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November 9, 2015

Ms. Jocelyn Samuels
Director, Office for Civil Rights
Attention: 1557 NPRM (RIN 0945-AA02)
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue, SW
Washington, DC 20201

Re: Nondiscrimination in Health Programs and Activities, 80 Federal Register 54172

Dear Director Samuels:

On behalf of the American Nurses Association (ANA), we are pleased to comment on the proposed rule referenced above, published in the Federal Register on September 8, 2015. As the only full-service professional organization representing the interests of the nation's 3.4 million registered nurses (RNs), ANA is privileged to speak on behalf of its state and constituent member associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.¹

ANA commends the Department of Health and Human Services (HHS) and the Office of Civil Rights (OCR) on the publication of the Notice of Proposed Rule Making to implement Section 1557 of the Affordable Care Act (ACA), which takes important steps to end discrimination in the delivery of health care. The proposed rule, if implemented, would protect against sex-based discrimination in three important areas: programs or entities that receive federal funds, credits, or subsidies; programs or activities administered by an executive agency; and programs or activities created under Title I of the ACA, including products sold on the state health insurance exchanges. The rule as proposed would make clear that all tax credits created by Title I of the ACA, as well as any funds extended by HHS to pay for health insurance coverage, are considered Federal financial assistance. It would utilize the approach of the Civil Rights Restoration Act in defining "health program or activity," and would make clear that sex discrimination includes discrimination on the basis of "pregnancy, false pregnancy, termination of pregnancy or recovery therefrom, childbirth or related medical conditions, sex stereotyping, or gender identity." In addition, the rule as proposed would set out explicit, detailed protections against discrimination on the basis of gender

¹The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

identity. All of these provisions would help eliminate sex discrimination in the delivery of health care.

While these are important steps, ANA urges HHS to take a number of additional steps to strengthen the rule and ensure that Section 1557 is broadly implemented across all federal health programs and activities.

I. Request for Comments on the Proposed Exceptions from the Prohibition on Discrimination on the Basis of Sex.

OCR seeks comments on whether the proposed rule appropriately protects religious beliefs, and asks for comments on whether additional exceptions should be granted for religious exemption. Section 1557 was narrowly tailored to end longstanding discrimination in health care, and as noted in the proposed rule, certain protections for health care providers regarding religious beliefs already exist. We therefore urge OCR to refrain from establishing additional exceptions for purposes of this rule.

II. Eliminate the Employment Discrimination Exception

The proposed rule would not apply to employment discrimination by a health program or activity except for discrimination in some employee health benefit programs.² ANA urges OCR to revise this narrow interpretation of Section 1557.

A civil rights statute should be read as broadly as possible to effectuate its purpose.³ This necessarily includes determining what activities or circumstances are subject to a prohibition against discrimination, as well as finding exceptions from the prohibition against discrimination. Section 1557 prohibits all discrimination under any covered health program or activity.⁴ The terminology used in the statute refers broadly to any individual under “any health program or activity” (rather than limiting it to a *participant or a beneficiary* who is *participating or enrolled* in any health program or activity). Carving out employment discrimination by health programs and activities contradicts the plain language of the statute.⁵ While HHS notes that Title VI does not reach employment discrimination in many instances, this limitation on Title VI’s reach is explicitly set out in Title VI itself.⁶ In contrast, Title IX and Section 504 have no such statutory exemption and have been consistently interpreted to bar discrimination in employment by covered entities.⁷ Section 1557 is drafted like Title IX and Section 504, without an employment

²Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,180.

³2A Sutherland Statutory Construction § 76:6 (7th ed.).

⁴42 U.S.C. § 18116 (2012).

⁵See *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984) (“If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress”).

⁶42 U.S.C. § 2000d-3 (2012).

⁷See *North Haven Bd. of Educ.*, 456 U.S. at 530 (1982) (finding Title IX reaches employment discrimination and noting that if Congress meant to incorporate Title VI’s employment exemption, it would have included similar language in Title IX, stating, “For although two statutes may be similar in language and objective, we must not fail to give effect to the differences between them.”); *Consol.*

discrimination exemption, and should be interpreted to reach employment discrimination just as these laws have been interpreted to reach employment discrimination. There is a particular need for this protection given the discrimination that female health care providers continue to face. For example, research published in the Journal of the American Medical Association in 2013 found that a gap in earnings between male and female physicians has not only persisted over the last 20 years but actually has grown.⁸ Further, gender inequality likely played a role in the reduced statutory compensation for Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), and Physician Assistants (PAs). Currently, 93 percent of NPs and CNSs are women; two thirds of PAs are women. Clinicians with those backgrounds that meet Medicare qualifications and bill Medicare directly are reimbursed at 85 percent of the physician fee – a relic of past discriminatory practices. When Congress mandated the use of RBRVS principles in 1992 it abjured the use of both years of experience and years of education in the establishment of fee levels. Gender-linked specialty discrimination was reintroduced only five years later (when 96 percent of nurses were women and more than 80 percent of physicians were men). Section 1557 does not provide a discrimination exemption for Medicare or Medicaid. The proposed rule should be revised to make clear that Section 1557’s prohibition against discrimination applies to employment discrimination by a health program or activity. As CMS moves increasingly towards a value-based reimbursement system it makes no sense that the allowed charges for an NP’s services that are billed “incident to” should be worth more than the same services billed under the NP’s NPI rather than a physician NPI.

III. Additional Comments

Section 92.207(b) of the proposed rule generally provides that plans shall not “deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions, on the basis of an enrollee’s or prospective enrollee’s race, color, national origin, sex, age, or disability.” Specific prohibited discriminatory actions pertaining to marketing practices or benefit designs, set forth in Section 92.207(b)(2), similarly refer to discrimination on the basis of race, color, national origin, sex, age, or disability.

Beneficiaries have witnessed discriminatory benefit design by some insurers, particularly in the coverage of prescription medications which are essential for many beneficiaries living with chronic and serious health conditions. Some marketplace plans have placed all or almost all medications to treat a certain condition on the highest cost tier. In addition, beneficiaries have experienced other design benefits that amount to discrimination of people with chronic conditions, including not covering certain medications or not following treatment guidelines, imposing excessive medication management tools such as unreasonable prior authorizations and/or step therapy, charging patients high cost sharing, and having narrow provider networks.

Rail Corp. v. Darrone, 465 U.S. 624, 635 (1984) (finding same with respect to Section 504 and noting that it would be “anomalous” to conclude that Section 504 “silently adopted a drastic limitation on the handicapped individual’s right to sue federal grant recipients for employment discrimination.”).

⁸Seth A. Seabury, et al., *Trends in the Earnings of Male and Female Health Care Professionals in the United States, 1987 to 2010*, 173 JAMA INTERNAL MED. 1748 (Oct. 14, 2013).

We urge OCR to revise the definition of what constitutes discrimination by including regulatory language clarifying that the practice of placing all or nearly all medications to treat a certain condition on the highest tier to be discriminatory. Additionally, we recommend clarifying that the definition of who is protected under Section 1557 is not limited to beneficiaries who are disabled under the definition in the Americans with Disabilities Act, but includes all beneficiaries with chronic health conditions or serious illness.

We appreciate the opportunity to share our views on this matter. If you have questions concerning the differential paid to nurse practitioners, please contact Peter McMenemy, Senior Policy Advisor/Health Economist (peter.mcmenemy@ana.org or 301.628.5073). For other questions contact Jane Clare Joyner, Senior Policy Advisor (janeclare.joyner@ana.org or 301.628.5083).

Sincerely,



Debbie D. Hatmaker, PhD, RN, FAAN
Executive Director

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
Marla Weston, PhD, RN, FAAN, ANA Chief Executive Officer