarification related to the restricted use of certain persons to interpret or facilitate communication. The prior regulations recognized that an individual with LEP cannot be required to provide their own interpreter. And that a minor can only be used to interpret in an emergency and that an adult accompanying an adult should not act as an interpreter without the person’s consent or in an emergency. The 2022 Proposed Rule adds an expectation that in an emergency situation, the reliance an accompanying adult or minor should be “a temporary measure”. We support this addition.

We also recommend that OCR add a requirement that a “companion” of an LE individual with LEP who needs language services must also be provided meaningful access including access to qualified interpreters and translated materials. We believe the same should be afforded to individuals with LEP, particularly parents/guardians with LEP of English-speaking minors/incapacitated adults. This could include individuals who participate in decision-making with the individual with LEP or need to understand the information for caregiving and other related reasons.

Further, we strongly support the inclusion of a definition of machine translation and recognition that machine translation of critical information must be reviewed by a qualified human translator. While the technology behind machine translation has improved in accuracy, the possibilities of significant consequences from inaccurate translation continue to exist. This is especially important in a health care setting where context and culturally appropriate language may not perfectly align with source documents or where materials contain complex, nonliteral, or technical language that may not have corresponding terminology in another language. If a covered entity uses a machine translation, it must have the translation reviewed by a qualified translator.
Finally, AAPCHO recommends that OCR amend the definition of qualified interpreter for an individual with a disability to more closely align with the qualified interpreter for a limited English proficient individual. For sign language interpreters, this should include proficiency in speaking and understanding both English and another relevant sign language. For transliterators, it would require proficiency in the relevant alternative communication modality (such as cued speech or oral transliteration). Further, any “interpreter for an individual with a disability” should communicate “without changes, omissions, or additions and while preserving the tone, sentiment, and emotional level of the original… statement” and also adhere to generally accepted ethics principles including client confidentiality. These additions will provide alignment between the different types of interpreters and those providing other communication assistance and recognize that similar standards should apply whether an interpreter is interpreting for an individual with LEP or a person with a disability.

6. **Nondiscrimination in the Delivery of Health Programs and Activities Through Telehealth Services (§92.211)**

AAPCHO strongly supports OCR’s proposal to explicitly include telehealth in the nondiscrimination provisions, as it is important that nondiscrimination languages align for this rising modality of care. Health center patients have benefited greatly from access to services through telehealth during the COVID-19 pandemic; HRSA notes that in 2021, health centers conducted over 26 million virtual visits. Health centers offer a variety of services to their patients via telehealth. In 2021, 54% of visits were for mental health, 31% of visits addressed substance use disorder, 27% of visits were for enabling services and 18% of visits were medical visits. Offering the option of telehealth to patients is a way to move past social determinants of health barriers that patients face when trying to access health care, such as lack of reliable transportation and lack of childcare options.

However, telehealth has not been equitable for patients with LEP and people with disabilities, and service platforms remain inaccessible to people with disabilities or people with limited English proficiency. As a basic step, AAPCHO strongly recommends OCR require telehealth platforms be able to include a third party, such as an interpreter or use of auxiliary aids and services. Second, all communication about telehealth that occurs prior to a telehealth appointment – including scheduling, information about system requirements and testing connections, appointment reminders, and log-on details – must be accessible to people with LEP and people with disabilities. Similarly, platforms should be adapted to meet the needs of people who are autistic, deaf or hard of hearing, blind, deaf/blind, movement impaired, or otherwise have difficulty in communicating via traditional telehealth models. Before the telehealth interaction, providers should assess for visual, cognitive, intellectual, mobility as well as functional needs to maximize the patient’s health care experience. AAPCHO recommends that OCR consider including notification of telehealth services in the list of electronic communications that must include the notice of availability of language assistance services and auxiliary aids and services. By adopting these recommendations, health care facilities, including health centers, will be equipped with the necessary tools and technology to continue to offer high quality, accessible care through telehealth.
B. DATA COLLECTION

AAPCHO appreciates the Biden administration’s whole of government commitment to equity and ensuring that federal data systems account for and address challenges affecting diverse communities throughout the nation. AAPCHO recommends that OCR require data collection across all covered entities. This is particularly important for AA and NH/PI communities that represent more than 50 ethnic groups and speak more than 100 languages, each with their own complex histories and experiences that contribute to their health and the health disparities afflicting them. Unfortunately, complete and accurate demographic data that disaggregates AA and NH/PI communities at a granular level is limited, creating barriers to effective, targeted interventions and either masking or completely erasing the experiences and challenges of entire segments of our communities; highly variable income levels, employment rates, health care outcomes, disease prevalence, and language a patient is best served in are all invisible in aggregated data. The lack of disaggregated data perpetuates existing disparities and does not allow nuanced solutions targeted to where they are needed.

Moreover, the current federal data practices enable the damaging “model minority myth” that stereotypes Asian Americans as a successful monolith, erasing the diverse experiences and ongoing barriers faced by many East Asians, Southeast Asians, and South Asians. This harm is compounded when Native Hawaiians and Pacific Islanders are subsumed into and then erased within categories like “Asian American and Pacific Islander”—a category that the OMB recognized years ago should be and are two separate categories but that too many federal agencies persist in using. The model minority myth is furthermore weaponized as a racial wedge between AA and NH/PIs and other communities of color. Disaggregated data has wide-reaching implications and can be a powerful tool for informing evidence-based policies and identifying unique barriers to access of services.

In requiring all covered entities to collect detailed demographic data, AAPCHO encourages HHS to utilize and strengthen existing data collection systems with HHS entities. For example, all federally qualified health centers are required to submit data to HRSA through an annual reporting system called the Uniformed Data System (UDS). FQHCs report data on utilization, patient demographics, insurance status, managed care, prenatal care, and birth outcomes, diagnosis, and financing.

Beginning in 2024, HRSA will implement an enhanced UDS system, UDS+, that will move health center reporting from patient-oriented tables, aggregated at the health center level, to more patient level-data. The data will show the breakdown of most outcomes by demographics and incorporate social drivers for the need for social services by demographics. Health centers will continue to report data that includes race, ethnicity, language, gender, gender identity, sexual orientation, and age, which are suggested in this data collection section. While disability status is not currently slated to be collected in UDS+, we know that HRSA is working closely with ONC on data standards and that disability is one of the elements in United States Core Data for Interoperability v3. Its inclusion in the future would satisfy the data ONC wants in its goals to improve equity. AAPCHO recommends that OCR coordinate with HRSA to ensure that patient demographic data is disaggregated into granular subpopulation groups for Asians, as well as granular subpopulation groups for Native Hawaiians and Pacific Islanders.
Additionally, we strongly encourage OCR to require covered entities to collect data on the primary language enrollees can understand and provide appropriate support for individuals with LEP. AAPCHO’s experience is that language is the second largest barrier to health care, following insurance status, for community health center patients in our nation. According to 2019 UDS data, 24% of all community health center patients, and 47 percent of AAPCHO’s members’ patients, are best served in a language other than English. Nationally, there are more than 25 million people, and nearly 1 in 10 working-age U.S. adults with LEP. Research demonstrates that language is a significant factor in a patient’s decision to seek and obtain care. Non-English speakers are 26% more likely than English speakers to not have a routine checkup with a doctor in the past year. Individuals that spoke a language other than English at home were 73% more likely to have no usual provider and 71% more likely to not have had a primary care visit in the past year than individuals who spoke English at home. Moreover, language barriers limit access to care. Our experience demonstrates that patients who know they will have difficulty explaining their medical needs or problems to a doctor or nurse are less willing to seek care.

C. NONDISCRIMINATION PROVISIONS

1. Discrimination Prohibited (§ 92.101)

AAPCHO appreciates that OCR has included this section outlining the types of discrimination that are prohibited. It is encouraging to see HHS recognize in the preamble to the proposed rule that people may experience discrimination in health care on more than one basis. AAPCHO recommends OCR include more explicit references to intersectional discrimination within the regulatory text by including “or any combination thereof” after “disability,” in § 92.101(a)(1). Specifically we propose this section read (edits bolded):

“Except as provided in Title I of the ACA, an individual must not, on the basis of race, color, national origin, sex, age, or disability, or any combination thereof, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any health program or activity operated by a covered entity.”

AAPCHO further supports OCR’s clarification in §92.101(a)(2) that prohibits “discrimination on the basis of sex stereotypes; sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; and gender identity.” AAPCHO recommends adding “transgender status” to the regulatory text. While the terms “gender identity” and “transgender status” are often used interchangeably, there have been instances in which those seeking to permit discrimination against transgender people have justified it by pressing distinctions between the two concepts. Therefore, explicit language is needed to prevent this discrimination and consistency throughout the final rule is important.

AAPCHO also proposes that the final rule makes clear that “pregnancy or related conditions” includes the termination of pregnancy. We propose that §92.101(a)(2) read (edits bolded):
“Discrimination on the basis of sex includes, but is not limited to, discrimination on the basis of sex stereotypes; sex characteristics, including intersex traits; pregnancy or related conditions, including termination of pregnancy; sexual orientation; transgender status; and gender identity.”

We also recommend including “transgender status” in § 92.206(b)(1), (b)(2) and (b)(4), and in §92.207(b)(3).

2. Equal program access on the basis of sex (§ 92.206)

AAPCHO supports this section and the clarification that providers may not refuse gender affirming based on a personal belief that such care is never clinically appropriate, and reaffirming that providers have a responsibility to exercise clinical judgment when determining if a particular service is appropriate for an individual patient. We suggest OCR strengthen the language pertaining to potential conflicts with state or local laws by stating, unequivocally, that Section 1557, as federal law, preempts any such state or local law restricting access to this care.

Further, consistent with our recommendation above, we encourage OCR to include “transgender status” to §92.206(b)(1), (b)(2) and (b)(4). We also believe that section (b)(2) would be clearer if shortened as indicated below. In addition, we recommend deleting the indicated language in (b)(4), as a provider could engage in a discriminatory denial of care even if a claimant cannot show that the care in question was on other occasions provided for other purposes.

Lastly, we believe this section would be strengthened by including specific examples of what constitutes discrimination based on pregnancy or related conditions, such as discriminating against someone because they had previously had an abortion or denying medically necessary care because it could prevent, complicate, or end a patient’s fertility or pregnancy.

Accordingly, we recommend OCR amend the proposed § 92.206(b) to read (edits bolded):

“In providing access to health programs and activities, a covered entity must not:

(1) Deny or limit health services, including those that are offered exclusively to individuals of one sex, to an individual based upon the individual’s sex assigned at birth, gender identity, transgender status, or gender otherwise recorded;

(2) Deny or limit a health care professional’s ability to provide health services on the basis of an individual’s sex assigned at birth, gender identity, transgender status, or gender otherwise recorded if such denial or limitation has the effect of excluding individuals from participation in, denying them the benefits of, or otherwise subjecting them to discrimination on the basis of sex under a covered health program or activity;
(3) Adopt or apply any policy or practice of treating individuals differently or separating them on the basis of sex in a manner that subjects any individual to more than de minimis harm, including by adopting a policy or engaging in a practice that prevents an individual from participating in a health program or activity consistent with the individual's gender identity, or subjects pregnant people to discriminatory treatment during childbirth, including rough handling, harsh language, or undertreatment of pain;

(4) Deny or limit health services sought for purpose of gender transition or other gender-affirming care, fertility care, or any health services that the covered entity would provide to an individual for other purposes if the denial or limitation is based on a patient’s sex assigned at birth, gender identity, transgender status, or gender otherwise recorded.

(5) Deny or limit services, or a health care professional's ability to provide services, on the basis of pregnancy or related conditions, including termination of pregnancy, contraception, miscarriage management, fertility care, maternity care, or other health services;

(6) Deny or limit services based on an individual’s reproductive or sexual health care decisions or history, including termination of pregnancy, miscarriage, or adverse pregnancy outcome; and

(7) Deny or limit services, or a health care professional's ability to provide services, that could prevent, cause complications to, or end fertility or pregnancies, including medications or treatments for disabilities or emergency medical conditions under 42 U.S.C. § 1395dd.

3. Nondiscrimination in Health Insurance Coverage and Other Health-Related Coverage (§ 92.207)

AAPCHO is supportive of the proposal in §92.207, as this would prohibit discrimination against patients with Medicaid, Medicare Part B, and coverage through the federal marketplace. For decades, health centers have developed extensive partnerships with state Medicaid agencies. Similar to health centers nationally, nearly 48% of AAPCHO member health center patients are Medicaid beneficiaries, 10% of AAPCHO member patients have Medicare, and 18% have private insurance.

AAPCHO encourages HHS to finalize § 92.207 to provide equal protections to all patients and create equitable discrimination protections for all types of health insurance coverage. Historically, health plans and insurance companies have implemented discriminatory practices that impact applicants and enrollees based on sex, race, color, national origin, age, and other intersecting identities. For example, private and public insurers have been found to discriminate based on relationship status and sexual orientation through policies that require single people or those in non-heterosexual relationships to pay out of pocket for certain reproductive health
services. Given these circumstances, patients face difficult decisions on where to obtain care and have little recourse if they experience discrimination in seeking care.

AAPCHO agrees with HHS’ judgment that the statutory text of Section 1557 is clear: Congress intended that the law apply to these entities and address these issues. We strongly support HHS’ restoration of and improvements to § 92.207, including its inclusion of specific forms of prohibited discrimination. We recommend, however, several changes to strengthen this section.

Consistent with our recommendations above, we suggest adding “transgender status” to § 92.207(b)(3):

“A covered entity must not, in providing or administering health insurance coverage or other health-related coverage: … (3) Deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, to an individual based upon the individual’s sex at birth, gender identity, transgender status, or gender otherwise recorded.”

Additionally, consistent with our recommendations above, we suggest clarifying what constitutes “discrimination based on pregnancy or related conditions” by amending § 92.207(b)(4), 92.207(b)(5) and 92.207(b)(7) as follows (edits bolded):

(4) Have or implement a categorical coverage exclusion or limitation for all services related to gender transition or other gender-affirming care, termination of pregnancy, contraception, fertility care, miscarriage management, pregnancy loss, maternity care, other reproductive and sexual health services, or any health services, if such denial, limitation, or restriction results in discrimination on the basis of sex;

(5) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost-sharing or other limitations or restrictions on coverage, for specific health services related to gender transition or other gender-affirming care, termination of pregnancy, contraception, fertility care, miscarriage management, pregnancy loss, maternity care, other reproductive and sexual health services, or any health services,, if such denial, limitation, or restriction results in discrimination on the basis of sex; or

(7) Deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations on coverage for health services that may prevent, cause complications to, or end fertility or pregnancies, if such denial, limitation, or restriction results in discrimination on the basis of sex.

4. Nondiscrimination on the basis of association (§ 92.209)

AAPCHO is pleased that this NPRM restores explicit protections against discrimination on the basis of association. This is consistent with longstanding interpretations of other
antidiscrimination laws, which cover discrimination based on an individual’s own characteristics or those of someone with whom they are associated or with whom they have relationship. As noted in the NPRM preamble, certain protected populations, including LGBTQ people, are particularly susceptible to discrimination based on association. An individual in a same-sex relationship or marriage could be subjected to discrimination based on their own and their spouse or partner’s sex, whereas that same individual might not be similarly mistreated were they not in a same-sex relationship. It is important that the final rule make clear that this kind of associational discrimination is within the ambit of the rule’s protections.

D. CONCLUSION

The proposed rule is a significant step forward to address discrimination in health care and provide stronger protections for individuals—especially those who are underserved—to get the health care they need. AAPCHO strongly supports the proposed rule, and hopes the Department takes our recommendations on areas to strengthen it. We believe this rule will have positive outcomes for Asian American, Native Hawaiian, and Pacific Islander communities.

Thank you for the opportunity to submit comments on the proposed rule. If you have any questions, please don’t hesitate to contact me at acarbullido@aapcho.org.

Sincerely,

Adam P. Carbullido
Director of Policy and Advocacy