

October 26, 2017
U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Strategic Planning Team
Attn: Strategic Plan Comments
200 Independence Avenue, SW, Room 415F
Washington, DC 20201
Email: HHSPlan@hhs.gov

To Whom It May Concern:

The U.S. Department of Health and Human Services (HHS) strategic plan lays out the goals, strategies, and future work of HHS, a department that serves every person in this country with regards to their health care needs. From implementation of the Affordable Care Act to improving the overall delivery of quality, affordable health care, HHS has a responsibility to provide access to care and protect the health and well-being of each person. The strategic plan lays out the values and work of the department, and must reflect the values and needs of all communities, including children, women, the elderly, LGBT people, people with disabilities, and people with limited English proficiency.

We, the undersigned, write to you to express grave concern about the exclusion of lesbian, gay, bisexual, and transgender (LGBT) people as a population from the HHS Strategic Plan FY 2018-2022. This significant omission calls into question HHS' dedication to "to advancing the health and well-being of all lesbian, gay, bisexual, and transgender...communities."¹

At the outset, the document fails to recognize that people who experience multiple forms of discrimination often face more severe negative health outcomes that demand multifaceted interventions. For example, low-income black women living in the South are more likely to be living with HIV than are their wealthy white male counterparts living in other parts of the United States.² Negative health outcomes uniquely impact young people and disproportionately impact marginalized communities who face various socioeconomic, cultural, and educational barriers to health services and other resources that can help improve health outcomes.

The strategic plan also contains language that, depending on application and interpretation, will likely create greater barriers to accessing health care. For example, the plan contains several references to serving and protecting individuals at every stage of life, beginning at conception. The references to life beginning at conception have been used by anti-abortion advocates who seek to limit access to the full range of reproductive health care services. The contention that life begins at conception is not supported by medicine or science and only serves to undermine the right to abortion access. In addition, it stands in direct contravention of the constitutional right to abortion that was guaranteed by the U.S. Supreme Court in 1973 in *Roe v. Wade*. We strongly recommend the elimination of any unconstitutional references to life beginning at conception and protecting the rights of the "unborn."

While the plan promises to protect the "unborn," it lays out little to help some existing marginalized communities. While the concept of "life beginning at conception" is mentioned

five times in the strategy, there is almost a complete absence of addressing maternal health. We appreciate the effort to increase access to preventive services and parenting classes as well as health services that improve the incidence of healthy childbirth. However, there is no mention of continued access to wellness visits through all stages of women's lives, including increasing access to the full range of reproductive health care services. Women's health care services should not solely be tied to pregnancy, birth, and care for an infant.

At several points throughout the strategic plan, the term "family" or "families" is used. We believe that there are many ways to be a family and are concerned that HHS may be defining family very narrowly given the absence of any mention of LGBT people and no discussion of racial and ethnic health disparities.

The complete absence of any mention of LGBT people is unacceptable and harmful. The erasure of LGBT people amounts to discrimination by omission. LGBT people are disproportionately impacted by health care inequities such as facing significant barriers to accessing care and feeling discriminated against or stigmatized by health care providers. Due to these and other factors, LGBT people face higher rates of HIV/AIDS, depression, PTSD and other mental health disabilities, an increased risk of some cancers, and are twice as likely as their heterosexual peers to have a substance use disorder.³ We strongly recommend that the draft strategic plan be revised to include interventions aimed at addressing the health and well-being of LGBT people.

LGBT people experience widespread health care disparities and are considered a vulnerable population. Transgender people in particular are at higher risk for a range of poor health outcomes. For example, the 2015 U.S. Transgender Survey, a national study of nearly 28,000 transgender adults, found that respondents were nearly five times more likely to be living with HIV than is the general population, with even higher rates for transgender women of color.⁴ For example, nearly one in five (19%) Black transgender women are living with HIV, more than 63 times the rate in the general population.⁵ Transgender respondents were nearly eight times more likely than the general population to be living with serious psychological distress based on the Kessler 6 scale, with higher rates correlating with experiences of discrimination, violence, and rejection.⁶ Transgender people are also much more likely to have a disability, with 39% of respondents answering positively to having a disability compared to 15% of the general population.⁷ The medical community and scientific research have repeatedly demonstrated that the poor health outcomes that LGBT people experience are associated with high rates of poverty, discrimination in the workplace, schools, and other areas, and barriers to nondiscriminatory health care that meets their needs. The Office of Disease Prevention and Health Promotion recognized these disparities in the LGBT community and made it a goal of the Healthy People 2020 report to improve the health, safety, and well-being of LGBT people.⁸ LGBT people were included in a number of other health objectives in the report, including mental health and mental illness, tobacco use, usual source of care, and health insurance coverage.⁹ In addition, the National Institute of Health (NIH) has formally designated sexual and gender minorities as a health disparity population in 2016 for NIH research.¹⁰

A major factor in these health disparities is the discrimination that LGBT people face when trying to access health care. While the Affordable Care Act significantly increased the percentage of LGBT people with insurance and helped prohibit discrimination against LGBT

people in coverage and care, LGBT people are still more likely than are non-LGBT adults to lack insurance and LGBT people still face discrimination.¹¹ A recent survey found that transgender LGB respondents were over five times more likely to avoid doctor's offices just to avoid the risk of experiencing discrimination than were their non-transgender LGB counterparts.¹²

Additionally, the 2015 U.S. Transgender Survey found that, just in the past year, 33% of those who saw a health care provider face some form of mistreatment or discrimination because of being transgender, such as being refused care, harassed, or physically or sexually assaulted, and 23% avoided seeing a doctor when needed due to fear of discrimination.¹³ We expect HHS to continue serving LGBT people and believe the strategic plan is an ideal opportunity for HHS to show that it plans to engage in targeted efforts to ensure that vulnerable populations like LGBT communities get the health care they need.

It is our request that the plan be revisited to take into consideration the large body of research clearly

demonstrating the need for specific and competent inclusion of LGBT people in all aspects of efforts to improve the health of all people in the U.S. In particular, we urge HHS to address the following points:

Increase Health Equity and Eliminate Health Disparities Faced by the LGBT Community

In previous strategic plans, HHS included explicit references to the LGBT population when discussing goals related to providing access to quality, competent care, improving data collection, supporting the healthy development of youth, and expanding access to culturally competent services, among other goals. Given the acknowledged health disparities that face the LGBT community, we urge HHS to continue to incorporate equity initiatives into its plans and programs.

- **Encourage Marketplace participation and ensure that there are no “bare” counties nationwide.**¹⁴ HHS should use its existing authority to continue to work with states to ensure that all consumers have a choice of plan in their county. For example, HHS should work with insurers to encourage and maximize Marketplace participation and avoid bare counties. Having counties without any insurer participating in the Marketplace would severely limit consumer choice, especially for low-income consumers who rely on premium tax credits that are only available through the Marketplaces. LGBT people are much more likely to be living in poverty than are their non-LGBT counterparts, and they are therefore more affected by bare counties.¹⁵
- **Ensure coverage of Essential Health Benefits (EHBs).** We urge HHS to guarantee EHBs to ensure a fair and affordable individual market. We also stress the importance of continuing to apply the EHB requirements to all issuers providing Qualified Health Plans (QHPs).¹⁶ This includes the prohibition of discrimination on the basis gender identity and sexual orientation.
- **Maintain nondiscrimination protections under Section 1557.** The final rule on Nondiscrimination in Health Programs and Activities clarifies nondiscrimination protections under Section 1557 of the ACA prohibiting discrimination based on health status, disability, age, race, gender, gender identity, and sex stereotyping,

among other factors.¹⁷ The rule went through a multi-year process of study and public input and incorporated over 20,000 public comments. The final rule ensures consumers receive the full benefit of coverage. It also clarifies that the Affordable Care Act's prohibition on sex discrimination guarantees access to health insurance coverage and health care for all individuals regardless of their gender identity or nonconformity with sex stereotypes. The rule is particularly important in addressing insurance discrimination against transgender people, who previously frequently encountered discriminatory insurance plan exclusions that denied them coverage for medically necessary care related to gender transition, even though the same services and procedures were routinely covered for non-transgender individuals.¹⁸ These protections are critical to addressing the barriers to coverage and care that LGBT people across the country routinely experience, such as health care providers using harsh or abusive language, blaming patients for their health status, being physically rough or abusive, or refusing care outright.¹⁹ As the Institute of Medicine has noted, discrimination and mistreatment by health care providers contribute to distrust of the health care system among many LGBT people and perpetuate disparities such as higher rates of smoking and tobacco use, higher incidence of depression and other mental health concerns, greater risk of HIV infection, and a lower degree of access to preventive screenings for conditions such as breast and cervical cancer.²⁰ Section 1557 protections are vital to addressing discrimination against LGBT individuals in health care settings and we urge HHS to maintain the current rule.

- **Explicitly include LGBT individuals in HHS's key goals to improve health care access.** LGBT people should explicitly be included in the populations at risk for limited health care access and HHS's efforts to assist them to access health services, as well as HHS's health promotion and wellness strategies that focus on specific populations at risk for poorer health outcomes. HHS's production and promotion of patient-centered health care delivery methods and interventions should also be inclusive of the needs of LGBT individuals.
- **Explicitly include transgender people in objectives focused on increasing economic opportunity.** The 2015 U.S. Transgender Survey revealed extensive workplace discrimination. For example, in the past year, nearly one-third (30%) of transgender workers report being fired, denied a promotion, or experiencing some other form of mistreatment in the workplace because of their gender identity or expression.²¹ Additionally, respondents were three times as likely to be unemployed as the general population.²² Discrimination at work and at school contribute to high rates of economic insecurity for transgender people. The same survey found that 29% of all respondents were living in poverty in 2015, more than twice the rate in the general population at the time the survey was taken (12%), with especially high rates of poverty among transgender people of color and transgender people with disabilities.²³ For these reasons, transgender people must be explicitly included in objectives focused on increasing economic opportunity, including, specifically, Objective 3.1 ("Encourage self-sufficiency and personal responsibility, and eliminate barriers to economic opportunity").
- **Explicitly include LGBT older adults and LGBT people with disabilities**

There are an estimated 2.7 million LGBT adults ages 50 or older living across the country.²⁴ A lifetime of discrimination, especially in housing and employment, and a long-term lack of legal and social recognition combine to create deep economic insecurity for LGBT elders. For example, 40% of LGBT adults ages 80 and older report living at or below 200% of the federal poverty level.²⁵ Research finds that these LGBT adults are frequently disconnected from traditional networks that support older Americans as they age. A reliance on chosen family, due to family rejection and legalized discrimination, creates social isolation and vulnerability for LGBT elders. The Department of Health and Human Services has previously identified LGBT elders as an “underserved population.”²⁶ Additionally, long-term discrimination, combined with a lack of competent, inclusive health care, leads to specific mental and physical health disparities. A study of older LGBT adults in California found that gay and bisexual men are more likely to report hypertension, diabetes, physical disability, and poor health status than are heterosexual men.²⁷

The same study of older LGBT adults in California found that older lesbian and bisexual women report higher rates of physical disability.²⁸ Research evidence also indicates that LGB people are more likely to be living with a disability than are their heterosexual counterparts and do so at younger ages.²⁹ Nearly half of LGBT older adults are living with a disability, with transgender older adults reporting particularly high rates.³⁰ Over a quarter of respondents to the 2015 U.S. Transgender Survey, who ranged from 18 to 87 in age, identified as a person with a disability.³¹ 39% of responders additionally met the ACS criteria for people with disabilities, compared to 15% of the general population.³² Nearly 1 in 10 also reported having social security and disability assistance as their only source of income.³³

For these reasons, the exclusion of LGBT older adults, in particular Objective 3.4 (“Maximize the independence, well-being, and health of older adults, people with disabilities, and their families and caregivers”), is troubling.³⁴ It is important that all older adults and all people living with disabilities are considered in HHS’ strategic plan.

- **Provide support for LGBT youth in need.**

We are concerned about the absence from the plan of language supporting the safety, well-being, and healthy development of children and youth, particularly vulnerable populations including LGBT youth. This language was present in prior HHS strategic plans. The absence of this language places LGBT children and youth in child welfare services at greater risk of not being placed with affirming families, or being subjected to harmful practices such as conversion therapy.

LGBT youth account for up to 40% of the homeless youth population.³⁵ Transgender youth are also disproportionately likely to be in the foster care system. A study found that 5.6% of Los Angeles youth in foster care identified as transgender and 11.1% identified as gender non-conforming.³⁶ This contrasts with 0.7% of American youth 13-17 overall identifying as transgender.³⁷ Studies of youth who “aged-out” of the foster care system without a permanent family found that only 58 percent of foster youth graduated high school by age 19, one in four were involved in the justice system within two years after

aging out of care, only 50 percent were employed by age 24, and 71 percent of young women were pregnant by age 21.³⁸ Other studies comparing children who remain in foster care to children who are adopted have shown that adopted children are 54 percent less likely to be delinquent or arrested, 19 percent less likely to become teen parents, and 76 percent more likely to be employed.³⁹

We are concerned that language in the plan to “affirmatively accommodate” religious beliefs could be utilized as a justification for HHS-funded adoption and foster care agencies in refusing to place children-in-care with otherwise qualified prospective parents based on those parents’ sexual orientation, gender identity, marital status, or religion. Such refusals could lead to increased harmful outcomes for youth served by child welfare services. HHS data show that in 2015, over 20,000 young people “aged out” of foster care (were emancipated) across the country, turning 18 without having found supportive, stable, permanent families.⁴⁰ As described in the paragraphs above, research demonstrates that these youths are at higher risk of increased involvement with the criminal justice system, unemployment, homelessness, and being trafficked.

We are also concerned about the Strategic Plan’s focus on success sequencing as a model to which young people should aspire and the absence of comprehensive sexuality education (CSE). Programs that incorporate elements of CSE have been shown to improve academic success; prevent child sexual abuse, dating violence, and bullying; help young people develop healthier relationships; delay sexual initiation; reduce unintended pregnancy, HIV, and other STIs; and reduce sexual health disparities among LGBT young people.⁴¹ Decades of research on sexual health education programs that include information on condoms and contraception—in addition to abstinence—have shown these programs to effectively delay sexual activity as well as increase condom and contraceptive use when young people do become sexually active.⁴² The strategic plan does not reflect this reality and instead borrows language and principles from ineffective and exclusionary abstinence-only-until-marriage programs. The success sequence asserts that people will reach middle class if they graduate high school, maintain a full-time job or have a partner who does, and have children after the age of 21, should they choose to become parents. This viewpoint is limited and narrow. Additionally, studies have shown that the sequence does not work because racial disparities are not solved only by greater individual responsibility.⁴³

While it is critical to assist youth develop healthy relationships, the narrow focus on relationships within the context of marriage in this plan is concerning. Healthy relationships exist across all spectrums of society and learning to communicate with peers, friends, adults, and coworkers in a respectful and healthy manner is critical to healthy development. Additionally, relationship education should incorporate content on how to recognize unhealthy relationships and address issues of consent, violence, and personal safety. We strongly recommend that the draft strategic plan expand the concept of healthy relationships to fully meet the needs of community members. In order for the health needs of young people to be fully addressed, they need to have life affirming and life-saving sexuality education. We strongly recommend that the draft HHS

strategic plan be revised to include comprehensive sexuality education that is inclusive and intersectional.

- **Support and fund research and data collection to better understand the health care needs of the LGBT community.**

The U.S. Department of Health and Human Services has already acknowledged the importance of collecting LGBT data, which makes the absence of any mention of this important goal concerning. The HHS LGBT Policy Coordinating Committee stated in their 2016 report that “there are many questions still left unanswered about LGBT health and human services, which is why improved data collection and coordination of research efforts will continue to be at the forefront of our efforts in this area.”⁴⁴ The report states that “collecting data [on sexual orientation and gender identity] and working with stakeholders on these issues will prove invaluable in informing the entire process [of minimizing barriers to access].”⁴⁵ LGBT Objective 1 for Healthy People 2020 is also to increase the amount of data collection instruments that include among their core questions gathering sexual orientation and gender identity data.⁴⁶

Developing high-quality data that more fully explore and facilitate understanding of LGBT health is essential if federal, state, local, and nongovernmental entities are to adequately and efficiently serve LGBT individuals and their families. For example, the absence of a question on gender identity in federal data collection instruments such as NHIS keeps invisible the experiences of the transgender community and leaves the federal government blind to the unique needs of this community. Similarly, the current wording of the sexual orientation question could lead some bisexual respondents to unintentionally misreport themselves as straight.

LGBT data collection has become an issue of pressing concern because the current administration has shown an intent to abandon it. For example, HHS proposed removing LGBT people from two critical surveys back in March, only restoring a sexual orientation question to one survey after a large outcry from the public.⁴⁷ The Census Bureau continues to exclude sexual orientation and gender identity from the American Community Survey, despite a clear programmatic need for such data collection.⁴⁸ Most recently, the Census Bureau planned to remove a sexual orientation question from the 2020 Census Barriers, Attitudes and Motivators Survey, deciding to keep it after drawing attention from advocates and legislators.⁴⁹ Accurate data collection on sexual orientation and gender identity allows us to understand the specific disparities facing the LGBT community, and sub-populations within it. Understanding disparities allows us to fully and appropriately advocate for specific policy changes to remedy those disparities.

Ensure respect for religious freedom does not undermine HHS’s obligation to protect people from discrimination and ensure equal treatment under the law for everyone.

The draft agency objectives include improving Americans’ access to health care, empowering people to make informed choices about their health, and strengthening the health care workforce to meet America’s diverse needs. Yet, several draft strategies could undermine these very

objectives and even cause people harm, especially women and LGBT people. These draft strategies call for HHS to “remove barriers” and “affirmatively accommodate” religious beliefs of persons or organizations that partner with the agency, including those that apply for grants or contracts to deliver services on behalf of HHS. In doing this, HHS must follow the October 6, 2017, Department of Justice guidance, titled “Federal Law Protections for Religious Liberty,” which sets out extreme interpretations of federal laws that govern religion, including the Religious Freedom Restoration Act (RFRA).⁵⁰ The guidance serves as a roadmap for using religion as a license to discriminate.

Under the guidance, for example, HHS contractors and grantees could claim a right to use a religious litmus test to decide whom they will serve within the agency-funded programs and which services they will provide, even if refusing to serve certain people or provide specified services conflicts with the law or the terms of the government grant or contract. As a result, organizations that partner with and get funding from HHS could claim a right to refuse to serve LGBT families or single mothers, or provide needed reproductive health care, gender-affirming care, PrEP, or counseling to interfaith couples or couples with a partner who is divorced.

HHS contractors and grantees could also claim a right to ignore bars against discrimination in hiring. A religiously affiliated organization could refuse to hire a doctor or nurse because she is the “wrong religion,” or is a single mother, which would violate their religious code of conduct.

These are just a few examples of the harm that could result from the draft strategies. In the end, these strategies will interfere with delivering evidence-based, quality medical services that meet the standard of care and with the patient-physician relationship by limiting the information, counseling, referral, and provision of critical services.

Religious freedom is a fundamental right, protected by our Constitution and federal law. It guarantees us all the right to believe (or not) as we see fit. But it doesn’t give anyone the right to use religion as an excuse to harm others. In fact, there have always been limits on the government’s ability to create religious and moral exemptions like those envisaged under these strategies. Under the Constitution, no exemption can impose burdens on third parties or override other significant interests. Nor may the government allow contractors or grantees the right to refuse to provide services, which amounts to imposing their beliefs on others. HHS must not create exemptions that have a harmful, discriminatory impact on others.

Religiously affiliated institutions historically have played an important role in addressing many of our nation’s most pressing social needs, as a complement to government-funded programs. However, effective government collaboration with faith-based groups does not require the sanctioning of taxpayer-funded religious discrimination or sweeping exemptions that result in denial of key services that the strategies propose. Thus, the draft Strategic Plan’s substantial emphasis on partnerships with faith-based organizations raises serious concerns.

Address Racial and Ethnic Health Disparities

While we appreciate the numerous references to addressing health and health care disparities, including those experienced by limited English proficiency persons, we note that there is a

concerning lack of reference to the distinct disparities that racial and ethnic minority populations, in particular, experience. Each year, approximately 83,000 African Americans die as a result of health disparities.⁵¹ Health disparities are caused by a multitude of factors and impacted by race, ethnicity, sex, immigration, and primary language, among others. This is one reason the HHS Office of Minority Health (OMH), Centers for Medicare & Medicaid Services Office of Minority Health and numerous other OMH divisions within HHS serve critical roles in supporting HHS' Strategic Plan. Racial disparities are particularly pronounced in reproductive and sexual health. Women of color fare worse than do white women in every aspect of reproductive health.⁵² Nearly all non-white racial and ethnic groups contract STIs at much higher rates than the majority white population.⁵³ Together, African American women and Latinas account for 80% of reported female HIV/AIDS diagnoses, even though they represent only 25% of the U.S. female population.⁵⁴ And while women of color are much more likely to die of cervical cancer than are white women, with the exception of African American women, they are less likely to receive regular Pap smears, a critical screening mechanism.⁵⁵

Racial and ethnic minority populations, including Asian Americans (AA) and Native Hawaiian Pacific Islanders (NHPI), disproportionately experience a number of chronic conditions due to factors including poverty, inability to afford quality coverage, and challenges accessing culturally competent care, among others. The AA and NHPI community speaks over 100 different languages and traces their heritage to more than 50 different countries.⁵⁶ As of 2016, 11% of AAs and 23% of NHPI families live below the poverty line.⁵⁷ Language barriers, lack of cultural competency, poverty, and immigration status all affect the ability of AAs and NHPIs to access coverage and care.⁵⁸

It is for these reasons that we strongly recommend that the Draft Strategic Plan be revised to explicitly reference disparities amongst racial and ethnic minority populations. Including more explicit references to racial and ethnic minority populations is consistent with numerous federal efforts including the HHS Action Plan to Reduce Racial and Ethnic Disparities, the first CMS Equity Plan for Improving Quality in Medicare, and the 2016 National Health Care Quality and Disparities Report from the Agency for Healthcare Research and Quality. Failure to include more references to the disparities that racial and ethnic minority populations in particular experience is a marked departure from the 2014-2018 HHS Strategic Plan. HHS should build on previous efforts using them as a foundation for furthering the elimination of disparities.

Conclusion

In conclusion, we wish to reiterate that “enhanc[ing] the health and well-being of Americans” includes LGBT Americans.⁵⁹ This vulnerable and marginalized community must not be erased. We urge you to consider the aforementioned issues in revising and finalizing your strategic plan.

Signed:

A Better Balance
Advocates for Youth
AIDS United
American Civil Liberties Union

Asian & Pacific Islander American Health Forum
Bend the Arc Jewish Action
Center for American Progress
CenterLink: The Community of LGBT Centers
Equality California
Family Equality Council
FORGE
GLMA: Health Professionals Advancing LGBT Equality
GLSEN
HealthHIV
HIV Medicine Association
Human Rights Campaign
International Association of Forensic Nurses
Lambda Legal
Los Angeles LGBT Center
Mazzoni Center
Movement Advancement Project
NASTAD
National Black Justice Coalition
National Center for Lesbian Rights
National Center for Transgender Equality
National Coalition for LGBT Health
National Health Law Program
National Latina Institute for Reproductive Health
National LGBTQ Task Force
National Partnership for Women & Families
Positive Women's Network-USA
SAGE
Sexuality Information and Education Council of the United States
Transgender Law Center
Trevor Project
True Colors Fund
Union for Reform Judaism
URGE: Unite for Reproductive & Gender Equity
Whitman-Walker Health
Witness to Mass Incarceration

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- ¹⁸ These services include cancer treatment or prevention, or reconstructive surgery following an injury. For more information about common misconceptions about health coverage for transgender individuals, see: Kellan Baker and Andrew Cray, “[Why Gender Identity Nondiscrimination in Insurance Makes Sense](#)” (Washington: Center for American Progress, 2013), available at <https://www.americanprogress.org/issues/lgbt/reports/2013/05/02/62214/why-gender-identity-nondiscrimination-in-insurance-makes-sense/>.
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