IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CHINATOWN SERVICE CENTER
767 N. Hill Street, Suite 400
Los Angeles, CA 90012; and

SAINT BARNABAS SENIOR SERVICES
675 S. Carondelet Street
Los Angeles, CA 90057,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 Independence Avenue SW
Washington, D.C. 20201; and

NORRIS COCHRAN, in his official capacity as Acting Secretary of Health and Human Services,
200 Independence Avenue SW
Washington, D.C. 20201,

Defendants.

Civil Action No. _____

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

INTRODUCTION

1. Plaintiffs are community-based organizations that serve older adults with limited English proficiency ("LEP") who rely entirely on language assistance services to access and understand healthcare services. These LEP individuals, who tend to face more dire health outcomes, rely on language assistance services to know their rights under federal law, to understand healthcare bills they receive, to communicate with medical providers, and to follow through on treatment guidance offered by healthcare professionals. In the last days of the Trump Administration, these language assistance services were culled from the civil rights regulations regulating healthcare entities, leaving LEP older adults uninformed and confused and unable to

effectively communicate with medical professionals during some of the riskiest and worst days of the COVID-19 pandemic.

2. Without notice of their rights, LEP older adults remain in the dark as to their right to free interpreter services at a medical appointment or what they can do when providers wrongly require LEP individuals to rely on unqualified informal or family-member interpreters, or how to get translation assistance so that they can understand their bills, healthcare guidance or other important healthcare documents. All the while, LEP patients have faced some of the worst outcomes of any population during the COVID 19 pandemic.[1]

3. Plaintiffs have suffered and will continue to suffer material and irreparable injury if the Defendant, Department of Health and Human Services ("HHS" or the "Department"), is not enjoined from administering its new final rule — Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to amend and be codified at 45 C.F.R. pt. 92) ("2020 Rule").

4. The 2020 Rule was finalized in the last months of the Trump Administration as an assault on the fundamental civil rights provisions and protections of the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA"), Pub. L. No. 111-148, 124 Stat. 119 (codified at 42 U.S.C. §§ 18001-18122 (2010)), and its original implementing regulations promulgated in 2016. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) (formerly codified at 45 C.F.R. § 92) (the "2016 Rule"). The 2016 Rule was the Department's implementation of key civil rights protections of the ACA, which Congress enacted in 2010 to expand access to healthcare, ensure that health services are broadly available in the United States, and address discrimination in healthcare access, including, pertinent to this

[1] https://www.healthaffairs.org/do/10.1377/hblog20200331.77927/full.

Complaint, discrimination against older adults and LEP individuals.[2] The 2020 Rule, without foundation or justification, effects a 180-degree reversal of the prior administration's 2016 Rule and furthers the very inequities the ACA was intended to remedy.

5. The ACA's landmark civil rights provision, 42 U.S.C. § 18116 (commonly known as Section 1557), intended to strike at barriers to healthcare by prohibiting discrimination in healthcare and health insurance. Section 1557 prohibits all health programs and activities receiving federal financial assistance, including medical providers, health systems, and health insurers, from discriminating against individuals on the basis of race, color, national origin, sex, age, or disability. Section 1557 was the first federal civil rights law to comprehensively prohibit discrimination in healthcare, complementing existing protections under other laws.

6. Multiple aspects of the 2020 Rule are contrary to statute, arbitrary and capricious, an abuse of discretion, or otherwise contrary to law. The Department arbitrarily and capriciously eradicated key provisions in the 2016 Rule that had obligated covered entities[3] to inform LEP individuals of their healthcare rights in languages they can understand — provisions that are critical to ensuring LEP individuals, including LEP older adults, have meaningful access to the healthcare to which they are entitled.

7. The 2020 Rule eliminated the 2016 Rule's requirements that covered entities provide: 1) notice of rights under the ACA, and 2) taglines in the top 15 non-English languages indicating the availability of free language assistance services. (Formerly codified at 45 C.F.R. § 92.8(d) (2016)). These requirements helped ensure that LEP individuals would be able to

[2] HHS itself stated that "meaningful access for individuals with LEP is a key component of the national origin protections under Title VI and Section 1557." 85 Fed. Reg. at 37,167. It further confirmed that it "strongly agrees that language assistance is often vital for ensuring access to Federally funded programs and activities in the healthcare system by individuals with LEP." *Id.* at 37,211.

[3] "Covered entities" are entities principally engaged in the business of providing healthcare that receive Federal financial assistance. *See* 45 C.F.R. § 92.3.

comprehend healthcare-related information, including health insurance and costs as well as the medical procedures, medications and health measures that their health professionals were attempting to communicate to them.

8. The 2016 Rule's notice provision required covered entities to post notices informing all individuals, including those with LEP, of their right to non-discrimination in the provision of healthcare under Section 1557. These rights include language assistance services when such services are necessary to provide meaningful healthcare access to LEP individuals.[4]

9. Taglines are short in-language statements advising LEP individuals how they may access free language services.[5] The 2016 Rule had required taglines to be included on all significant communications and publications in the top 15 languages spoken by LEP individuals in the covered entity's state. They were also required to be posted in conspicuous physical locations where the entity interacts with the public, and on a covered entity's website. 81 Fed. Reg. 31,469 (Formerly codified at 45 C.F.R. § 92.8 (2016)).

10. The 2016 Rule's requirements for notices and taglines were promulgated to enable healthcare professionals and LEP individuals to communicate effectively. They were vital to ensuring that LEP older adults can understand their rights, that their necessary healthcare would not suffer from a lack of communication, and that they would not lack for proper and timely treatments and services due to communication barriers. These are life and death issues, particularly

[4] The 2016 rule provided illustrative language that covered entities could use:

> "[Name of covered entity]…[p]rovides free language services to people whose primary language is not English, such as: Qualified interpreters; Information written in other languages. If you need these services, contact [Name of Civil Rights Coordinator.] If you believe that [Name of covered entity] has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance…." [followed by instructions]. 81 Fed. Reg. 31473.

[5] An illustration of a shorter tagline was also included in the 2016 Rule: "ATTENTION: If you speak [insert language], language services, free of charge, are available to you. Call 1-xxx-xxx-xxxx." *Id.*

during a public health emergency like COVID-19 and for LEP older adults, whose age makes them more at-risk of hospitalization and death, yet in its 2020 Rule the Department tossed them aside with a proverbial wave of its hand.

11. The record supporting the 2016 Rule shows that HHS required in-language taglines in an effort to ensure meaningful access to healthcare by balancing the needs of LEP individuals with costs to covered entities, even providing sample taglines in 64 languages and sample notices for covered entities to use. 81 Fed. Reg. 31,443.

12. The lack of evidentiary basis to support the wholesale removal of protections for LEP individuals in the 2020 record[6] — including the lack of an adequate cost/benefit analysis — cannot survive judicial review.

13. Particularly harmed by the 2020 Rule are the more than 6.5 million older adults over the age of 60 who are LEP[7], including some four million Medicare beneficiaries who are LEP[8], and the community-based organizations that serve them. These organizations have witnessed a surge in demand for language assistance services from LEP older adults, impairing their regular operations. Meanwhile, the 2020 Rule forces LEP older adults to navigate a healthcare

[6] The record instead supports the opposite. It includes numerous instances of studies demonstrating the importance of ensuring languages services are available to LEP individuals. For example, the Asian & Pacific Islander American Health Forum ("APIAHF") point to a study by Centers for Medicare & Medicaid Services which found "Communication and language barriers are associated with decreased quality of care and poor clinical outcomes, longer hospital stays, and higher rates of hospital readmissions. Evidence suggests that access to communication and language assistance for patients and consumers is important to the delivery of high quality care for all populations." Comments of APIAHF (August 13, 2019), p. 31 *available at* https://www.apiahf.org/resource/apiahf-comment-letter-to-ocr-section-1557/ (citing Understanding Communication and Language Needs for Medicare Beneficiaries, Centers for Medicare & Medicaid Services, April 2017. Available here: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf)

[7] U.S. Census Bureau, 2019: ACS 1-Year Estimates Subject Tables, Population 60 Years And Over In The United States, https://data.census.gov/cedsci/table?q=S0102&tid=ACSST1Y2019.S0102.

[8] CMS Office of Minority Health, Understanding Communication and Language Needs of Medicare Beneficiaries, Apr. 2017, available at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf.

system without adequate language assistance services, making healthcare activities, like registering for a COVID-19 vaccination appointment, fraught with challenges.

14. Defendants' unlawful and arbitrary rollback of healthcare protections harms Plaintiffs. Plaintiffs bring this action to vacate the 2020 Rule and enjoin its implementation because it is arbitrary, capricious, an abuse of discretion, and contrary to law, in violation of the Administrative Procedure Act ("APA"), 5 U.S.C. § 706(2)(A); and exceeds Defendants' statutory jurisdiction, authority, and limitations in violation of the APA, 5 U.S.C. § 706(2)(C).

JURISDICTION AND VENUE

15. The Court has subject matter jurisdiction pursuant to 28 U.S.C. §§ 1331, 1346, and 2201(a). Jurisdiction is also proper under the judicial review provisions of the Administrative Procedure Act, 5 U.S.C. § 702.

16. Declaratory and injunctive relief is sought consistent with 5 U.S.C. §§ 705 and 706, and as authorized in 28 U.S.C. §§ 2201 and 2202.

17. Venue is proper in this judicial District under 28 U.S.C. §§ 1391(b)(2) and (e)(1). Defendants are United States agencies or officers sued in their official capacities. Defendants are residents of this judicial District, and a substantial part of the events or omissions giving rise to this Complaint occurred and are continuing to occur within this district.

PARTIES

18. Plaintiffs Chinatown Service Center and Saint Barnabas Senior Services are organizations that serve LEP older adults. They have both been harmed by the elimination of language access protections in the rule implementing Section 1557 because they have experienced a significant strain on their operations and have been unable to carry out their work.

19. Plaintiff Chinatown Service Center (CSC) is a community-based organization serving Chinese Americans and immigrants in Los Angeles, California. CSC provides important

social services to LEP individuals, like assisting them with understanding documents, including healthcare notices, they receive in the mail. Defendants' actions have injured CSC, causing it to direct staff to work overtime and bring on additional volunteers to meet the demand for additional language assistance. It has also experienced difficulty meeting contract deliverables due to diverted staff time necessary to assist LEP clients with language access needs.

20. Plaintiff Saint Barnabas Senior Services (SBSS) is a social services agency located in Los Angeles, California that serves older adults, including over 70% who are LEP. Their case managers routinely assist LEP older adults navigate the healthcare system. Defendants' elimination of language access protections has forced SBSS to rearrange its usual services in light of the surge of LEP older adults seeking language assistance services with the COVID-19 vaccination process. It has already shifted funds to meet the surge for in demand for language assistance related to the vaccine.

21. Plaintiffs are aggrieved by Defendants' actions and have standing to bring this action because the 2020 Rule harms their organizational interests, and will continue to cause injury unless and until the 2020 Rule is vacated.

22. Defendant HHS is a cabinet agency within the executive branch of the United States government, and is an agency within the meaning of 5 U.S.C. § 552(f). HHS promulgated the 2020 Rule and is responsible for its enforcement.

23. Defendant Norris Cochran is the Acting Secretary of HHS and is sued in his official capacity.

ALLEGATIONS

I. LEGAL BACKGROUND

A. The Patient Protection and Affordable Care Act

24. The ACA, enacted to expand access to affordable, quality healthcare and coverage across the United States, instituted significant changes to the American healthcare system. Recognizing that inadequate health insurance coverage was a significant barrier to healthcare access, Title I of the ACA ("Title I") made significant reforms to the private health insurance market and public insurance programs. The ACA strengthened protections for older adults in particular by, *inter alia*, limiting how much more insurers can charge based on age, lowering out-of-pocket costs for Medicare beneficiaries, ensuring coverage for preexisting conditions (the incidence of which is higher among older adults), and enhancing opportunities for older adults to live in the community rather than institutional settings.

25. The ACA's landmark civil rights provision, Section 1557, was the first federal law to expressly and comprehensively prohibit discrimination in the American healthcare system on the basis of race, color, national origin, sex, age, and disability. 42 U.S.C. § 18116. The new law incorporated the protected classifications and enforcement mechanisms from Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d *et seq.* ("Title VI") (race, color, and national origin); Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 *et seq.* ("Title IX") (sex); the Age Discrimination Act of 1975, 42 U.S.C. § 6101 *et seq.* ("Age Act") (age); and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 ("Section 504") (disability).

26. Under Section 1557:

> an individual shall not, on the ground prohibited under [Title VI, Title IX, the Age Act, or Section 504], be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any 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 [Title I] (or amendments)," and "[t]he enforcement mechanisms provided for and available under such [Title VI, Title IX, Section 504] or such [Age Act] shall apply for purposes of violation of this subsection.

42 U.S.C. § 18116(a). Section 1557 expressly applies to "any health program or activity, any part of which is receiving Federal financial assistance" or is administered by the federal government. *Id.*

27. As the ACA's full name — the Patient Protection and Affordable Care Act — makes clear, the central purpose of the Act is to ensure both patient protection and affordable care. And as HHS touts on its website, "The Section 1557 statute extends nondiscrimination protections *to individuals* participating in:

- Any health program or activity, any part of which receives funding from HHS
- Any program or activity that HHS administers under Title I of the ACA, such as the Federally-facilitated Marketplace
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces."

https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html (emphasis added).

28. The ACA authorizes the Secretary of HHS to "promulgate regulations to implement this section." *Id.* § 18116(c).

29. A companion provision, Section 1554 of the ACA, 42 U.S.C. § 18114, prohibits the Secretary of HHS from:

> promulgat[ing] any regulation that—(1) creates unreasonable barriers to the ability of individuals to obtain appropriate medical care; (2) impedes timely access to health care services; (3) interferes with communications regarding a full range of treatment options between the patient and provider; (4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions; (5) violates the principles of informed consent and the ethical standards of health care professionals; or (6) limits the availability of health care treatments for the full duration of a patient's medical needs.

30. The Supreme Court has found that failure to provide appropriate language assistance and discrimination on the basis of national origin are inextricably linked.[9]

B. The Administrative Procedure Act

31. The APA defines "rule making" as the "agency process for formulating, amending, or repealing a rule." 5 U.S.C. § 551(5). The APA defines "rule" to include "the whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy.…." § 551(4).

32. The APA requires agencies to engage in a notice and public comment process prior to formulating, amending, or repealing a rule. 5 U.S.C. §§ 551(5), 553. The process is intended to "give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments." § 553(c).

33. Under the APA, a reviewing court shall "hold unlawful and set aside" agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law…[and] in excess of statutory…authority," 5 U.S.C. § 706(2)(A),(C), or that is "without observance of procedure required by law." § 706(2)(D).

II. REGULATORY BACKGROUND

A. The Period Leading up to the 2016 Rule

34. In 2013, HHS issued a request for information ("RFI") concerning the implementation of Section 1557. Responses to the RFI documented the barriers to effective care faced by LEP individuals denied access to adequate language assistance services. The comments also provided data showing that this pervasive discrimination deters people from seeking care,

[9] *See Lau v. Nichols*, 414 U.S. 563, 568 (1974)(holding that language assistance services are required to ensure that LEP individuals have meaningful access, and that the denial of such access is a form of national origin discrimination).

including preventive care, due to a fear of experiencing discrimination, resulting in serious, adverse health consequences.[10]

35. On September 8, 2015, HHS promulgated its proposed Section 1557 implementing regulations, the 2015 NPRM. 80 Fed. Reg. 54,172.

36. During the notice-and-comment period on the 2015 NPRM, HHS received nearly 25,000 comments from individuals, civil rights organizations, health providers, insurers, and state and local governmental agencies, among others. 81 Fed. Reg. at 31,376. These comments further substantiated the significant, widespread discrimination faced by LEP individuals, older adults, LGBTQ people, women and individuals seeking pregnancy-related care, and people with disabilities, as well as persons who are members of more than one of these protected classes (*i.e.*, intersectional discrimination) and the critical need for HHS's robust enforcement of Section 1557's protections.

B. The 2016 Rule

37. On May 18, 2016, HHS published the 2016 Rule to implement Section 1557's protections. 81 Fed. Reg. 31,376. The Rule went into effect on July 18, 2016, with provisions applicable to health insurance and group benefit design becoming applicable on January 1, 2017, the first day of the plan year following the Rule's publication. *Id.*

38. The Department stressed that the 2016 Rule was intended to effectuate Section 1557's broad antidiscrimination mandate and to serve the ACA's central purpose of "expand[ing] access to care and coverage and eliminat[ing] barriers to access." *Id.* at 31,377. The 2016 Rule made express factual findings that discrimination within the healthcare system contributes to

[10] Comments of City of New York (August 13, 2019), p. 11, *available at* https://www1.nyc.gov/assets/cchr/downloads/pdf/NYC-Comments-Nondiscrimination-in-Health-and-Health-Education-Programs-or-Activities-2019.pdf (citing Ku, L., & Flores, G. (2005). Pay now or pay later: providing interpreter services in health care. Health Affairs, 24(2), 435-444.)

inadequate insurance coverage and poor health outcomes, exacerbates health disparities in underserved communities, and contributes to the inequitable distribution of healthcare resources. *Id.* at 31,444. HHS further found that "individuals who have experienced discrimination in the healthcare context often postpone or do not seek needed care," and are denied the ability to obtain health services provided to others, resulting in adverse health effects. *Id.*

39. To address these barriers and fulfill Section 1557's nondiscrimination mandate, the 2016 Rule detailed the obligations of healthcare providers and insurers with respect to, *inter alia*, LEP individuals, including older adults. Relevant to this Complaint, the 2016 Rule's key provisions included: (a) clarifying that Section 1557 broadly applies to all health providers and insurers that receive federal financial assistance, *id.* at 31,467 (formerly codified at 45 C.F.R. § 92.4 (2016)); (b) establishing detailed language access requirements to ensure nondiscriminatory access to health services for LEP individuals, *id.* at 31,410-11 (formerly codified at 45 C.F.R. § 92.201 (2016)); (c) establishing requirements to provide individuals with a nondiscrimination statement and a notice of rights, as well as in-language taglines, *id*. at 31,395 (formerly codified at 45 C.F.R. § 92.8 (2016)); and (d) establishing a uniform enforcement scheme for all forms of discrimination prohibited by the statute, *id*. at 31,439-40.

40. Consistent with Section 1557's general statutory prohibition against discrimination, the 2016 Rule provided in relevant part that, "[e]xcept as provided in Title I of the ACA, an individual shall not, on the basis of race, color, national origin, sex, age, or disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any health program or activity to which this part applies," and set forth specific prohibitions and exceptions. *Id.* at 31,469-70.

41. Under the 2016 Rule, "[a] covered entity shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities." *Id.* at 31,470 (formerly codified at 45 C.F.R. § 92.201(a)(2016)). The required language assistance services "must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency," which included offering qualified interpreters for oral communications and qualified translators for written content at no cost to the individual. *Id.* (formerly codified at 45 C.F.R. § 92.201(c)-(d)(2016)). The 2016 Rule restricted entities' ability to rely on family members to provide translation or interpretation services, and imposed specific requirements for the use of video remote interpretation services. *Id.* at 31,470-71 (formerly codified at 45 C.F.R. § 92.201(e)-(f)(2016)). Although it fell short of requiring telephonic interpretation services in every instance, it made clear that it expected most covered entities to, at a minimum, provide qualified interpreters remotely, "given the widespread commercial availability of relatively low-cost language assistance services such as remote oral interpretation via telephone, as well as the nature and importance of covered entities' health programs or activities." 80 Fed. Reg. 54,184.

42. The 2016 Rule also required covered entities to take appropriate and ongoing steps to notify beneficiaries, enrollees, applicants, and members of the public of the entity's Section 1557-compliant nondiscrimination policy, including furnishing notice that the entity provides the language access services in the top 15 languages spoken by LEP individuals in the relevant state, auxiliary aids and services for LEP individuals, and information on how to obtain those services. 81 Fed. Reg. 31,469 (formerly codified at 45 C.F.R. § 92.8 (2016)).

43. The 2016 notice requirement significantly improved upon notice requirements other relevant civil rights statutes by mandating more specificity and clarity about how to remedy discrimination. The notices were required to contain information about the process for filing a grievance with the covered entity and with HHS's Office for Civil Rights. *Id.* at 31,469 (formerly codified at 45 C.F.R. § 92.8 (2016)). The 2016 Rule allowed covered entities to "combine the content of the notice required….with the content of other notices if the combined notice clearly informs individuals of their civil rights under Section 1557." *Id.* (formerly codified at 45 C.F.R. § 92.8(h)(2016)). The notice was required to be included in all significant publications and communications, in conspicuous physical locations, and on a covered entity's website; an abridged notice had to be included in small-sized significant publications and communications. *Id.* (formerly codified at 45 C.F.R. §92.8(b)(2016)). To simplify the requirement for covered entities, the 2016 Rule made available electronically a sample notice that met the Rule's requirements. *Id.* (formerly codified at 45 C.F.R. §92.8(c)(2016)).

44. The 2016 Rule further required covered entities to include short in-language "taglines" indicating the availability of language assistance services free of charge, along with instructions on and how to access such services. *Id.* at 31,468 (formerly codified at 45 C.F.R. § 92.4). Such taglines were required to be included in significant communications and locations as well as on the covered entity's web site. *Id.* at 31,469 (formerly codified at 45 C.F.R. § 92.8(f)). Covered entities were required to include the in-language taglines translated into the top 15 languages of a state for larger-sized communications and those posted in physical locations and into the top two languages for smaller communications. *Id.* (formerly codified at 45 C.F.R. §§ 92.8(d)-(g) (2016)). To ease the burden on covered entities, HHS provided sample

nondiscrimination notices and taglines as appendices to the 2016 Rule, making translated versions of both available for covered entities' use in 64 languages. *Id.* at 31,453, 31,472-73.

45. The 2016 Rule further articulated a uniform legal standard to be applied to all forms of discrimination prohibited by Section 1557. This included the availability of compensatory damages, associational and intersectional discrimination claims, and disparate impact claims, as well as the existence of a private right of action to challenge prohibited discrimination in court. *Id.* at 31,472 (formerly codified at 45 C.F.R.§ 92.301 (2016)); *see also id.* at 31,439-40. As explained in the 2015 NPRM, HHS intended this approach to avoid inconsistent application of the enforcement mechanisms in the statutes incorporated by Section 1557, and "to simplify and make uniform, consistent, and easy to understand the various nondiscrimination requirements and rights available under Section 1557, as appropriate." 80 Fed. Reg. 54,194.

46. The 2016 Rule noted that Section 1557 explicitly allowed for claims of intersectional discrimination, an important addition to the nondiscrimination principle. 81 Fed. Reg. 31,405. Intersectional discrimination occurs when individuals experience discrimination on the basis of multiple protected classes or identities. For example, one study that compared functional limitations across intersections of race and gender found that all demographic groups exhibited worse functional limitation trajectories than white men, and specifically that Black and Latino women had the highest disability levels.[11] Thus, an individual suffering multiple forms of discrimination (such as age plus sex) in the provision of healthcare may experience a worse health outcome than if the individual were subject to one type of discrimination.

[11] *See, e.g.*, Comments of Justice in Aging, ("JIA"), p. 13 (August 13, 2019), *available at* https://www.justiceinaging.org/wp-content/uploads/2019/08/1557-NPRM-Justice-in-Aging-Comments.pdf (citing David Warner and Tyson Brown, Understanding How Race/Ethnicity and Gender Define Age-Trajectories of Disability: An Intersectional Approach, Soc Sci Med, Apr. 2012).

47. In promulgating the 2016 Rule, HHS carefully weighed a variety of expected costs and benefits of the Rule's requirements. 81 Fed. Reg. 31,444-65. The rule noted that HHS intended to minimize the cost impact of the notice and tagline requirements by providing sample, translated notices and taglines for entities' use. *Id.* at 31,453. HHS determined that, based on the evidence gathered, the costs associated with the Rule's requirements would be offset by the public health benefits associated with individuals' ability to access healthcare free from discrimination. *Id.* at 31,459¬62.

48. For example, in the 2016 Rule, the Department cited research showing that LEP individuals with access to adequate language assistance services "experience treatment-related benefits, such as enhanced understanding of physician instruction, shared decision-making, provision of informed consent, adherence with medication regimes, preventive testing, appointment attendance, and follow-up compliance," and that providers also benefit by the ability to "more confidently make diagnoses, prescribe medications, reach treatment decisions, and ensure that treatment plans are understood by patients." *Id.* at 31,459.

C. The 2019 Rulemaking

49. On June 14, 2019 — less than three years after the 2016 Rule took effect — Defendants issued the 2019 NPRM, in which they turned their back on their prior findings and proposed erasing or reversing many of the 2016 Rule's core protections. 84 Fed. Reg. 27,846.

50. The 2019 NPRM proposed a number of measures that would weaken the 2016 Rule's language access and nondiscrimination protections. They included: (1) removal of the requirement that all significant communications contain non-discrimination notices and translated taglines regarding the availability of free language assistance services, (*id.* at 27,868), (2) adoption of revisions that would diminish the governing standard and test to assess a covered entity's

compliance with providing meaningful access to LEP individuals (*id.* at 27,892), and (3) the elimination of remote video interpreting standards (*id.* at 27,866).

51. The 2019 NPRM also proposed other ways to weaken Section 1557's non-discrimination protections that would impact LEP persons, as well as others. These changes removed express protections and eliminated the uniform legal standard for violations of Section 1557. *Id.* at 27,850-51, 27,856, 27,860, 27,865, 27,868, 27,869-70, 27,870-71, 27,883-84.

52. During the 2019 NPRM notice and comment period, HHS received an outpouring of comments opposing the massive rewrite of its Section 1557 implementing regulations. Individuals, civil rights groups, medical and public health organizations, scholars, members of Congress, state and local agencies, healthcare providers, individuals, and others submitted a total of 198,845 comments regarding the proposed rule change. 85 Fed. Reg. 37,164. As they had done for the 2013 RFI and 2015 NPRM, thousands of commenters detailed the widespread discrimination in healthcare settings experienced by LEP people, LGBTQ people, women and other individuals seeking reproductive healthcare or with pregnancy-related conditions, individuals with disabilities, and individuals belonging to more than one protected class (*i.e.*, intersectional discrimination), and described the need for the robust protections contained in the 2016 Rule. The commenters maintained that the proposed rule would lead to increased discrimination in healthcare, which would lead people to delay or forgo healthcare and would result in adverse health outcomes and the need for increased healthcare services overall. Commenters noted that based on these anticipated increased disparities, the proposed rule effectively encouraged discrimination. *Id.* at 37,165, 37,211, 37,165, 37,211.

53. As the COVID-19 pandemic took hold in the United States during in the spring of 2020, a coalition of 26 state attorneys general urged the Department to either withdraw the

proposed rule or suspend rulemaking during the pandemic.[12] In an April 30, 2020 letter to HHS, they cited data showing that the pandemic was exacerbating health disparities, particularly in communities of color and immigrant communities.[13] As a result, Section 1557's robust nondiscrimination protections were more critical than ever to protect members of high-risk groups from being denied adequate care during this unprecedented public health crisis. The letter warned that the publication of a final rule under these circumstances would unnecessarily burden healthcare providers who were responding to the crisis. Further, the final rule would harm their efforts to effectively respond to the pandemic. "By removing critically important protections to help ensure that disproportionately impacted communities get the care that they need, the Rule would undermine this crucial work and could prove deadly."[14]

54. Nevertheless, Defendants issued the final version of the 2020 Rule on June 12, 2020, making only insignificant changes to the proposed rule. The 2020 Rule went into effect on August 18, 2020.

D. The 2020 Rule

55. The 2020 Rule "eliminated the 2016 Rule's notice and tagline requirements entirely." *Whitman Walker Clinic, Inc. v. U.S. Dept. of Health and Human Services*, Civil Action No. 1:20-cv-01630 (JEB), slip op. at 73 (D.C.D.C. Sept. 20, 2020). It relieved healthcare entities of the duty to ensure that each LEP individual has meaningful access to services. It replaced the 2016 Rule's requirement that covered entities "take reasonable steps to provide meaningful access to *each individual* with limited-English proficiency," with a requirement to "take reasonable steps

[12] *See* Letter from Attorney General Xavier Becerra to Secretary Alex Azar (Apr. 30, 2020), https://oag.ca.gov/news/press-releases/attorneys-general-becerra-and-healey-urge-hhs-not-finalize-rule-would-permit.
[13] *Id.*
[14] *Id.*

to ensure meaningful access to [its] programs and activities by limited English proficient individuals" in the aggregate. 85 Fed. Reg. 37,245 (codified at 45 C.F.R § 92.101(a)).

56. In self-assessing if and what meaningful access is owed under the 2020 Rule, an entity must consider:

> (i) [t]he number or proportion of limited English proficient individuals eligible to be served or likely to be encountered in the eligible service population;
>
> (ii) [t]he frequency with which LEP individuals come in contact with the entity's health program, activity, or service;
>
> (iii) [t]he nature and importance of the entity's health program, activity, or service; and
>
> (iv) [t]he resources available to the entity and costs.

85 Fed. Reg. 37,245 (codified at 45 C.F.R § 92.101(b)).

57. By replacing the requirement to provide meaningful access to "each individual" with a generalized duty, eliminating the case-by-case review for compliance, and relegating enforcement to private complaints by LEP individuals, the new rule significantly weakens protections for LEP people.

58. The 2020 Rule makes it easier for entities to avoid providing any language assistance services by asserting that they serve too few LEP individuals or have insufficient resources to warrant providing language assistance services.[15] The requirement to provide language assistance services now only applies when the covered entity itself has determined that it is obligated to provide language access services at all. *Id.*

59. The 2020 Rule also deletes the 2016 Rule's notice and tagline requirements, leaving it in the covered entity's discretion to ascertain what, if any, information it will provide to LEP individuals on their rights to language assistance services. This change from protecting "each

[15] 85 Fed. Reg. 37,245 (§ 92.101(b)).

individual" to protecting LEP individuals in the aggregate means that enforcement of this requirement is now subject only to the implausible prospect of complaints by impacted LEP individuals. Yet in a catch-22, the 2020 Rule has simultaneously eliminated any required notice of their right to free translation services and of their right to notice about how to appeal the denial of language assistance services. In these circumstances the ability to file a complaint is self-evidently inadequate to ensure meaningful access. By not setting any requirements for covered entities to provide notice to LEP individuals, the 2020 Rule effectively delegates enforcement of compliance with language assistance requirements to the covered entities themselves.

60. HHS justified the removal of these notice and tagline protections based primarily on the costs associated with the 2016 Rule's tagline requirement. 85 Fed. Reg. 37,162, 37,211, 37,224, 37,227, 37,232. In so doing, Defendants failed to consider alternatives to removal, including the alternative recommended by covered entities themselves of simply reducing the frequency of notices or more narrowly defining significant communications and publications.

61. HHS found that at least *some* costs incurred by covered entities to comply with the 2016 Rule, "such as revising internal documents, IT costs, and setting up relationships with outside vendors" were "sunk." 85 Fed. Reg. 37,232. That is, covered entities would save no money by terminating some of the notices they have been providing. *Id.* Yet it concluded that while the final rule "does not prohibit entities from continuing to provide the type and number of notices and taglines required by the 2016 Rule," it nonetheless "gives covered entities the flexibility to *not* provide them." 85 Fed. Reg. at 37,232 (emphasis added). This was illogical and arbitrary. Having found that repealing the notice requirement "may impose costs, such as decreasing access to, and utilization of healthcare for non-English speakers," 85 Fed. Reg. 37,232, it made no sense to allow

covered entities to terminate those protections for which they would incur no, or at most, *de minimis* costs to continue to provide.

62. HHS also failed to adequately consider its previous position that in light of the importance of most covered entities' programs and activities, it expected most of them to provide, at a minimum, telephonic interpretation services. It also failed to adequately consider the harms of the 2020 Rule, including the cost of confusion engendered by the removal of taglines and notices, the impact of the rule change on access to care and treatment, LEP individuals' reliance on taglines and notice of rights, and the frustration of the ACA's mandate to expand access to healthcare. HHS did not sufficiently address its own prior finding in its 2016 Rule that the benefits of the notice and tagline requirements outweighed its costs, or why the benefits it found just three years prior in 2016 were no longer quantifiable.

63. Nor, even assuming the benefits were not quantifiable, did HHS even attempt to weigh the former rule's costs against the substantial *qualitative* benefits identified by commenters and recounted at length by the agency itself.[16] There is no dispute that such qualitative benefits

[16] *See, e.g.,* 85 Fed. Reg. at 37,165 ("the proposed rule ignores the costs to individuals, especially LEP individuals, who will allegedly encounter additional barriers to healthcare as a result of the proposed change"); *id.* at 37,175 ("the proposed changes . . . will lead to confusion among individuals and lead healthcare providers to discriminate based on race, color, and national origin" and "will result in LEP beneficiaries having less knowledge of available language assistance services"); *id.* at 37,204 (removing language access protections "may result in decreased access to, and utilization of, healthcare by . . . people with LEP"); *id.* at 37,210 ("this change will result in a number of LEP individuals unable to access healthcare, and will contribute to discrimination and to healthcare disparities for LEP individuals"); *id.* at 37,211 ("informed consent is compromised when a language barrier prevents a patient from understanding what he or she is consenting to" and "individuals with LEP face unique challenges in healthcare that are mitigated by language access services,,…the proposed rule might weaken access by patients with LEP to quality healthcare, resulting in patients' avoiding or postponing the medical care they require out of fear of discrimination or mistreatment due to their national origin or the language they speak"); *id.* at 37,212 ("the proposed rule will adversely affect patient-provider dialogue in addiction treatment programs"); *id.* at 37,234 (two commenters point to a 2017 study finding that easily accessible language interpretation services avoided an estimated 119 readmissions that were associated with savings of $161,404 per month in an academic hospital. Two commenters pointed to a 2010 report finding that at least 35 of 1,373 malpractice claims were linked to inadequate language access.")

exist. When proposing the 2020 Rule, HHS admitted that repealing the requirements for taglines could "[decrease] access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services." 84 Fed. Reg. at 27,855.

64. In finalizing the 2020 Rule, HHS erroneously concluded that elimination of the notice and tagline requirement would be offset by comparable notices required under existing regulations. 85 Fed. Reg. at 37223[17]. For example, HHS wrongly found that the eliminated notices and taglines were duplicative of requirements in other health programs and activities, including the tagline requirements for Medicare Advantage and Part D ("MA and PD") plans. 85 Fed. Reg. 37,231, 37,240. But HHS's response misstated its own guidance to MA and PD plans. The agency had already *eliminated* existing tagline requirements in its MA and PD plan guidance, effective 2020. *See* CMS, Medicare Communications and Marketing Guidelines (September 5, 2018), Appendix 2, (requiring entities to post taglines, also known as "disclaimers," in any non-English languages spoken by at least five percent of the plan's benefit package service area); CMS, Medicare Communication and Marketing Guidelines (Aug. 6, 2019) (removing the tagline requirements). In removing the Section 1557 tagline requirements, HHS left Medicare beneficiaries without any taglines on these important documents that would inform them of the availability of free language assistance services.

65. HHS found that the requirements in the 2016 Rule were duplicative of requirements in other statutes, without even acknowledging that its finding was contrary to HHS's explicit findings in the 2016 Rule.[18] HHS had previously found that the 2016 Rule's notice requirement is

[17] Finding that even an annual notice "would be largely duplicative of nondiscrimination notice requirements that already exist under Section 1557's underlying civil rights regulations."

[18] 81 Fed. Reg. at 31,377 ("OCR recognizes the efficiencies inherent in harmonizing regulations to which covered entities are subject under various laws. Indeed, entities covered under Section 1557 are likely also subject to a host of other laws and regulations, including CMS regulations, the Genetic Information Nondiscrimination Act of 2008,

more comprehensive than other requirements, and it had also previously determined that the Section 1557 notice would satisfy the Title VI notice requirement as outlined in 45 C.F.R. § 80.6(d), so that separate notices were not required. It had also done so for other required notices as long as the combined notice clearly informed individuals of their rights under Section 1557. That is, the 2016 Rule notice requirements provided the most comprehensive, yet concise, summary of an individual's rights under Section 1557; building on Section 504, Title VI, Title IX and the Age Discrimination Act such that the Section 1557 notice was more comprehensive and obviated the need for other notices.

66. The 2020 Rule prioritized cost savings rather than patient protection or eradicating discrimination. Where, as here, protection of patients and eradication of discrimination against individuals are the "principal objectives" of a statute, the agency charged with enforcing those objectives may not "prioritize non-statutory objectives to the exclusion of the statutory purpose." *Gresham v. Azar*, 950 F.3d 93, 104 (D.C. Cir. 2020), cert. granted, No. 20-37, 2020 WL 7086046 (U.S. Dec. 4, 2020), and cert. granted sub nom. *Arkansas v. Gresham*, No. 20-38, 2020 WL 7086047 (U.S. Dec. 4, 2020).

III. HHS's 2020 RULE FAILS TO PROTECT LEP INDIVIDUALS FROM DISCRIMINATION.

67. The 2020 Rule's elimination of the notice and taglines requirements and weakening of other protections for LEP individuals undermines access to healthcare. The purpose of the nondiscrimination provisions of the ACA was to address the discrimination and barriers to accessing healthcare faced by LEP individuals.

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the Family and Medical Leave Act, the ADA, Title VII of the Civil Rights Act of 1964, and State laws. OCR will coordinate as appropriate with other Federal agencies to avoid inconsistency and duplication in enforcement efforts."

68. Almost 68 million people in the U.S. speak a language other than English at home, and more than 25 million people are LEP, meaning they speak English less than "very well."[19] More than two million Medicare beneficiaries speak Spanish, more than 200,000 speak Chinese, and more than 150,000 speak Vietnamese.[20]

A. Plaintiff Chinatown Service Center

69. Chinatown Service Center is the largest community organization serving Chinese Americans and immigrants in Southern California. It has served the community for 50 years and provides services and advocacy that promote the health, dignity, and wellbeing of underserved communities and LEP immigrants.

70. CSC serves over 22,000 clients on an annual basis, and nearly 40% of CSC's clients are 60 years old or older.

71. CSC offers a variety of services to the community and operates a robust social services department with a team of case managers. One of CSC's social services is helping clients read letters. The "read-letter" service assists LEP clients by interpreting their letters and other important documents. These letters include communications from healthcare providers, insurers, government agencies, and others. Previously, CSC's LEP clients were able to rely on the language access protections under the 2016 Rule to facilitate their access to healthcare.

72. However, the elimination of the notice and tagline requirements has helped create an unprecedented demand for case management services. In the last four months of 2020, CSC's social services encounters more than doubled compared to 2019, averaging about 5,328 encounters per month compared to only 2,290 from 2019 for the same period. The same is true for CSC's

[19] U.S. Census Bureau, *Characteristics of People by Language Spoken at Home, American Community Survey 1-Year Estimates*, tbls. S1601, S1603 (2018), https://data.census.gov/cedsci/table?q=language&hidePreview=false&tid=ACSST1Y2018.S1601.
[20] CMS Office of Minority Health, *supra* note 7.

"read letter" services, which climbed to almost 2,000 in the last four months of 2020 compared to only 1,337 compared to the same period in 2019.

73. The increased demand for language assistance services has significantly strained CSC's resources and operations. Outside their offices during the COVID-19 public health emergency, they have witnessed long lines of mostly LEP older adults waiting for assistance from case managers.

74. CSC has had to prioritize certain types of cases over others, taking on about fifty fewer Housing Choice Voucher Program Section 8 applications and determinations, which can be time intensive, compared to 2019.

75. Given the surge, CSC has also experienced difficulty meeting grant deliverables for funding to support its Medi-Cal enrollment and immigration naturalization programs. It had to pay case managers overtime and bring on more volunteers than in years past.

76. As Los Angeles County prepares to vaccinate individuals 65 years old and older, CSC has received requests from its LEP older adult clients to assist them with registering for vaccine appointments since the county's webpage and telephone hotline, the two primary ways to make an appointment, contain inadequate language access options.

B. Plaintiff Saint Barnabas Senior Services

77. Saint Barnabas Senior Services is a non-profit social services agency that operates three senior centers in Los Angeles. Founded in 1908, SBSS strives to empower a diverse community of older adults to live well, feel well, and age well in the community with dignity and respect.

78. In 2020, SBSS served over 11,000 older adults, providing them nutrition, health and wellness programs, and case management services. Over 70% of its clients are LEP, 94% live below the poverty line, and many depend on Medicare and Medicaid for their healthcare coverage.

79. SBSS's case managers routinely assist its clients in navigating the healthcare system, and beginning in January 2021, as Los Angeles County began to allow individuals 65 years and older to get the COVID-19 vaccine, SBSS began receiving many vaccine-related inquiries.

80. One of the primary issues its older adults are reporting is difficulty understanding vaccine-related information because some of the materials, like post-care instructions, are not available in their language, nor do they come with in-language taglines. Furthermore, the county health department does not advise them of their rights to free language assistance services in the vaccine process.

81. The Los Angeles County COVID-19 vaccine telephonic hotline and webpage are available in English and Spanish. The webpage also features a small, inconspicuous globe icon on the top left-hand corner next to the word "Translate" that embeds an automated Google translation in various languages.

82. The lack of in-language translation options has required SBSS's staff to spend more time helping LEP older adults access vaccine appointments. Because of language barriers, several of SBSS's clients have reported having to wait for the organization's case managers to help register them for an appointment, resulting in a delay in their vaccination date.

83. Nothing in the registration process notifies the individual about their right to a free, qualified interpreter. Therefore, LEP older adults ask SBSS staff to accompany them to help them interpret during the vaccination process.

84. The increased demand for language assistance services has significantly strained SBSS's resources and operations. The organization has limited funding to provide transportation services, and the more rides given to older adults with their case managers to assist them in

interpreting, the fewer rides the agency can provide to clients for other vital healthcare appointments.

85. In addition, SBSS is preparing to alter its meal delivery program, one of its core services. Because the staff who deliver meals are the same staff to transport clients to medical services, it will need to adjust the meal delivery schedule to accommodate for increased trips to take LEP older adults to the vaccination centers and help with interpretation. If the county properly advised LEP older adults of their right to language assistance services, our staff would not need to accompany them, freeing up more resources to continue delivering meals as usual.

86. SBSS is concerned that the demand for language assistance services in the vaccine process among its LEP older adults will impair its ability to meet grant deliverables under contracts with the local Department of Aging. They have been forced to reallocate funds typically used for other services to meet the language-assistance surge related to the vaccine.

C. Older Adults with Limited English Proficiency are Uniquely Harmed

87. Particularly harmed by the 2020 Rule are older LEP individuals. Older Medicare beneficiaries may not be savvy with digital communication methods and thus rely primarily on paper documents, including educational materials and medical bills sent via mail.[21] There are more than 6.5 million people over the age of 60, including four million Medicare beneficiaries, who are LEP.[22]

[21] *See, e.g.*, Comments of American Society of Cataract and Refractive Surgery (August 9, 2019), p. 2, *available at* https://www.regulations.gov/document?D=HHS-OCR-2019-0007-97638.
[22] *See, e.g.*, Comments of JIA, p. 2.

88. People age 65 and older need access to healthcare the most: individuals 65 years and older represent 15 percent of the population, but use medical services more frequently than their younger counterparts.[23]

89. When health entities fail to provide interpretation and other language assistance services, they deny LEP individuals the ability to meaningfully access healthcare services, assess options, express choices, follow medication instructions, ask questions, and seek assistance.[24] LEP patients often receive a lower quality of care than English-proficient patients, in terms of incidence of medical errors and understanding of the treatment plans.[25] Removing the protections of the 2016 Rule exacerbates these inequities in healthcare delivery — the very inequities Section 1557 was created to address. Indeed, Spanish-speakers "are less likely than English-speakers to say they understand the services covered by their plan and their out-of-pocket costs well" and "more likely to experience gaps in their coverage….reporting they need services that are not covered by their

[23]National Health Expenditure Fact Sheet, Centers for Medicare & Medicaid Services, *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet#:~:text=Medicare%20spending%20grew%206.7%25%20to,16%20percent%20of%20total%20NHE.&text=The%20largest%20shares%20of%20total,the%20households%20(28.4%20percent).

[24] Nat'l Health Law Program & Access Project, *Language Services Action Kit, 40* (Feb. 2004), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2002_may_providing_language_interpretation_services_in_health_care_settings__examples_from_the_field_lep_actionkit_reprint_0204_pdf.pdf.

[25] Alexander R. Green & Chijioke Nze, *Language-Based Inequity in Health Care: Who is the "Poor Historian"?*, American Medical Association Journal of Ethics, 263-271 (Mar. 2017), https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/medu1-1703.pdf. *See also* 63 Elizabeth A. Jacobs, et. al., Shared Networks of Interpreter Services, At Relatively Low Cost, Can Help Providers Serve Patients With Limited English Skills, Health Affairs, Vol. 30, No. 10, (Oct. 2011), *available at* https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0667. (finding that although translation services may lead to a marginal increase in operating costs for healthcare providers, these costs are far outweighed by the costs associated with "medical errors, greater malpractice risk, poor quality of care, and disparities in morbidity and mortality between English-speaking patients and those with limited English proficiency.").

plan."[26] Lack of knowledge about language services could further exacerbate these issues, potentially leading to gaps in crucial services for LEP individuals.[27]

90. By contrast, access to qualified interpreter services for patient care has been demonstrated to reduce errors in communication, significantly shorten hospital stays, reduce 30-day readmission rates, and improve overall patient satisfaction.[28]

91. By removing tagline requirements for healthcare entities, the 2020 Rule diminishes public knowledge of the means and methods for accessing healthcare and health insurance. The standardization and posting requirements for taglines under the 2016 Rule alerted both the public and providers of the critical importance and availability of free, qualified interpreter services. Their elimination hampers the ability of LEP individuals to know about their rights to language assistance services and to demand those services. LEP individuals are no longer regularly informed of their rights that allow them to meaningfully access the programs and services available to them.

92. HHS's removal of notice of non-discrimination requirements renders LEP people less able to address any form of discrimination they may experience. When healthcare providers impose significant delays in the provision of interpreters or require LEP persons to rely on

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[26] Samantha Artiga, et al., *The Role of Language in Health Care Access and Utilization for Insured Hispanic Adults* at 5, KAISER COMMISSION ON MEDICAID AND THE UNINSURED (Nov. 2015), *available at* http://files.kff.org/attachment/issue-brief-the-role-of-language-in-health-care-access-and-utilization-for-insured-hispanic-adults. (Cited in Comments of APIAHF, p. 23).

[27] Another study found that "some degree of detectable physical harm occurred in 49.1% of reported LEP patient adverse events, whereas only 29.5% of reported adverse events for patients who speak English resulted in detectable physical harm." Further, the study stated that "half (52.4%) of the adverse events experienced by LEP patients were attributable to some failure in communication, compared with 35.9% for English speaking patients." Chandrika Divi et al., Language proficiency and adverse events in US hospitals: a pilot study, 19 INT'L J. QUALITY HEALTH CARE 60, 62 (2007), https://academic.oup.com/intqhc/article/19/2/60/1803865. The data underscores the crucial nature of language services for LEP individuals. Without these services, LEP individuals can face severe health consequences. In addition, LEP individuals without an interpreter on the date of admission and date of discharge had longer hospital stays than those with interpretation services. Mary Lindhom et al., *Professional Language Interpretation and Inpatient Length of Stay and Readmission Rates*, 27 J. GEN. INTERNAL. MED. 1294, 1297-98 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3445680/pdf/11606_2012_Article_2041.pdf.

[28] *See, e.g.*, Mary Lindhom et al., *Professional Language Interpretation and Inpatient Length of Stay and Readmission Rates*, 27 J. GEN. INTERNAL. MED. 1294, 1297-98 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3445680/pdf/11606_2012_Article_2041.pdf.

unqualified informal or family-member interpreters, the LEP person will face wrongful communication barriers to care. But under the 2020 Rule, they are not notified of their rights, so they have not been informed that such actions are impermissible discrimination or how to file a complaint to remedy such discrimination.

93. The COVID-19 pandemic makes language access services especially critical, as healthcare providers must quickly triage patients of all backgrounds according to their symptoms and public health officials attempt to distribute information and guidance documents to diverse communities. Early reports indicate that LEP patients may face worse outcomes when seeking emergency care for COVID-19 symptoms and have experienced significant difficulty accessing interpreter services in the face of overly taxed healthcare systems.[29]

CLAIMS FOR RELIEF

COUNT ONE

Violation of APA § 706(2)(A), (C) – Not In Accordance with Law and in Excess of Statutory Authority

94. Plaintiffs reallege and incorporate by reference all preceding paragraphs.

95. Section 1554 of the ACA, as noted *supra*, Complaint ¶ 29, forbids the HHS Secretary, *inter alia*, from promulgating "*any* regulation" that impedes timely access to healthcare services or interferes with communications regarding a full range of treatment options between the patient and provider (emphasis added).

[29] *See e.g.*, David Velasquez, *et al.*, *Equitable Access to Health Information for Non-English Speakers Amidst the Novel Coronavirus Pandemic*, Health Affairs (Apr. 2, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200331.77927/full/; Claudia Boyd-Barrett, *Community Groups Serve as Pandemic Information Lifeline to Non-English Speakers, California Health Report* (Mar. 31, 2020), https://www.calhealthreport.org/2020/03/31/community-groups-serve-as-pandemic-information-lifeline-to-non-english-speakers/.

96. By HHS's own account, the 2016 Rule facilitated access to healthcare by increasing LEP individuals' understanding of their rights and improving their ability to communicate with providers about treatment options. 85 Fed. Reg. at 37,162.

97. The 2020 Rule's elimination of the protections accorded to LEP individuals under the 2016 Rule was a facially prohibited regulation that impeded timely access to healthcare services and interfered with an LEP individual's communications regarding a full range of treatment options.

98. The 2020 Rule violates Section 1554 of the ACA, 42 U.S.C. § 18114, because it removes protections in the 2016 Rule designed to reduce barriers to, and ensure timely access to healthcare; and thus creates unreasonable barriers to care, impedes timely access to healthcare services, and limits the availability of healthcare treatments. The 2020 Rule's language access provisions interfere with communications regarding a full range of treatment options between LEP patients and their providers, and loosen the requirements on healthcare providers and insurers to provide full disclosure of all relevant information to LEP individuals making healthcare decisions.

99. Section 1557 provides that "an individual shall not…be excluded from participation in, be denied the benefits of, or be subject to discrimination under any health program or activity." 42 U.S.C.…." §18116(a). Yet, contrary to the statute, HHS replaced the assessments of each individual's needs under the 2016 Rule with a rule that aims only to, at best, the needs of LEP individuals as a group at large. The 2020 Rule places the onus on LEP individuals to file complaints of inadequate language assistance services, while also removing notice of how to file such complaints altogether.

COUNT TWO

**Violation of APA § 706(2)(A)–Arbitrary and Capricious–
Failure to Weigh Rule's Harms Against Putative Benefits or to Support its Conclusions with Substantial Evidence**

100. Plaintiffs reallege and incorporate by reference all preceding paragraphs.

101. The elimination of the 2016 Rule and promulgation of its 2020 Rule replacement is arbitrary and capricious because the Department failed to weigh the alleged harm caused by the 2020 Rule against the benefits the agency had found that the 2016 Rule's notice and tagline requirements provided to LEP individuals.

102. While HHS had authority to devise regulations that would implement the statute's objectives in the most efficient and economical manner, it was not free to prioritize costs — even assuming its cost assessment was supportable — over the statute's purpose of eradicating discrimination in healthcare coverage. Its 2020 Rule impermissibly conflated promotion of cost cutting with cost-efficient implementation of statutory objectives.

103. An agency action is arbitrary and capricious where "the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co*., 463 U.S. 26, 43 (1983). And "an agency changing its course by rescinding a rule is obligated to supply a reasoned analysis for the change beyond that which may be required when an agency does not act in the first instance." *Id*. at 42. "Nodding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decision making." *Gresham*, 950 F. 3d at 104. The 2020 Rule repeals the 2016 notice and tagline requirements based

on its determination that the 2016 Rule imposed substantial administrative costs on covered entities that the agency had not anticipated at the time the earlier rule was adopted. 85 Fed. Reg. 37,231, 37,162-63. But it never attempts to ascertain whether these added costs — even if correctly calculated[30] — exceeded the benefits of the former rule. Nor did it tackle evidence presented in comments that its calculations were faulty and greatly overstated the costs of complying with the 2016 Rule.[31]

104. HHS's failure was arbitrary and capricious because: (1) it ignored its obligations to at least make "an attempt at empirical justification,"[32] (2) it failed to analyze comments that the 2016 Rule had yielded quantifiable benefits, and (3) it arbitrarily ignored the findings in its 2016 Rule that the benefits exceeded the costs.

COUNT THREE

Violation of APA § 706(2)(A)–Arbitrary and Capricious–
Failure to Consider Unchanged Facts

105. Plaintiffs reallege and incorporate by reference all preceding paragraphs.

106. "[A]n agency's decision to change course may be arbitrary and capricious if the agency ignores or countermands its earlier factual findings without reasoned explanation for doing

[30] To arrive at its estimated costs savings on postage, printing and mailing the 2020 Rule "*assumes* that health insurance entities would not voluntarily append notices and taglines to routine monthly premium statements absent the 2016 Rule, but are doing so because of it (or because of a requirement in another regulation that bases its requirement on the 2016 Rule's requirement)." 85 Fed. Reg. at 37321 (emphasis added). HHS offers no evidence to support its assumption, but the validity of its assumption is critical to the accuracy of its savings calculation. If even *some* health insurance entities would have voluntarily appended notices in the absence of the 2016 rule the savings HHS estimates are overstated.

[31] As was described more thoroughly in the comments by National Health Law Program, in calculating costs, HHS appears to have used information from just a few insurers and pharmacy benefit managers and extrapolated that data to the entire healthcare system. In addition, the examples provided by the Office of Management and Budget from entities concerned about costs demonstrated that the sample taglines often went far beyond that which was required, either included more than 15 languages or a tagline more comprehensive than the 19-word English tagline provided as a sample. Thus, as the National Health Law Program concluded, "HHS cannot rely on inflated costs from an extremely small sample as justification to repeal this provision." Comments of National Health Law Program ("NHeLPNHLP") (August 12, 2019), pp. 69-70, *available at* https://healthlaw.org/resource/nhelp-comments-on-proposed-rulemaking-for-section-1557-nondiscrimination-in-health-and-health-education-programs-or-activities/.

[32] *Ill. Commerce Comm'n v. FERC*, 756 F.3d 556, 561, 564–65 (7th Cir. 2014).

so. An agency cannot simply disregard contrary or inconvenient factual determinations that it made in the past, any more than it can ignore inconvenient facts when it writes on a blank slate." *FCC v. Fox Television Stations, Inc*., 556 U.S. 502, 557 (2009) (Kennedy, J., concurring); *accord Organized Village of Kake v. Dept. of Agriculture*, 795 F.3d 956, 969 (9th Cir. 2015) (en banc) (an agency's change in policy when there has been no demonstrated change in the underlying facts, but only a change in the Administration, is arbitrary and capricious).

107. The 2020 Rule is arbitrary and capricious because the record does not demonstrate that HHS considered facts that were accepted as part of the 2016 Rule, and for which there was no material change in the intervening four years.

108. The notice and tagline requirements of the 2016 Rule were predicated, as noted at ¶ 10, in substantial part, on evidence that LEP individuals face discrimination and other barriers to healthcare, with negative downstream consequences on individual health, community healthcare, and the distribution of healthcare resources. *See* 81 Fed. Reg. 31,431, 31,459. Without those protections, HHS further found, LEP individuals would delay care or not seek it at all and providers would face malpractice claims. *Id.*

109. By HHS's own account, these underlying facts have not changed. In rolling back the protections in the 2016 Rule, HHS did not attempt to rebut its earlier factual findings showing the pervasiveness of discrimination and health barriers to LEP individuals and members of other protected groups. Nor could it — the administrative records developed through the 2013 RFI, 2015 NPRM, and 2019 NPRM demonstrate the significant and ongoing barriers to healthcare imposed by discrimination by healthcare providers and health insurers. Unlike the 2016 Rule, which properly considered the public health costs of delayed or denied care resulting from discrimination in its cost-benefit analysis, the Department's regulatory impact analysis in the 2020 Rule was silent

on adverse public health effects, and the related costs to individuals, state and local governments, providers, and insurers, rendering the cost-benefit analysis fundamentally flawed and unreliable.

COUNT FOUR

Violation of APA § 706(2)(A)–Arbitrary And Capricious– Failure to Consider Alternatives

110. Plaintiffs reallege and incorporate by reference all preceding paragraphs.

111. It was arbitrary and capricious for HHS to promulgate the new 2020 Rule without considering alternatives to repeal of the notice and tagline protections afforded by the 2016 Rule.

112. "An agency is required to consider responsible alternatives to its chosen policy and to give a reasoned explanation for its rejection of such alternatives." *Am. Radio Relay League, Inc. v. FCC*, 524 F. 3d 227, 242 (D.C. Cir. 2008) (internal quotations omitted).

113. HHS treated its alternatives as a binary choice between retaining and repealing the 2016 Rule's notice and tagline provisions. It considered no alternatives to outright repeal, a lapse that was arbitrary and capricious.

114. Citing to its concerns about the costs of continued application of the prior Rule's notice and tagline requirements, HHS invited comments. While an agency's obligation to consider alternatives "extends only to 'significant and viable' alternatives,'" *Id.* (quoting *Farmers Union Central Exchange v. FERC*, 734 F.2d 1486, 1511 n.54 (D. C. Cir. 1984)), very few of the comments from covered entities cited by HHS called for complete abolishment of the notice and tagline requirements. Instead, most proposed that notice be furnished on an annual basis, when updated, and upon request.[33]

[33] *See, e.g.*, Comments of Viva Health (August 13, 2019), p. 1, *available at* https://www.regulations.gov/document?D=HHS-OCR-2019-0007-127421 . Another commenter also suggested sending the long form notice and taglines to enrollees once per year. *See* Comments of EmblemHealth (August 13, 2019), p. 2, *available at* https://www.regulations.gov/document?D=HHS-OCR-2019-0007-147348.

115. Some covered entities recommended modifying the notice requirement to an annual notice of rights rather than requiring notice with each significant communication. While HHS expressed concerns about printing and mailing costs, a rule that narrowed the universe of communications and publications requiring taglines and notices would have caused less harm, for example, as would creating waiver provisions for covered entities claiming hardship or undue burden.[34]

COUNT FIVE

Violation of APA § 706(2)(A)–Arbitrary and Capricious–
Failure to Give Reasoned Consideration to Comments

116. Plaintiffs reallege and incorporate by reference all preceding paragraphs.

117. The 2020 Rule is arbitrary and capricious because of the Department's failure to provided reasoned consideration to the overwhelming number of comments that were contrary to the 2020 Rule.

118. Where, as here, "a party seeks review of agency action under the APA [], the district judge sits as an appellate tribunal. The ''entire case' on review is a question of law." *Am. Bioscience, Inc. v. Thompson*, 269 F.3d 1077, 1083 (D.C. Cir. 2001). And, in such cases, where a party raises serious, material arguments, "it most emphatically remains the duty of [the reviewing] court to ensure that an agency engage the arguments raised before it - that it conduct a process of reasoned decision making." *NorAm Gas Transmission Company v. FERC*, 148 F.3d 1158, 1165 (D.C. Cir. 1990).

119. Not only was HHS's failure to consider alternatives to repeal of the 2016 Rule's notice and tagline requirements and its failure to give weight to the harms of repeal identified by

[34] HHS itself identified cost saving alternatives. It considered "limiting the frequency of required mailings to one per year to each person served by the covered entity," a step that it said would reduce the regulatory impact cost "significantly," down to $63 million, 2020 Rule, 85 Fed. Reg. 37223.

commenters arbitrary, its failure even to consider these comments was itself arbitrary and capricious.

COUNT SIX

Violation of APA § 706(2)(A)–Arbitrary and Capricious– Disconnect Between Facts Found and Choice Made

120. Plaintiffs reallege and incorporate by reference all preceding paragraphs.

121. The 2020 Rule is arbitrary and capricious because its findings are inconsistent with regulations it adopted in the 2020 Rule.

122. To avoid being arbitrary, an agency must demonstrate a "rational connection between the facts found and the choice made." *United States v. State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29, 43 (1983).

123. HHS found that at least *some* costs incurred by covered entities to comply with the 2016 Rule, "such as revising internal documents, IT costs, and setting up relationships with outside vendors" were "sunk." 85 Fed. Reg. 37,232. That is, covered entities would save no money by terminating some of the notices and taglines they have been providing. *Id.*

124. HHS then concluded that while the final rule "does not prohibit entities from continuing to provide the type and number of notices and taglines required by the 2016 Rule," it nonetheless "gives covered entities the flexibility to *not* provide them." 85 Fed. Reg. 37,232 (emphasis added).

125. This conclusion makes no sense. Having found that certain costs of compliance were sunk *and* that repealing the notice and tagline requirement "may impose costs, such as decreasing access to, and utilization of healthcare for non-English speakers," 85 Fed. Reg. 37,232, HHS's 2020 Rule illogically allows covered entities to stop providing even those beneficial

services for which it admits the costs are already sunk, meaning they are services it costs covered entities nothing to provide.

COUNT SEVEN

Violation of APA § 706(2)(A)–Arbitrary and Capricious– Failure to Consider Reliance Interests

126. Plaintiffs reallege and incorporate by reference all preceding paragraphs.

127. It was arbitrary and capricious for HHS to toss aside the 2016 Rule without considering the damage being done to legitimate reliance interests of persons who relied in good faith on the protections afforded by the ACA as implemented through the 2016 Rule.

128. An agency must also consider "serious reliance interests" when, as here, it departs from a longstanding policy. *Dep't of Homeland Sec. v. Regents of the Univ. of California*, 140 S. Ct. 1891, 1913 (2020) (quoting *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016)) (holding that DHS's rescission of the Deferred Action for Childhood Arrivals ("DACA") program was arbitrary and capricious, in part for its failure to account for reliance interests).

129. Although it received comments pointing out that repeal of the 2016 Rule regarding notice and tagline requirements would harm LEP individuals and others that relied on the 2016 Rule, the agency failed to address those concerns, instead stating that "[i]t is unfortunate that, by administrative action, the 2016 Rule may have unreasonably raised expectations about nondiscrimination protections that are not found in the underlying statutes, but this final rule cannot be held responsible for that." 85 Fed. Reg. 37,166.

130. HHS also arbitrarily failed to address requests to clarify the basis for its findings. The 2019 NPRM received nearly 200,000 comments,[35] with the vast majority of comments that were related to the notice and tagline provisions requesting clarification on the meaning of

[35] 85 Fed. Reg. 37,164.

"significant" publications and communications. HHS cited no comments seeking an outright repeal of such portions of the 2016 Rule. It declined to clarify what was meant by "significant" documents and communications in its 2020 revision, merely stating that "the requirements were not mandated by statute," and then issuing the hand-waving argument that HHS "believes that other protections…better serve the language access needs of LEP individuals" without clarifying what those protections were. *See* 85 Fed. Reg. 37,176.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court:

1. Declare that the 2020 Rule is arbitrary, capricious, an abuse of discretion, or not in accordance with law within the meaning of 5 U.S.C. § 706(2)(A);

2. Declare that the 2020 Rule is in excess of the Department's statutory jurisdiction, authority, or limitations, or short of statutory right within the meaning of 5 U.S.C. § 706(2)(C);

3. Vacate and set aside the 2020 Rule;

4. Enjoin the Department and all its officers, employees, and agents, and anyone acting in concert with them, from implementing, applying, or taking any action whatsoever under the 2020 Rule;

5. Award reasonable attorneys fees and costs to plaintiffs' counsel; and

6. Grant such other relief as the Court deems just and proper.

Dated February 5, 2021

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**Motion for admission pro hac vice pending*.
*** Admission to the U.S. District Court for the District of Columbia pending.*

Respectfully submitted,

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